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WIN

INMO
Journal of the
Irish Nurses and
Midwives Organisation

World of Irish Nursing & Midwifery

Latest INMO CPD education programme
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Celebrating nurses and midwives
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Disability: The importance of social inclusion
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Yoga to alleviate back problems
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INMO calls for agreements to be implemented

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On the cover this month: Karen McGowan, INMO president and ED nurse
Photo: Collins Photo Agency

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Breastfeeding: The best start

Health benefits for infants

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

Long-term benefits for children

Beyond the immediate benefits for children, breastfeeding contributes to a lifetime of good health. Adolescents and adults who were breastfed as babies are less likely to be overweight or obese. They are less likely to develop type 2 diabetes and perform better in intelligence tests.

Benefits for mothers

Breastfeeding also benefits mothers. It reduces risks of breast and ovarian cancer later in life, helps women return to their pre-pregnancy weight faster, and lowers rates of obesity.

Support for mothers is essential

Breastfeeding has to be learned and many women encounter difficulties at the beginning. Nipple pain, and fear that there is not enough milk to sustain the baby are common. Health facilities that support breastfeeding – by making trained breast-feeding counsellors available to new mothers – encourage higher rates of breastfeeding. To provide this support and improve care for mothers and newborns, there are 'baby-friendly' facilities in about 152 countries thanks to the WHO-UNICEF Baby-friendly Hospital initiative.

Work and breastfeeding

Many mothers who return to work abandon breastfeeding partially or completely because they do not have sufficient time, or a place to breastfeed, express and store their milk. Mothers need a safe, clean and private place in or near their workplace to continue breastfeeding. Enabling conditions at work, such as paid maternity leave, part-time work arrangements, on-site crèches, facilities for expressing and storing breast milk, and breastfeeding breaks, can help.

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For more information log onto www.breastfeeding.ie

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Reports must now be acted on

AS OUR ADC approaches, we are focused on completing the implementation of agreements arising from the work of the INMO on behalf of members over the past year. One major piece of work that was agreed as part of the strike settlement in 2019 was the establishment of an Expert Review Body on Nursing and Midwifery.

This group was set up following a recommendation from the Labour Court with the purpose of carrying out an extensive examination of the nursing and midwifery professions. The review group was also tasked with addressing a number of the longstanding claims relating to nurse and midwife managers which the INMO had been pursuing during the 2019 strike.

The Review Body has been carrying out its work for almost two years and finally published its report on March 29. On behalf of our members, I would like to thank the members of the Body, particularly ICTU general secretary Patricia King.

The Expert Review Report made recommendations in relation to the future of nursing and midwifery in Ireland, dealing with issues such as undergraduate and postgraduate education and development, digital health, nursing and midwifery workforce planning and management, and leadership and governance. The most pertinent recommendations to our members deal with grades and structures arising from the Labour Court recommendation, which include:

- As previously notified, module 1 of the Body's work recommended payment of 3.28% to nurse/midwife managers to address the pay differential created as a result of the introduction of the enhanced nurse/midwife scale in 2019, following the INMO strike. As nurse and midwife managers know this matter is the subject of intensive dialogue within the sectoral bargaining process under Building Momentum
- The reconfiguration of the group chief director of nursing and midwifery role to that of executive nurse/midwife lead level in each regional health area
- Increase of the salary of the director of nursing grade in each of the nine Model 4 hospitals to that of the area director of nursing for mental health
- Discontinuation of the hospital banding system. A new system for determining director of nursing/midwifery and assistant director of nursing/midwifery grading to be agreed between the parties that will take account of revised roles, scope and responsibility in the context of Sláintecare
- The PHN salary scale to be merged/aligned with that of the CNM2/CMM2 salary scale
- Extend the revised PHN/CNM2/CMM2 salary scale by the addition of one further scale point and the introduction of a long service increment
- The extension of the specialist qualification and location allowance to be paid to CNM3s and CMM3s
- Nurses and midwives to be represented on the most senior HSE operational decision-making forums to ensure their input in the strategic direction of the health services.

The Minister and HSE must act on this report. It is paramount to the future of Irish healthcare and ensuring that nurses and midwives remain in the system and central to its development and organisation.

The recommendation that working hours in the public service should be restored to pre-Haddington Road Agreement levels from July 1, 2022 has been agreed by government, which has directed the Minister for Health to engage with healthcare unions. One of the main reasons why our members endorsed the latest public sector pay agreement, Building Momentum, was because of the commitment to reverse the Haddington Road hours. Nothing short of full implementation of the reversal will be acceptable. The INMO has advised government of this.

These issues and many more will be debated at the ADC in Sligo. We're looking forward to seeing delegates in person again where we can chart a better future forward together that recognises and rewards members of our profession.

Phil Ní Sheaghdha
General Secretary, INMO

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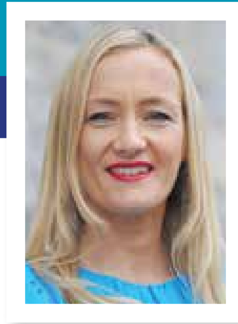
A positive focus
with the president

Karen McGowan, INMO president



Anticipating ADC 2022

IT IS very exciting to have our in-person annual delegate conference (ADC) back this year. Experience and connectivity in our profession is necessary and promotes the strength that is there by being part of this union. I would like to welcome the new and existing members to the Executive Council. The past term was a very challenging one. I would like to thank those members of the Council who have finished their terms. It was a pleasure to serve alongside them all over the past two years. The knowledge and commitment shown was exceptional. I recently had the pleasure of opening the Sláintecare webinar and chairing two panel discussions. The first session was on menopause in the workplace which had input from entrepreneur and former nurse Norah Casey. The second session discussed the lessons learned from Covid-19 with great input from delegates in person and online.

The ANP role on the frail intervention team

THIS month I spoke with Carol Lyons, an advanced nurse practitioner (ANP) in falls and frailty in the older adult. This is a key role within the FIT (Frail Intervention Team) team in Beaumont Hospital, Dublin. This role is emergency department based and the FIT team is made up of multidisciplinary health professionals.

Ms Lyons qualified in 1997 and has considerable experience in cardiology, surgery and gerontology. Having been a CNM2 for 12 years, an opportunity to become an ANP arose with the national clinical care programme for older adults, which she jumped at.

Carol Lyons, advanced nurse practitioner in falls and frailty in the older adult at Beaumont Hospital in Dublin

Ms Lyons told *WIN* that having a nursing voice on the FIT team is instrumental to the overall plan of care for these patients, who are over the age of 75. The value of having her on the team really showed once Ms Lyons came to ED.

"The process of assessing these patients is more in depth and enhances the therapies that are available within the FIT team. There was a need to reduce the length of stay and waiting lists, but we also need to be vigilant while these patients are in ED as delirium has increasingly detrimental effects the longer they stay in ED," Ms Lyons said.

She runs a clinic once a week to follow up on patients who were seen in ED. The clinic is divided between a falls clinic in the morning and a general gerontology clinic in the afternoon.

Ms Lyons feels that her role is most effective in the emergency care setting and she is very proud to be bringing a ward-care approach to the ED. She explained that there had been a need to implement change and it had meant a lot to her to be able to do that.

"It is a great experience to be leading out as the nurse on this team and I'm also involved with educating nurses undertaking their postgraduate diplomas," she said.

This role has invigorated her passion and skillset. She is passionate about nursing and, as someone who thought she would always stay on the ward, she encourages others to not fear change.

Her vision is for further developments in the evolution of the FIT. There is a plan for an ED consultant geriatrician to join them and she believes there is also a need to increase the number of ANPs on the team.

Executive Council update

THE Executive Council met on April 4 and 5 in what was one of its final meetings ahead of annual delegate conference, after which a new Executive Council will take over. I can assure you that the role of the Executive Council member is taken very seriously. Each seat is represented by articulate and diligent nurses and midwives. Our monthly meetings are vital to ensure debate is had on all agenda items. Members of the Council are available for emergency meetings to discuss issues that arise. Decisions are made as a collective.

The enhanced practice scale, the pandemic bonus, the hours body and the expert review group are all evidence that the INMO is working for you. These gains are from the ongoing engagement of the Executive Council and INMO management. The general secretary and the management team work tirelessly for members and I thank them most sincerely for that on behalf of the officers and Executive Council members.

I am very proud of the outgoing members of the Executive as they leave a wonderful legacy of how the Council works for members. There is unfinished business and as president I will lead discussions on the outstanding issues with the incoming Executive Council. As with anything in industrial relations, it's about a collective approach and keeping pressure on those we are negotiating with.

The new Executive Council will meet and gel together as part of a new team in order to continue the work that is required. It is a wonderful opportunity and an honour to be a representative for your area of work and to be their voice at the table. *Go raibh míle maith agaibh*.

Get in touch

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

Public health measures need to be reintroduced urgently

CONCERNED at the high rates of hospital admissions due to Covid-19 caused by the higher rates of infection in the community, the INMO and Irish Association for Emergency Medicine came together last month to call for government assistance to curb the spread of Covid-19. This came as more than 10,000 patients had been without a bed since the mask mandate was lifted on February 28 and at a time when over 1,600 patients were in hospital with Covid-19.

The INMO, representing nurses in EDs and overcrowded wards, and the Irish Association for Emergency Medicine, representing ED doctors, said that hospitals are overwhelmed and staff need real assistance.

In addition to the serious patient risks, there are significant risks for frontline staff who are now exhausted, dealing with wave-upon-wave of patients diagnosed with Covid-19 as well as other drivers of increased attendances, including a significant increase in acute mental health emergencies and increased paediatric admissions.

The two bodies called on government, public health officials and HSE senior management to take action and reintroduce public health measures, particularly the simple ones of mask-wearing in indoor and congregated settings, and working from home.

According to HPSC figures:

- 89,432 of the pandemic's total 1,442,877 cases had occurred within the two weeks prior to March 27, meaning that 6.2% of Covid infections occurred in approximately 1-2% of the pandemic's timeframe
- 58% of all Covid-19 deaths in Ireland have been linked to outbreaks, with more than 90% of those linked to outbreaks in healthcare facilities.

INMO general secretary Phil Ní Sheaghdha: "Hospitals are currently not safe for patients or for staff because of the level of overcrowding and Covid infection levels"

INMO president Karen McGowan: "Our members currently feel like they are getting no support and are being left to deal with the worst of this virus by themselves"

Irish Association for Emergency Medicine president Fergal Hickey: "Our hospitals have been hanging together by a thread of goodwill of staff but that is about to snap"

INMO general secretary Phil Ní Sheaghdha said: "The INMO and our colleagues in the Irish Association for Emergency Medicine have come together to call on the government and public health teams to review measures ahead of the peak of the latest wave of the Covid virus. Wearing masks and working from home will assist, they will not stop the spread, but have and will reduce intensity of infection and reduce cross infection. Mandating these measures is now a matter of urgency.

"Predictable overcrowding in winter, mixed with higher community spread of an airborne contagious infection means decision-makers are not in the dark. Abandoning our public acute hospitals is a decision that government cannot make, this would be the wrong decision for patients and the wrong one for staff.

"Hospitals are currently not safe for patients or for staff because of the level of overcrowding and Covid-19 infection levels. We need clear and coherent public health advice from government and senior public health officials. The public need to be made aware of why we need them to once again step up to the plate in order to protect those who are working on our frontlines."

INMO president Karen McGowan, who is an ED nurse, said: "When senior clinicians from a medical and nursing perspective sound the alarm to this extent someone must stop and pay attention. Between our two organisations we have been calling on government and senior public health officials to act when it comes to implementing public health advice.

"Our members currently feel like they are getting no support and are being left to deal with the worst of this virus by themselves. If staff are saying this is how unsafe it is, people cannot remain silent. The government cannot put their heads in the sand, Covid-19 is still such a dangerous and highly transmissible virus that over 1,600 in hospitals are infected with it. Our members feel like they have been thrown to the wolves. They were already burned out after two years of Covid but now we are back to serious hospital overcrowding. Not only do we have record overcrowding, we will have record levels of staff out sick from Covid-19.

Irish Association for Emergency Medicine president Fergal Hickey said: "The situation in Irish hospitals at present is the worst that many of my colleagues and I have seen in our careers – it is intolerable for all who work in hospitals. Our hospitals have been hanging together by a thread of goodwill of staff but that is about to snap.

"The problem of overcrowding at this level is not a new phenomenon in our hospitals. Medical professionals have been sounding the alarm for a long time now. Immediate stronger public health measures are needed – not doing so and abandoning the hospitals to the inevitable will lead to preventable unnecessary higher levels of illness requiring hospital admission and, sadly, for some a fatal outcome. Hospitals are currently not safe for patients or for staff because of the level of overcrowding and Covid-19 infection levels.

"It has been repeatedly and robustly proven over recent decades that ED crowding results in an excess 30-day mortality for all patients and recently published UK research confirms that delay to admission is, of itself, a cause of avoidable mortality to the patient subjected to this long wait, irrespective of overall levels of crowding."

HSE called out for using pandemic as excuse to not publish reports

THE HSE cannot hide behind Covid-19 as a reason not to publish independent reports into the health service, the INMO said last month, following the need for a Freedom of Information Request to release the Independent Review of Unscheduled Care Performance.

INMO general secretary Phil Ní Sheaghdha said: "Organisations such as the Irish Patient's Association should not have to get important reports such as the Independent Review of Unscheduled Care Performance through Freedom of Information request.

"It has been an extremely challenging two years for the health service on the back of several record-breaking winters in succession. It is not good enough for the HSE to deem Covid as a reason not to publish independent reviews into our health service.

"Hospital overcrowding will always be a relevant issue to our members. Since the chief operations officer wrote that Covid has deemed an independent review into overcrowding into nine of our most overcrowded hospitals in the country as not relevant, over 106,813 patients have been without a bed in Irish hospitals.

"The results of this review are particularly damning when it comes to the times patients were waiting to be admitted to our emergency departments, with patients waiting nearly 17 hours in Galway University Hospital. We know that if a patient is on a trolley for more than five hours it can have a significant detrimental impact on their health and indeed their mortality.

"Covid has made the recommendations in this independent review even more pertinent, with the authors of the report calling for a review of infection prevention and control measures to be carried out. This was a problem pre-Covid and one we are facing now in extremely overcrowded hospitals where Covid-19 infections rates are high and the practice of placing 'any bed, anywhere, anytime' continues despite the clear consequences for patients and staff.

"Reports such as these cannot be written off as unimportant or irrelevant because of Covid, in fact they should be viewed as even more important due to the implications of Covid-19 on overcrowded hospital environments.

"Hospital overcrowding is a real feature in our hospitals and one that the INMO has been sounding the alarm on for far too long. The INMO has been calling for independent reviews into different hospitals when our hospitals have been at their worst when it comes to overcrowding during the pandemic and yet this report has been gathering dust."

The 'Independent Review of Unscheduled Care Performance' made 30 recommendations and was carried out in late 2019 under Prof Frank Keane, former president of the Royal College of Surgeons Ireland.

March hospital overcrowding worst on record

MARCH 2022 recorded the worst for hospital overcrowding for the month of March since the INMO began counting trolley numbers in 2006. In the first quarter of 2022, 29,506 admitted patients were left without a bed, including 11,001 in the month of March.

The most overcrowded hospitals of March 2022 include:

- University Hospital Limerick – 1,671 patients
- University Hospital Galway – 947 patients
- Letterkenny University Hospital – 781 patients
- Cork University Hospital – 735 patients
- St Vincent's University Hospital – 699 patients.

INMO general secretary, Phil Ní Sheaghdha said: "When nurses and midwives use phrases like 'out of control' and 'chaotic' to describe hospital overcrowding we do not do so lightly. It has been the worst March for overcrowding since our union began counting trolleys in 2006 with 11,001 without beds.

"It was an extremely busy month for those working in our hospitals with over 37% of those who have been on trolleys since the beginning of 2022 presenting to our hospitals in March.

"Hospitals are currently not safe for patients or for staff because of the level of overcrowding and Covid-19 infection levels. We need clear and coherent public health advice from government and senior public health officials. The public need to be made aware of why we need them to once again step up to the plate in order to protect those who are working on our frontlines."

Cork – out of control

In the case of Cork, INMO members reported that overcrowding in the city was out of control. This came on a day that saw 76 patients without a bed in the city, with 53 on trolleys in Cork University Hospital and 23 on trolleys in the Mercy University Hospital.

INMO IRO Liam Conway said: "The number of patients for whom there are no beds in the two acute hospitals in Cork city is out of control. Our members are exhausted and completely burned out. It's not sustainable and the fact is we will see dedicated staff who have worked through the pandemic, walking out of their jobs if this situation isn't taken seriously. It's absolutely crucial that the HSE works with us now to prevent that happening.

"We need both the government and South/SouthWest Hospital Group to tackle the issue of capacity and discharge facilities for complex discharges and delayed discharges across Cork city and county. The issue is that the admission rates remain significantly higher than the discharge rates.

"Cork South Central, in which both hospitals are located, is well represented at the Cabinet table. The concerns of our members must be dealt with. Government must take action in the short and medium term.

"On the back of the recent Emergency Department Taskforce meeting, INMO members in Cork want to see public health measures reintroduced in order to support frontline services which are under extreme pressure. Action must be urgently taken to mitigate the levels of pressure that our nursing and midwifery workforce are under in Cork City."

INMO director of industrial relations Albert Murphy updates members

Pandemic payment – who is eligible?

AFTER weeks of negotiations with our union, the HSE has finally issued a circular in regards to the Pandemic Special Recognition Payment.

As we are currently back in the throes of Covid-19, the INMO and other healthcare unions believe that the date to be eligible for this payment must be extended to take stock of current circumstances.

Proposals from the HSE have not addressed the issue of the inclusion of those working in private hospitals and general practices.

We will continue to press for these matters to be dealt with outside of this process through the industrial mechanisms of the state.

At the time of going to print, the Department of Health has yet to publish details on how payment will be administrated.

The full value of the pandemic payment is worth €1,000, free of all taxes. Eligible employees must have been employed between March 1, 2020 and June 30, 2021 and have been identified as working in Covid-19-exposed healthcare environments. For part-time employees, the payment will be paid pro rata on the following basis:

- Employees whose contracted hours are ≥ 60% WTE for their grade shall receive €1,000
- Employees whose contracted hours are ≤ 60% WTE for their grade shall receive €600.

Employees who worked less than four weeks in the specified period are not included.

The following questions and answers will be useful to HSE/Section 38 employees.

Who is eligible?

Employees who, between March 1, 2020 and June 30, 2021, worked in an environment which warranted their inclusion in Sequence Group 1 and 2 for the vaccination programme. This only applies to those directly employed by the HSE or Section 38 agencies and those eligible in vaccination and testing centres. (For other healthcare workers covered by the government decision, information will be circulated when available).

How is an employee who was out on long-Covid treated in the context of minimum period?

Eligible employees (including those eligible employees who may be on sick leave with Covid-19 within the eligibility period) who worked within the period whose contracted hours meet the four-week threshold should be given the payment.

If an eligible employee worked for a number of employers during the period, are they entitled to more than one payment?

No. Employees are only entitled to one Recognition Payment.

Do employees/trainees have to apply for the payment?

For eligible employees working throughout the specified period, no application is required. Service managers, at site location level, must identify and verify the staff within scope to their own payroll departments, via the normal channels, as a net payment, using the short-term payments process, normally used. Upon acceptance of the payment, the employee confirms their agreement to the full terms and conditions that apply.

However, eligible employees who commenced work during the period or moved jobs during the period in scope must complete the declaration form. Trainees, such as supernumerary nursing/midwifery students, must complete the declaration form and submit it by June 30, 2022

Is the payment taxable or subject to other statutory deductions?

The Recognition Payment is paid tax free and is not subject to other deductions.

Is the payment pensionable?

The Recognition Payment is non-pensionable.

Is the payment payable to staff working from home?

The Recognition Payment only applies where an employee was working in the eligible environment during the period March 1, 2020 to June 30, 2021. This environment does not include an employee's home.

Is the payment payable to students or Interns?

Yes. Students (e.g. supernumerary students) and intern staff are entitled to recognition for periods they worked/trained in a Covid-19 exposed environment.

Is the payment payable to retirees, new starters, leavers and redeployed staff?

Yes. Retirees, new starters, leavers and redeployed staff are entitled to recognition for periods they worked, subject to the minimum threshold.

Any staff member who has left HSE or Section 38 employment, but is within scope, will be required to make contact with the HSE/Section 38 area to provide the necessary details, including the completion of any forms required to change personal details such as bank accounts etc, required to action payment. They must also sign the declaration. This must be submitted by June 30, 2022.

Appeals and resolution

Disputes involving interpretation of this Circular or disputes affecting groups of workers will be referred to an agreed joint management/union resolution procedure. All appeals must be submitted by August 31, 2022. No appeals will be considered, if submitted after this date. The outcome of the appeal process will be full and final.

As the INMO receives further information on the Pandemic Payment, members will be notified via email. If any member has further questions on the pandemic payment, please don't hesitate to contact your local INMO rep.

Is your INMO membership up to date?

Important message from the INMO

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

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

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

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

on recent national issues

Changing roles

ALBERT MURPHY has been appointed INMO director of industrial relations as part of the union's reorganisation of areas of responsibility following the retirement of Dave Hughes as deputy general secretary in January.

Mr Murphy has been a member of the INMO industrial relations team for more than 14 years, starting in January 2008 as IRO for several Dublin hospitals, including Mater Misericordiae, Mater Private and Bon Secours, Glasnevin.

In 2014 he added the role of organiser to his areas of responsibility, when he was charged with leading the development of enhanced workplace structures in large hospitals.

He became assistant director of IR in 2019 for the Dublin North East region.

See full interview in next month's issue of WIN

Restoration of pre-HRA hours expected by July 1

THE INMO has welcomed the government decision to implement the hours body recommendation that the working time in the public service should be restored to pre-Haddington Road Agreement levels from July 1, 2022.

In January 2022, the Independent Body Examining Additional Working Hours chaired by Kieran Mulvey sent recommendations on working hours for civil and public servants to the Minister for Public Expenditure and Reform.

The INMO would like to thank all the members of the hours body including the chair Kieran Mulvey and trade union nominees Liam Doran and Peter McLoone for their invaluable contribution in producing the hours body report.

The recommendation by the independently chaired hours body and subsequent decision by government is one that will benefit the retention of nurses and midwives.

The Haddington Road hours have disproportionately impacted the largely female workforce within our professions. The additional hours have pushed many nurses and midwives into part-time work due to the additional pressure that was put on caring responsibilities.

We know that since 2013 the additional unpaid hours have had a considerable negative impact on morale, and the retention of nurses and midwives within the public health service.

The INMO has already written to HSE regarding reinstatement of pre HRA rosters from July 1, 2022.

In remembrance of colleagues who lost their lives in the workplace

THE INMO, as a member of the Irish Congress of Trade Unions, marks Workers' Memorial Day on April 28 every year to honour and remember those who have died in the workplace.

The INMO was represented at an event in the Garden of Remembrance on April 28 at the Garden of Remembrance with Minister Damien English, the Irish Congress of Trade Unions, the Health and Safety Authority and IBEC.

In Ireland in the 10 year period between 2012 and 2021, 481 people were killed in work-related incidents and many thousands more were severely injured or made ill. In addition to these official figures, we have lost many more frontline workers to Covid-19 over the past two years. In 2021, 38 people were killed in workplace accidents.

These are unacceptable figures which can be reduced through a combined and intensified effort by all concerned. By working together and promoting the practice of safety and health in workplaces throughout Ireland, we will achieve a significant drop in these dreadful numbers. We all have a responsibility to make sure that happens.

World news

Nurses and midwives in action around the world

Australia
- Nurses union calls for an urgent inquiry into assaults on staff at mental health unit
- Stop telling us to cope: local nurses join strike, but can only walk away for one hour

Brazil
- Nurses protest for better wages

Canada
- Nurses short-staffed and frustrated as pandemic drags on
- Almost 60% of nurses considered leaving profession in past year, survey shows

Paraguay
- More than 2,000 unemployed nurses in Paraguay

Portugal
- Nurses complain of non-payment of overtime and work exhaustion

Spain
- Nurse union asks for the approval of the Healthcare Worker Anti-Aggression Law as soon as possible
- Union warns about the lack of midwives, which will cause "collapse"
- Union warns that the 10% increase in nursing degree places is "insufficient" in some communities

UK
- NHS staffing crisis is jeopardising patients' safe care, say nurses
- 'Undervalued and underresourced' - nursing union hits out over unfilled roles

US
- Nurses join strike to demand better hospital staffing

UHL theatre nurses vote for action over breaches of Working Time Act

THEATRE nurses at University Hospital Limerick have voted 100% in favour of industrial action due to the ongoing breaches of the Organisation of Working Time Act, 1997 in relation to compensatory rest time following call outs during on-call at weekends.

On behalf of members, the INMO has put a final proposal to management seeking additional theatre nurses on shifts to ensure compliance with the law however the union had not received a formal response or any management proposals at the time of going to press.

Mary Fogarty, INMO assistant director of IR: "Additional nurses are needed on shifts to ensure compliance with the Organisation of Working Time Act, 1997"

In tandem with this dispute is the continuous overscheduling of elective theatre lists causing delays in nurses being able to go off duty.

The Workplace Relations Commission has engaged the parties in this specific matter but the proposals emanating from management were not acceptable.

Location allowance for paediatrics HDU

Meanwhile, the INMO has written yet again to UHL management regarding the outstanding claim for the payment of the location allowance to nurses working in the paediatric high dependency unit at the hospital.

The payments due to INMO members are covered under national agreements since 1999 and the delay in resolving the matter is unacceptable.

If the claim remains unresolved, the union will proceed to refer the matter to the WRC in the near future.

– Mary Fogarty, INMO assistant director of IR

Merlin Park older person services reconfigured ahead of expansion

OLDER person services at Merlin Park CNU are being reconfigured pending the completion of a new facility to be built on the hospital grounds.

The reconfiguration aims to designate units 5 and 6 of the community nursing unit into separate long-stay and short-stay units, with the aim of increasing intermediate and respite capacity and alleviating pressures on the acute system.

In advance of the new build approved for older person services on the Merlin Park Hospital grounds, all staff and residents with their families recently met with the general manager of older persons services to discuss proposals to reconfigure the two nursing units within the CNU.

Subsequently management requested engagement with the unions on reconfiguration of the current 52-bed CNU facility, which has 26 in each of unit 5 and unit 6. The units currently have low occupancy and management said the review was in the best interests of patient care, infection prevention and control measures, and safe staffing.

The units are being reconfigured into one 26-bed long-stay unit (unit 5) and one 26-bed short-stay unit (unit 6). With more single occupancy rooms, unit 6 was considered the most appropriate unit for short stay, and will have 13 intermediate care beds and 13 respite beds.

Meeting with management took place to discuss staffing of both units, safety concerns, accommodations and clerical cover.

The short-stay unit was due to begin accepting patients late last month and the long-stay unit has begun the phased process of moving residents to their new unit.

The INMO was advised of a requirement to recruit four additional nurses for the short-stay unit, two of whom were going through recruitment process as we went to press.

– Karen Liston, INMO IRE

Holiday premiums at Milford

THE INMO has lodged a query with management of Milford Care Centre regarding the payment of holiday premium to staff working in the service.

In accordance with the Organisation of Working Time Act 1997, a holiday premium is payable to an employee who does not have a fixed salary each week.

When a staff member is on annual leave they should receive their normal pay, including premium earnings they would receive ordinarily when working, rather than just their basic pay.

The average earning is calculated over a 13-week reference period, ending immediately before taking the annual leave.

We will keep members updated once a response from HR is received.

– Karen Liston, IRO IRE

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

Hospital discharges failing to keep up with admissions

INMO members in Beaumont Hospital once again called on hospital management to advise the general public to avoid attending its emergency department and seek other care pathways ahead of the Easter weekend last month.

This came on a day when the hospital yet again saw high levels of overcrowding with as many of 20 admitted patients being cared for on trolleys.

Speaking ahead of the holiday period, INMO president Karen McGowan, who is an ANP in Beaumont emergency department (ED), said: "Overcrowding in our EDs is predictable over any public holiday period. Every effort must be made by the hospital to create extra capacity during such periods.

"Colleagues in Beaumont are under severe pressure. It is time for management to intervene and seek the assistance of private hospitals in the area and to advise local GPs of the serious level of overcrowding.

INMO IRO Maurice Sheehan added: "The level of overcrowding in Beaumont is extremely concerning. We received reports from Beaumont that 20 patients in ED had already been admitted without being placed in beds and all extra capacity was being used. The ED was at full capacity with nurses struggling with overflows of patients who have been admitted.

"The discharge rates in Beaumont are not keeping up with the admission rates. The union has called for a more focused approach to patient discharge and more frequent consultant-led ward rounds focused on discharging patients. On top of this, the ED is also understaffed at present.

"INMO members in Beaumont are calling on hospital management to call on the public to use other avenues such as GPs, minor and rapid injury clinics and if necessary other EDs in the city."

INMO haemovigilance officers gain equality with med science colleagues

INMO members across the country who are working as haemovigilance officers have voted overwhelmingly to accept the WRC proposal secured by the INMO for significant pay increases and equal pay with their colleagues at senior medical scientist grade.

This will be worth over €9,000 for those at the top point of a new pay scale, as well as a reduction in the working week to 37 hours and an increase in annual leave to 29 days per annum.

Terms and conditions for all haemovigilance officers have now been standardised and INMO members will now have equality between them and their counterparts across the country surrounding pay and terms and conditions of employment.

The INMO notified the HSE of the acceptance of the proposals. The HSE has since confirmed that it is engaging with the acute hospitals on immediate implementation of the agreement.

Under the agreement, a new pay scale for the role of haemovigilance officer is being created equating to that of senior medical scientist (9-point higher scale).

CNM2s will now move on to this new scale, with retrospection to January 1, 2021. Members will move to the nearest point but not below existing salary plus one increment. They will move up a further increment with effect from January 1, 2022.

– Liam Conway, INMO IRO

Long-time INMO rep for Louth County stands down

LONGSTANDING INMO rep for Louth County, Colette Vize, is standing down from her position for health reasons. In recognition for her dedication and hard work on behalf of members and the INMO over several years, she was presented with a bouquet of flowers from Louth County members. Ms Vize will continue to support and share her invaluable experience with her colleague Emma Ross, INMO rep Louth County. INMO IRE Karen Clarke extended the INMO's gratitude to Ms Vize for all her support and commitment to the Organisation over the years.

South/South West

Custom and practice

'CUSTOM and practice' came into play for a large acute hospital within the Southern region ahead of Good Friday regarding service and rostering arrangements.

The INMO's success assured that 'custom and practice' was maintained and that the service did not run where staff had already been rostered off for Good Friday in line with the custom and practice within the department. The INMO successfully ensured that this remained a day off for members in 2022.

Cork and Kerry acute hospitals

THE INMO secured payment dates for the overtime arrangements under the WRC agreement across Cork and Kerry acute hospitals last month. In addition, payment dates have been sought for the final implementation of meal breaks under this agreement.

Nazareth House Mallow

INMO members working at Nazareth House, Mallow, are to be balloted on pay proposals secured by the INMO following negotiations with the employer.

This would see an increase in basic pay and maintain the alignment to public sector pay rates for members working in this 120-bed residential care home.

In addition, an increase in allowances is incorporated into these proposals.

Members were set to ballot on these proposals as we went to press.

– Liam Conway, INMO IRO

Health impact of climate crisis exposes need for investment in nursing

THE inextricable link between human health and the environment was the focus of this year's World Health Day, for which the chosen theme was 'Our Planet, Our Health'.

The International Council of Nurses (ICN) joined the World Health Organization (WHO) in marking the global awareness day, which is celebrated on April 7 each year.

The realities of global warming, coupled with the pandemic and the dire geopolitical situations that exists in many parts of the world, highlight that the need for investment in nursing and healthcare generally has never been greater.

Just as health can never be taken for granted, we cannot ignore the powerful impact nurses and midwives can make to mitigate climate change and to support people and communities around the world to adapt to its effects.

Outlining the impact global warming has had on health, ICN president Pamela Cipriano said: "Nurses are witnessing first-hand the effects of climate change on people's health, including worsening respiratory conditions, the effects of extreme heat, disruption in food sources and increased deaths in children under five from diarrhoeal disease because of a lack of access to safe water supplies.

"Its effects are felt around the world, but most keenly by people in lower income countries, another example of the gross health inequalities that must be addressed."

Dr Cipriano continued: "We need to reset our health systems with a massive expansion in the size of the nursing workforce, and investment in nursing education, jobs and leadership so that more nurses are in a position to influence the big picture of changes that are needed. Nurses are ready to make their contribution, but if we are to avert a catastrophic global climate crisis, governments need to seriously act on the commitments they made at the COP26 meeting last year and elsewhere."

ICN chief executive Howard Catton added: "We know the pandemic and the tense geopolitical situations around the world mean it is harder for governments to invest in combating global warming and also, importantly, in nursing and healthcare more generally.

"We agree with the WHO that governments must put wellbeing and equity at the heart of their approach, and to achieve this goal means putting sufficient and sustained health spending at the centre of everything they do. We are well aware of the serious repercussions if they do not."

Building a stronger healthcare workforce

During World Health Worker Week 2022 (April 4-8), the ICN welcomed the publication of the WHO new Global Competency and Outcomes Framework. The framework, to which the ICN contributed, reflects the true complexity of building a stronger, well-educated healthcare workforce to achieve universal health coverage.

Competency-based training for nurses can transform educational programmes with a focus on improving population and health outcomes. The framework will help to guide governments to create their best possible nursing workforce, and be a useful tool to establish accurate data about registered nurses globally.

The ICN applauded the new WHO Competency Framework, which is designed to ensure that the education of healthcare workers means they can meet the needs of the populations they serve.

The competency-based model of education, which the ICN has long been calling for, is in line with the current Strategic Directions for Nursing and Midwifery. It means nurse education globally will be values based and focused on the acquisition of knowledge, skills and attitudes. This will bring benefits such as improved efficiency and efficacy of learning, improved preparedness of nursing students for practice and, most importantly, better health outcomes for patients and communities.

International Nurses Day celebrates leadership

THE theme chosen by the ICN for this year's International Nurses Day (IND) celebration is 'Nurses: A Voice to Lead – Invest in Nursing and respect rights to secure global health'.

The ICN commemorates this important day each year with the production and distribution of IND resources and evidence.

It has launched a compilation of case studies submitted by nurses across the world to showcase the incredible range of innovative work nurses do every day.

These stories, which were highlighted on the ICN and IND websites throughout the year, reflect the work of nurses caring for Covid-19 patients throughout the pandemic, as well as the wide variety of nursing that continued throughout the pandemic to care for those suffering from other conditions.

From birth to death, non-communicable diseases to infectious diseases, mental health to chronic conditions, in hospitals, communities and homes, nurses provide accessible, affordable, person-centred, holistic care for all.

The pandemic has exposed the many weaknesses caused by underinvestment in health systems around the world.

The theme for IND 2022 demonstrates the need to

invest in nursing, to build a resilient, highly qualified nursing workforce and to protect nurses' rights in order to transform health systems to meet the needs of individuals and communities. **#IND2022**

global news affecting nursing and midwifery

Finnish strike for better conditions for HCWs

THE INMO recently expressed solidarity with our Finnish colleagues when on April 1, 2022, 25,000 healthcare professionals, including nurses, went on strike in six hospital districts in Finland to demand decent salaries and working conditions.

The strike is led by trade unions, Tehy, the union of health and social care professionals in Finland, and SuPer, the Finnish union of practical nurses.

The Finnish Nurses Association, an ICN member, is not a negotiating partner, but closely collaborates with Tehy and fully supports the strike.

Tehy and SuPer called for the two-week strike, which included a ban on overtime work for those not involved in the strike. The strike was in protest at the lack of improvement in working conditions and salaries, despite the stress endured by health workers during the pandemic.

Protests in Finland: *More than 2,000 nurses joined the protest march for better pay and working conditions in Helsinki last month. Pictured above leading the demonstrations were: Silja Paavola (in blue), chair of SuPer, the Finnish Union of Practical Nurses; and Millariikka Rytkönen (in red), chair of Tehy, the Union of Health and Social Care Professionals (Photo: Jussi Helttunen)*

Pay increases offered by employers fell far short of the rises requested by staff representatives. Tehy and SuPer have proposed a rescue programme to tackle the shortage of social and healthcare professionals and to improve working conditions, including an extra 3.6% increase annually over the next five years on top of the standard pay increase. A further strike of 40,000 healthcare professionals will take place mid-April unless an agreement can be reached.

While some hospital managers and chief medical officers have expressed their concern that the strike will affect patient safety and the health of patients, many nurses on social media have said that, due to the protected work rules in place during the strike, they are experiencing better staffing than usual.

One nurse in a paediatric intensive care ward said they now have nine nurses per shift, which is much higher than in the past three months. Another nurse in the dialysis treatment centre of Turku University Hospital said that, contrary to reports, they currently have five nurses in the protected work, which is more than in normal times, and that all the necessary dialysis treatments have been done, with no one left without treatment.

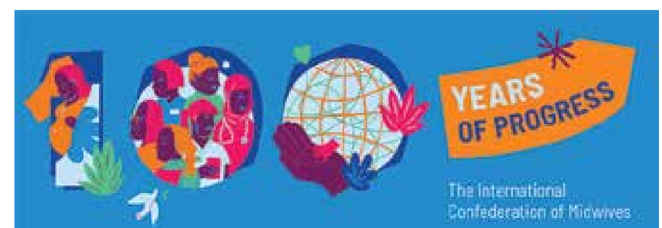
The INMO wishes our Finnish colleagues well in their efforts to achieve improved conditions for staff and patients.

Midwives advocate for investment in quality care

THE global midwifery community is coming together to advocate for investment in quality care around the world on the International Day of the Midwife (IDM) on May 5.

Celebrating its 100th anniversary this year with the theme '100 Years of Progress', the International Confederation of Midwives (ICM) believes investment in quality care will improve sexual, reproductive, maternal, newborn, child and adolescent health in the process.

The ICM reflects on a number of issues on IDM each year and said that each passing year feels more significant for midwives and midwifery than the one before it. In 2020, the ICM celebrated the WHO-sanctioned Year of the Nurse and Midwife. Last year, the United Nations Population Fund, the ICM and the WHO collaborated to release a significant piece of midwifery research, *The State of the World's Midwifery (SoWMy) 2021 Report*, and this year the Confederation celebrates the ICM's 100th anniversary.



What these milestones don't reflect is how every midwife has contributed to the increase in awareness and representation the profession is receiving. IDM is an excellent opportunity to carry forward this advocacy work, and the ICM toolkit provides the resources to do exactly that.

The INMO will be celebrating IDM (as well as IND) and looks forward to members joining the celebrations. Both days provide time to reflect on the extraordinary contribution made by members of the professions in the lives of people every day. It is also time to re-emphasise that investment in midwifery and nursing is an investment in the health and wellbeing of our nation, and an investment that offers an incredible return for our society. **#IDM2022**

ATTR-CM IS LIFE-THREATENING[1]

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Vyndaqel 61 mg is indicated for the treatment of wild-type or hereditary transthyretin amyloidosis in adult patients with cardiomyopathy (ATTR-CM)[2]

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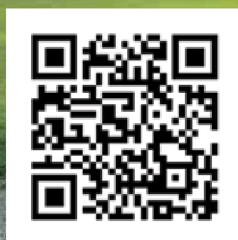

▼ This medicinal product is subject to additional monitoring. This will allow quick identification of new safety information. Healthcare professionals are asked to report any suspected adverse reactions. Refer to section 4.8 of the SmPC for how to report adverse reactions.

Vyndaqel®▼ (tafamidis)

ATTR-CM=transthyretin amyloid cardiomyopathy; CV=cardiovascular.

1. Maurer MS, Schwartz JH, Gundapaneni B, et al. Tafamidis treatment for patients with transthyretin amyloid cardiomyopathy. N Engl J Med. 2018;379(11):1007-1016 **2.** VYNDAQEL Summary of Product Characteristics.

Vyndaqel▼ 61 mg soft capsules (tafamidis) Prescribing Information: Before prescribing Vyndaqel please refer to the full Summary of Product Characteristics. **Presentation: Vyndaqel 61 mg soft capsules.** Each soft capsule contains 61 mg tafamidis. **Uses:** Vyndaqel is indicated for the treatment of wild-type or hereditary transthyretin amyloidosis in adult patients with cardiomyopathy (ATTR-CM). **Dosage:** Treatment should be initiated under the supervision of a physician knowledgeable in the management of patients with amyloidosis or cardiomyopathy. When there is a suspicion in patients presenting with specific medical history or signs of heart failure or cardiomyopathy, etiologic diagnosis must be done by a physician knowledgeable in the management of amyloidosis or cardiomyopathy to confirm ATTR-CM and exclude AL amyloidosis before starting Vyndaqel, using appropriate assessment tools such as: bone scintigraphy and blood/urine assessment, and/or histological assessment by biopsy, and transthyretin (TTR) genotyping to characterise as wild-type or hereditary. The recommended dose is one capsule of Vyndaqel 61 mg (tafamidis) orally once daily. Vyndaqel 61 mg (tafamidis) corresponds to 80 mg tafamidis meglumine, tafamidis and tafamidis meglumine are not interchangeable on a per mg basis. Vyndaqel should be started as early as possible in the disease course when the clinical benefit on disease progression could be more evident. Conversely, when amyoid-related cardiac damage is more advanced, such as in NYHA Class III, the decision to start or maintain treatment should be taken at the discretion of a physician knowledgeable in the management of patients with amyloidosis or cardiomyopathy. There are limited clinical data in patients with NYHA Class IV. If vomiting occurs after dosing, and the intact Vyndaqel capsule is identified, then an additional dose of Vyndaqel should be administered if possible. If no capsule is identified, then no additional dose is necessary, with resumption of dosing the next day as usual. There are no recommended dosage adjustments for elderly patients or patients with renal or mild and moderate hepatic impairment. Limited data are available in patients with severe renal impairment (creatinine clearance less than or equal to 30 mL/min). Tafamidis has not been studied in patients with severe hepatic impairment and caution is recommended. There is no relevant use of tafamidis in the paediatric population. **Method of Administration:** The soft capsules should be swallowed whole and not crushed or cut. Vyndaqel may be taken with or without food. **Contra-indications:** Hypersensitivity to the active substance or to any of the excipients as listed in section 6.1 of SPC. **Warnings and Precautions:** Contraceptive measures should be used by women of childbearing potential during treatment with tafamidis and for one month after stopping treatment. Tafamidis should be added to the standard of care for the treatment of patients with transthyretin amyloidosis. Physicians should monitor patients and continue to assess the need for other therapy, including the need for organ transplantation, as part of this standard of care. As there are no data available regarding the use of tafamidis in organ transplantation, tafamidis should be discontinued in patients who undergo organ transplantation. Increase in liver function tests and decrease in thyroxine may occur. This medicinal product contains no more than 44 mg sorbitol in each capsule. Sorbitol is a source of fructose. The additive effect of concomitantly administered products containing sorbitol (or fructose) and dietary intake of sorbitol (or fructose) should be taken into account. The content of sorbitol in medicinal products for oral use may affect the bioavailability of other medicinal products for oral use administered concomitantly. **Pregnancy and Lactation:** Tafamidis is not recommended during pregnancy and in women of childbearing potential not using contraception. Available data in animals have shown excretion of tafamidis in milk. A risk to the newborns/infants cannot be excluded. Vyndaqel should not be used during breastfeeding. **Interactions:** In a clinical study in healthy volunteers, 20 mg tafamidis meglumine did not induce or inhibit the cytochrome P450 enzyme CYP3A4. *In vitro* tafamidis inhibits the efflux transporter BCRP (breast cancer resistant protein) at the 61 mg/day tafamidis dose with IC50=1.16 μM and may cause drug-drug interactions at clinically relevant concentrations with substrates of this transporter (e.g. methotrexate, rosuvastatin, imatinib). In a clinical study in healthy participants, the exposure of the BCRP substrate rosuvastatin increased approximately 2-fold following multiple doses of Page 2 of 2 2020-0065522 61 mg tafamidis daily dosing. Likewise, tafamidis inhibits the uptake transporters OAT1 and OAT3 (organic anion transporters) with IC50=2.9 μM and IC50=2.36 μM, respectively, and may cause drug-drug interactions at clinically relevant concentrations with substrates of these transporters (e.g. non-steroidal anti-inflammatory drugs, bumetanide, furosemide, lamivudine, methotrexate, oseltamivir, tenofovir, ganciclovir, adefovir, cidofovir, zidovudine, zalcitabine). Based on *in vitro data*, the maximal predicted changes in AUC of OAT1 and OAT3 substrates were determined to be less than 1.25 for the tafamidis 61 mg dose, therefore, inhibition of OAT1 or OAT3 transporters by tafamidis is not expected to result in clinically significant interactions. No interaction studies have been performed evaluating the effect of other medicinal products on tafamidis. **Undesirable Effects:** The following adverse events were reported more often in 176 ATTR-CM patients treated with tafamidis meglumine 80 mg compared to placebo: flatulence [8 patients (4.5%) versus 3 patients (1.7%)] and liver function test increased [6 patients (3.4%) versus 2 patients (1.1%)]. A causal relationship has not been established. Safety data for tafamidis 61 mg are not available as this formulation was not evaluated in the double-blind, placebo-controlled, randomised phase 3 study. **Legal category:** S1A. **Marketing Authorisation Numbers:** EU/1/11/717/003– 61mg (30 capsules). **Marketing Authorisation Holder:** Pfizer Europe MA EEIG, Boulevard de la Plaine 17, 1050 Bruxelles, Belgium. For further information on this medicine please contact: Pfizer Medical Information on 1800 633 363 or at EUMEDINFO@pfizer.com. For queries regarding product availability please contact: Pfizer Healthcare Ireland, Pfizer Building 9, Riverwalk, National Digital Park, Citywest Business Campus, Dublin 24 + 353 1 4676500. **Last revised:** 04/2021 ▼ This medicinal product is subject to additional monitoring. This will allow quick identification of new safety information. Healthcare professionals are asked to report any suspected adverse reactions. See section 4.8 of the SmPC for how to report adverse reactions.

Ref: VY 61MG 2_0

Further information available upon request.

PP-VYN-IRL-0095 Date of Preparation: January 2022 © 2022 Pfizer Inc. All rights reserved.

DCU hosts nursing and midwifery festivals

First in-person nursing and midwifery conferences held since 2020

IN LATE March, nurses and midwives met in DCU for the first in-person clinical and policy festivals since 2020. The All-Ireland Maternity Festival and the Sláintecare Nursing's Challenge Festival were jointly hosted by the INMO and the Maternity and Midwifery Forum.

The programmes provided a glimpse of the future choices for midwifery and nursing on the island of Ireland with a desire for more technology, more flexible working and better opportunities for inclusion evident.

Despite the impact of the omicron variant of Covid-19, by using online technology and adapting to circumstances, the full programme went ahead with 1,500 people attending the festivals over the two days. Around 400 attended in person with the rest watching online.

A week before the event some 700 had planned to attend but as HSE and NHS staff were hit by infections, the INMO with the Maternity and Midwifery Forum and Narrowcast Media Group made the event fully available online.

An issue which overlapped the two conferences was menopause as a hidden challenge for women's health and nursing. Its effects on patients and the need for professionals to be much more aware was discussed.

It was also agreed that the effect of menopause on nurses and midwives themselves, meant that there was a need to adapt working practices and recognise how it can force much-needed senior professionals to retire early.

At the Sláintecare Nursing Festival Nora Casey, broadcaster and former nurse, gave a personal testimony, laying out in detail the effects of the menopause on her and how she tackled it in order to keep working. This was followed by Loretta Dignam from the Menopause Hub and Steve Pitman, INMO head of education and professional development, who discussed the findings of the Organisation's menopause survey.

Participants agreed that lessons should be learned from the pandemic in terms of inclusivity, flexibility and innovation in working practices. It was agreed that these should be built on and that the use of mobile and online technology be permanently integrated into work practices.

It was also agreed that the challenge of menopause must be recognised by policymakers who risk losing professional nursing and midwifery staff at the height of their careers.

Opening the midwifery festival, Lynda Moore, midwife and INMO Executive Council member, gave a powerful speech on the challenges facing midwifery in Ireland.

She was followed by Shelia McClelland, chief executive of the Nursing and Midwifery Board of Ireland, who spoke on new challenges for maternity services and midwifery.

Dr Dale Spence from Northern Ireland brought delegates up to date with the continuity of carer policy in the UK which is under strain because of midwife staff shortages.

A range of seminars were held on topics including early pregnancy loss, the hidden world of non-severe maternal morbidity, iron deficiency in pregnancy, and the lessons learned during the pandemic.

Dr Susan Kent, associate professor at DCU, called for a chief midwifery officer for Ireland and a midwifery voice at senior management level in all maternity units across the country.

Sláintecare dominated the second day of the All-Ireland Nursing Festival. Opened by Karen McGowan, INMO president, the issues of technology and inclusion in nursing and how we can enhance and improve on current best practice were to the forefront.

Contributions came from Rachel Kenna, chief nursing officer at the Department of Health; Loretto Grogan, director of nursing and national clinical information officer for nursing and midwifery ONMSD; with Georgina Bassett, deputy chief nursing officer at the Department of Health also speaking.

Dr Briege Casey, associate professor at DCU presented on her work with homeless patients.

Staff wellbeing was high on the agenda with Prof Ciaran O'Boyle, professor of psychology at the RCSI; Dr Patricia Gillen, from the Nursing and Midwifery Research and Development department at Ulster University; and Elaine Fallon, staff engagement and wellbeing lead at Saolta University Health Care Group, mapping important strategies to support staff.

Ms McGowan and Prof Jonathan Drennan of University College Cork explored how supporting advanced practice roles can lead to vast improvements in service.

There were too many sessions to do justice to them all here but the full programme of videos and specialist sessions is available to all INMO members.

To view the Nursing Slaintecare box set go to: **https://vimeo.com/showcase/9408551**

To view the Maternity and Midwifery Festival box set go to: **https://vimeo.com/showcase/9410835?page=2**

Neil Stewart is editorial director for the Maternity and Midwifery Forum

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1. VARIVAX Summary of Product Characteristics February 2022.

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IE-VVX-00044

New appointments at the INMO

MAEVE BREHONY joined the Irish Nurses and Midwives Organisation in March as the assistant director of industrial relations for the Dublin North and Northeast (DNNE) region.

She previously worked as senior industrial relations officer for the Financial Services Union since 2016 and was a regional officer with Unite from 2014 to 2016.

She has an advanced diploma in applied employment law from the Honourable Society of King's Inns and a diploma in first line management from the National College of Ireland (NCI).

Speaking of her new role Ms Brehony said: "I'm absolutely delighted to take on this challenging role and work with the fabulous team in DNNE and throughout the INMO.

"As an organisation the INMO appealed to me as it's deeply invested in advocating for, and delivering positive change to, the working lives of our nurses and midwives and their profession."

Ms Brehony has also held the positions of secretary and vice chair of ICTU's Health and Safety Committee and was a panellist at the Industrial Relations News conferences entitled 'Wage bargaining prospects for 2016 and beyond: private and public sectors' in 2016 and 'Workplace Transformation: Coping with the impact of Covid-19' in 2020.

COLM PORTER is the new assistant director of industrial relations for the INMO's Southern Region. Originally from Co Wexford, he completed a bachelor of commerce degree at NUIG, specialising in industrial relations and human resource management. Following graduation he went on to complete an MA in international politics in Dublin City University.

In 2010 he moved to the UK to start his career in the British trade union movement. While there he worked for the Public and Commercial Services Union as a regional organiser and, more recently, with UNISON, where he was the national officer responsible for the union's ambulance membership. He was also the lead negotiator on the NHS pension scheme.

Speaking about joining the INMO team Mr Porter said: "Looking at the Irish response to the Covid-19 pandemic from the UK, it was clear to me that the INMO was the most effective voice in speaking up for healthcare workers and ensuring that their contribution was recognised. I am delighted to be working for a trade union that puts members at the centre of everything that we do and makes sure the views of nurses and midwives are heard at all levels of the health service and government."

Mr Porter is delighted to be back in Ireland with his family and is looking forward to meeting INMO members across the Southern region and to working with the team to support them.

MARK O'CONNOR joined the INMO in December 2021 as industrial relations executive (IRE) for the Dublin South Mid-Leinster region. He is the IRE for CHO7, St Michael's Hospital and the Royal Victoria Eye and Ear Hospital.

Before taking up his new role with the INMO he worked in support services in St Vincent's University Hospital for over 15 years. While there he was actively involved in trade unionism, serving as a shop steward for several years. Stemming from this experience and wanting to enhance his understanding of industrial relations, he obtained a diploma in human resources from NCI.

Mr O'Connor is currently completing a degree in human resource management in NCI. He is an associate member of The Chartered Institute of Personnel and Development.

He is looking forward to working with members, telling *WIN*: "I have always been a strong believer in unity among workers. Only by working together can we bring about the positive changes we seek in our workplaces. I am honoured to now work for the INMO, who have a long history of building and maintaining this unity among the nursing and midwifery professions and beyond. *Ní neart go cur le chéile.*"

Workplace safety

Karen Eccles discusses the new health and safety in the workplace representative roles negotiated by the INMO with the HSE

MAY 2020 marked the bicentenary of Florence Nightingale, recognised as one of the first safety and quality leaders in healthcare. In 1860, Nightingale established the first professional nursing school in the world at St Thomas' Hospital, where I completed my theatre and anaesthetic course many moons ago. In recognition of the necessity for both patient and workforce safety, she published her *Notes for Hospitals* in 1858.[1] A theme that is still relevant today is the hand hygiene practice she implemented during the Crimean War in 1853-1856, which led to a demonstrable reduction in patient mortality.

Nightingale astutely identified that health and safety was the responsibility of all, a tenet that remains central to modern healthcare delivery. Recognising the role that culture and leadership played in the drive for change, she provided evidence to support her theories. These theories remain central to core nursing principles in 2022. In *Notes on Nursing*, Nightingale presented the precautionary principle.[2] This principle states that on identifying a threat to human or environmental health, precautionary measures should be taken even if some causes and effect relationships are not clearly understood at the time.

The INMO, having identified the clear link between mask wearing and a reduction in transmission of Covid-19, pursued the requirement for nurses and midwives to wear FFP2 respirator masks. The union sought for employers to provide these masks to their staff, placing responsibility of risk in the workplace directly with the employer, as legislated for under the Safety, Health and Welfare at Work Act 2005.[4]

Covid-19 has significantly changed the standards required for the health and safety of workers. It has heightened health and safety awareness and exposed weaknesses in current practice and design. However, the pandemic also offers us an opportunity to effect substantial change and create a deeper understanding of employers' responsibility to ensure, as far as is reasonably practicable, our health and safety while at work.

Additionally, the virus has accelerated changes in practice from social distancing to remote working and shone a spotlight on work-related stress. As stated in the HSE's *Policy for Prevention and Management of Stress in the Workplace 2018*,[3] it is essential that all employers fully understand the impact of work-related stress on the employee and that risk assessments are required to assess this risk. As is required under Section 19 of the Safety, Health and Welfare at Work Act 2005, they must recognise the effect of staffing deficiencies, poor skill mix, alongside shift patterns and frequency, all of which create additional workplace stress.[5]

Staying with Nightingale's relevance a moment longer, in *Notes on Hospitals*, she clearly advocated for natural ventilation and, where necessary, mechanical assistance to reach the required ventilation rates to improve air quality. Air quality in our hospitals during the pandemic was a significant problem, with overcrowding causing an additional burden. The INMO believes that the HSE, as an employer, has an obligation to provide proper air filtration units where insufficient ventilation is identified across our hospitals

and is actively working to address this.

Nurses and midwives now have a significant role in providing leadership and bringing changes to health and safety culture. Previous tolerance of poor working conditions perpetuated a lack of change. Recognising this – and the legislative requirement that employers must provide safe workplaces – has seen the INMO develop its National, Safety, Health and Welfare at Work Strategy. This strategy identifies the risks that directly impact upon nurses and midwives as employees, and aims to recruit and train safety representatives in all work locations. This will provide significant improvements in workplace health and safety.

In addition to standard representation, the INMO has successfully negotiated with the HSE for a:

- Safety representative in all emergency departments
- Nurse/midwife safety representative in all other work locations
- National, safety, health and welfare at work representative – a position which I currently hold.

Legislation

The primary legislation covering the health and safety of employees in the workplace is the Safety, Health and Welfare at Work Act 2005.[4] This sets out the rights and obligations of both employers and employees. It also provides for substantial fines and penalties for breaches of the health and safety legislation.

Key sections of the Act that nurses and midwives should be aware of include:

- Section 19: Employers are required to identify hazards in the place of work, assess the risks and put control measures in place to mitigate risks identified and be in possession of a written risk assessment
- Section 20: Employers are required to prepare a Safety Statement, and in the safety statement, they should advise their employees how they are going to manage risk in their department and make available to the employee all the written risk assessments completed for the area of work and the statement should be brought to the attention of employees on commencement of employment and at least annually or when significant change takes place
- Section 25: Employees are entitled to select a safety representative to represent them on safety and health matters with their employer
- Section 26: Employers are required to consult with their employees for the purpose of making and maintaining arrangements to co-operate on health and safety matters, which can be facilitated by membership of the local workplace safety committee
- Safety representatives shall be given, without loss of remuneration, the time necessary, both to gain the knowledge and training necessary and to discharge their functions
- A safety representative does not have any duties as opposed to functions and cannot be held legally accountable for putting a proposal into effect.[5]

Safety representative role

- The safety representative will collectively provide representation by delivering and providing to our membership an additional level of support and expertise on workplace health and safety matters
- Their presence in the workplace establishes, at local workplace level, clear visible structures for representation on matters of health and safety
- Their role facilitates awareness and collective sharing of information that empowers nurses and midwives with the confidence to identify and challenge workplace health and safety concerns
- Their role and recognition ensure employer legislative compliance to consult and facilitate employee participation
- The role allows nurses and midwives the opportunity to use more effectively the legal authority afforded specifically to safety representatives in ensuring health and safety in our workplaces.

The INMO is requesting that each branch elects a safety liaison officer. This officer will, with the assistance of branch members, recruit one safety representative in their emergency department and two safety representatives in all locations aligned to their branch.

The safety liaison officer will organise the necessary training required for the role. On completion of training the representatives will be entitled to join the local workplace safety committee to raise nurses and midwives' occupational health and safety concerns.

The Covid-19 pandemic has brought little positivity, but what it has done is created a seismic change in how we as nurses and midwives view our workplace health and safety. This is reflected in the fact that 60 INMO members have come forward to date and have been trained as safety representatives.

The challenges existing in our workplace can create both immediate and cumulative long-term effects on our health and potentially our careers.[6] A recognised global shortage of nurses and an ageing workforce[7] requires us, as nurses and midwives, to challenge and compel employers to identify and risk assess the needs of older workers in order to improve retention and secure career longevity.

Finally, in a female-dominated profession, recognition has been given to the impact menopause can have on women's health and safety at work. This must be recognised by the provision of appropriate policies in this area.

We can improve physical, chemical, biological and psychosocial risk factors including work-related stress, violence and aggression, musculoskeletal disorders and lone-working risks in the healthcare workplace by ensuring that policy and procedures in this area are fully implemented and that the necessary training is provided.

Employers who fail to implement safety measures must be challenged using the relevant legislation and through the enforcement agency, the Health, and Safety Authority. The Health and Safety Function Unit support the HSE has developed statutory occupational health and safety training and is an extremely useful point of contact to assist with concerns identified. You can contact its help desk at Tel: 1800 444925.

Safety representative recruitment is ongoing and if you would like any further information on the role, please contact me by email: karen.eccles@inmo.ie

Karen Eccles is the INMO national safety, health and welfare at work representative

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Magnet hospitals:

Mental health and wellbeing in the workplace

Healthcare workplaces can be redesigned to promote the mental health and wellbeing of staff and improve outcomes of patients in their care, writes a team from UCC

IT IS widely reported that the healthcare workforce has higher levels of burnout compared to other professions. Burnout rates vary greatly across the nursing workforce and between organisations; a large European study reported burnout rates ranging from 10%-78%.[1] These levels are also prevalent in doctors, with reports of burnout ranging from 25-60%.[2,3,4]

Burnout among the healthcare workforce can result in absenteeism,[5] poor retention rates,[5] and job dissatisfaction.[6] It may lead to negative effects on patients, such as lower patient satisfaction,[4] medical errors,[7] reduced quality of care[5] and increased mortality.[8]

Burnout and the wellbeing of healthcare staff have come to the fore during the Covid-19 pandemic and pressures on staff from high workloads and illness. One way to reduce burnout and improve wellbeing is through enhancing the working environment for staff.

There is a history of research in US hospitals that examined the relationship between the working environment and staff and patient outcomes. During the 1980s, when faced with high turnover and poor retention, several US hospitals were highly successful in recruiting and retaining staff compared to similar organisations.[9,10,11] These were designated as Magnet hospitals.

Magnet4Europe redesigns work environments in healthcare to promote the mental health and wellbeing of health professionals, enhance their productivity, and in doing so improve outcomes of patients under their care.[10]

Magnet4Europe, funded by the European Commission Horizon 2020 Research and Innovation Programme, is the largest research study on the wellbeing of the healthcare workforce in Europe. Jointly led by leading health workforce researchers Prof Aiken at the University of Pennsylvania and Prof Sermeus at Katholieke University in Leuven, the study is taking place across six European countries: Belgium, Germany, Norway, Sweden, the UK and Ireland as well as in the US. More than 60 European and 66 US Magnet hospitals are involved in Magnet4Europe.

Magnet hospitals are characterised by a flat, decentralised organisational structure, decision-making led by empowering frontline staff, and leaders capable of producing change and improvements.[13] These environments were associated with lower nurse burnout, lower intention to leave and higher job satisfaction compared to non-Magnet hospitals.[10,14] They also had better patient outcomes, including improved safety, fewer adverse events and lower mortality rates.[4,14]

In Ireland, the study is led by Prof Drennan along with Dr Brady, Dr Lehane, and Dr McCarthy from the School of Nursing and Midwifery, UCC. Fifteen Irish hospitals are partaking in this innovative project. These are:

- Beaumont Hospital
- Bon Secours Hospital Cork
- Connolly Hospital, Dublin
- Cork University Hospital

• Letterkenny University Hospital, Donegal
• Mater Misericordiae University Hospital, Dublin
• Mercy University Hospital, Cork
• Our Lady of Lourdes Hospital, Drogheda
• South Infirmary Victoria University Hospital, Cork
• St James's Hospital, Dublin
• Tallaght University Hospital, Dublin
• Tipperary University Hospital
• University Hospital Galway
• University Hospital Limerick
• University Hospital Waterford.

The aim of Magnet4Europe, is to use a co-design approach to redesign the organisation in hospitals by implementing the Magnet principles and examining changes in wellbeing, including burnout, in the healthcare workforce.

Magnet4Europe uses a randomised wait-list cluster design to evaluate the effectiveness of transferring the Magnet principles into European hospitals, thus each hospital takes part in the intervention. The Magnet model consists of five components:

• Transformational leadership
• Structural empowerment
• Exemplary professional practice
• New knowledge, innovation and improvements
• Empirical quality results.[15]

European hospitals are twinned one-to-one with US Magnet hospitals with the aim of transferring knowledge, skills, tools, and best practices. Learning collaboratives, hosted jointly by UCC and University of Pennsylvania, occur monthly promoting success and sustainability, involving engagement from all parties in Magnet4Europe.

Furthermore, hospitals in Ireland involved in the project come together to share ideas and discuss progress. To date innovations include establishing councils for staff nurses and clinical nurse managers. Finally, the study involves critical mass to allow for sustainability, as well as feedback to the organisations on staff reported work environment and wellbeing.

While the Magnet principles are standardised, the intervention in each hospital is tailored to their specific needs based on assessments and measures of staff wellbeing. These indicate what changes are required to implement the Magnet principles as well as interventions required to impact on wellbeing.

As recommended by the European Framework for Action on Mental Health and Wellbeing,[16] this study will go beyond previous research which solely investigated the associations of mental health and wellbeing, to using an approach that will enhance the working environment for nurses and other healthcare staff.

UCC is working with universities across Europe and the US on the study, including; University of Pennsylvania, KU Leuven, King's College London, London School of Hygiene and Tropical Medicine, University of Southampton, Technische Universität Berlin and Karolinska Institute.

Dr Noeleen Brady is a postdoctoral research fellow, Prof Jonathan Drennan is chair of Nursing and Health Services Research, and Dr Elaine Lehane and Dr Vera McCarthy are lecturers, all at the School of Nursing and Midwifery at University College Cork

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Process of evolution:

21 years of the CPC role

A group of clinical placement co-ordinators discuss how their multifaceted role has evolved to meet the needs of the healthcare environment

THE clinical placement co-ordinator (CPC) role is unique to the Irish nurse education system. The post was first established in 1997 as 'clinical practice co-ordinator'. The role was later made permanent following a recommendation from the Commission on Nursing.[1] This is the first of two articles examining the result of a recent evaluation of the role. It will explore and discuss the role as it has evolved and the future of the role in a changing healthcare setting.

The CPC role has evolved significantly since its establishment. The Commission of Nursing 1998 described CPCs as being skilled clinical nurses and recommended the role to guide and support student nurses and to ensure clinical placements met the requirements of education programme.[1]

The introduction of the diploma programme supported by the CPC role, resulted in fundamental changes in the education and training of student nurses. Its aim was to meet the changing characteristics of nursing knowledge, healthcare and society. This diploma programme led the way to a four-year direct entry undergraduate nursing degree programme in 2002 which was unique to Ireland. The CPC role in midwifery was adopted in 2006 following the commencement of the direct entry midwifery programme.

While the of CPC role was established as both a temporary and experimental position the Commission on Nursing positively reviewed the role and recommended a national evaluation and the continued development of the post. The posts at the time were at ward sister level and the Commission also recommended that they should be permanent and remain responsible to the nurse practice development co-ordinators (NPDC).

Defining the role

In a report commissioned by the Department of Health,[2] Prof John Drennan defined the role of the CPC as, "an experienced nurse who provides dedicated support to student nurses in a variety of clinical settings however, unlike the role of mentor/preceptor they do not have a client/patient caseload".[3]

Prof Drennan concluded that the role of the CPC was evaluated as a positive addition to the realm of student support and the clinical team. The positioning of the post within the associated healthcare provider (AHCP) also adds to the dimension of a CPC being a link between student nurses and midwives and the various groups that provide student support. This was essential in light of the changing role of the nurse tutor following the full integration of pre-registration nurse education into the third-level sector and the development of a formal preceptorship role for clinical nurses.

In 2007 McNamara described the CPC as a "dedicated presence for nursing students; facilitating the establishment, maintenance and development of the clinical teaching partnership between staff nurses and students; and monitoring the clinical learning environment to ensure safe practice".[4]

NMBI describes Midwifery CPCs as registered midwives and clinical midwifery managers who liaise with named Midwifery lecturers to monitor the quality of the clinical learning environment on an ongoing basis and guide and support students to ensure the clinical practice placements provide an optimum learning environment .[5]

CPCs support the clinical team with the orientation and socialisation of students to the clinical area. Formal induction programmes are arranged for all student nurses and midwives prior to clinical placement. CPCs are in a unique position as they understand both the clinical area and the learning needs of the student. The support provided relates to adaptation to the clinical learning environment, guidance in the achievement of learning outcomes, supporting both the student and the preceptor and personal development such as coping mechanisms and resilience.

Pastoral care and support

Pastoral care has always been an integral part of the role and this was increasingly evident during the pandemic. The clinical area is daunting and often students are apprehensive. CPCs develop trusting relationships with students so they feel free to seek support and advice. CPCs are in a position to listen, empathise and advocate for the needs of the student. Occasionally the CPC may need to support both the

student and the preceptor if there is conflict between them. They act as mediators and help discuss any issues in a fair and transparent manner.

Studies have shown increasing numbers of students registering with disability services in the higher education institutes (HEIs) and receiving additional support.[6] The CPCs liaise with HEIs in relation to the completion of the clinical needs assessment and collaborate with both the HEI and the AHCP to make necessary reasonable accommodations for the students while they are on placement.

Butler et al state that the process of assessment for students in clinical practice is dependent on the creation of a supportive clinical environment, which includes the need to support preceptors in their role.[6] Therefore, oversight of the clinical learning environment through audit and resulting action plans and the provision of preceptor training and supports is imperative.

CPCs support nurses, midwives and their preceptors in their teaching role on a continuous basis to ensure student outcomes are achieved. CPCs regularly review the students National Competency Assessment Document and in Midwifery the National Competency Assessment Tool, which students are required to complete in full during clinical placement.

Guidance is provided with assessment tools to ensure fair and accurate assessment of students and up-to-date resources are made available for clinical staff. Some students may require additional help to be deemed competent on clinical placement. In this case a competency development learning support plan may be put in place. Both the student and the preceptor are guided through the process by the CPC.

Theory-practice gap

Bridging the theory-practice gap necessitates the creation of opportunities to underpin classroom teaching through the development of professional and practical skills in a safe and supportive environment. The primary focus for all teaching in the clinical areas must be the clinical practitioners in line with the principle that the registered nurse/midwife must always be regarded as the most appropriate clinical practitioner.[4] However, preceptors primary responsibility is patient care and therefore CPCs play a significant evolving role in teaching students and providing educational resources, discussion, reflection, and promoting evidence-based practice.

NMBI requires nurses and midwives to complete preceptorship training with a refresher course every two years.[8] While an online preceptorship programme has recently been launched on HSEland, CPCs continue to play a significant role in the delivery of the workshop component of this programme. Nurses and midwives within all settings are increasingly availing of CPC support to develop their competence and confidence in preceptoring students on clinical placement.

Reflective practice

Reflective practice has become an integral part of the undergraduate programmes. It is the process of turning thoughtful practice into a learning situation. CPCs support and guide students and preceptors in this core aspect while on clinical placement. It can take student some time to make sense of the clinical area particularly when dealing with patients with complex needs. By reviewing experiences in this way students can understand the situation and learn from it.

Clinical learning environment

The clinical learning environment is at the core of undergraduate nurse education[2] but has changed dramatically with increased focus on quality patient care, increasing technology/digital health, complexities of care and an aging population. There are also the challenges of recruitment and retention.

Audit

An integral part of role of the CPC is the monitoring and auditing of clinical areas which must meet a number of criteria and this standard must be maintained. The CPC works in collaboration with the clinical nurse/midwifery managers (CNM/CMM), NPDC/Midwifery Practice Development Unit, director of nursing/midwifery and HEI to ensure the clinical areas are suitable learning environments for students. Action plans are initiated as needed.

The CPC ensures that the supernumerary status of the student is protected during clinical placement, which allows the student to focus primarily on learning opportunities while actively participating in patient care. Any day-to-day issues with the clinical learning environment are discussed between the CPC and CNMs/ CMMs.

Since the Commission on Nursing and the establishment of the link with the NPDC, CPCs have played as significant role in practice development. As a member of the nurse and midwifery practice development teams, CPCs are required to participate in clinical audits, develop policies and set standards. Many CPCs work on practice development initiatives and projects. This helps to maintain the professional development of the CPC.

Due to their physical presence in the clinical learning environment, CPCs are well placed to promote and model evidence-based practice to clinical staff. CPCs also support clinical staff by advising staff regarding best practice, promoting new standards and guidelines or listening and feeding back issues staff encounter in the clinical area. Alongside the rest of the practice development team they can implement measures to enhance quality nursing practice.

Link

While CPCs are the link between the student and the clinical area, they also act as a link between the HEI and the clinical area. In order to ensure the smooth running of the nursing and midwifery degree programmes, CPCs are also involved in working groups between the hospitals and HEI, where they collaborate in relation to policies pertaining to students, including the development of learning outcomes.

In summation, the role of the CPC is multifaceted and is ever evolving to meet the needs of a continuing changing health care environment.

Rachael Dolan is a CPC at Our Lady of Lourdes Hospital, Drogheda, Angela Lally is a CPC at Connolly Hospital, Dublin, Breid Lyons is a CPC at Beaumont Hospital, Dublin, Ann Marie Murray is a CPC at Our Lady of Lourdes Hospital, Drogheda and Dawn Whittaker is a midwifery CPC at University College Hospital, Galway

The second article in this series will explore the result of a recent role evaluation and discuss the future of the role in a changing healthcare setting.

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Royal College of Midwives

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All Ireland Annual Midwifery Conference

Midwives - Visible and Valued

Thursday, 17 November 2022

Slieve Russell Hotel, Co Cavan

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www.inmoprofessional.ie/conference

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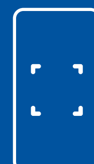

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Pride in our professions

Steve Pitman kicks off the International Day of the Midwife and International Nurses Day celebrations with a call for greater recognition of the work of nurses and midwives worldwide

REPRESENTING more than 140 midwifery organisations and one million midwives worldwide, the International Confederation of Midwives (ICM) celebrates its centennial year in 2022, and has reflected this in its theme for this year's International Day of the Midwife (IDM) on May 5: '100 years of Progress'.

The ICM was founded in Belgium in 1922, originally as the International Midwives Union (IMU). To mark the IDM, Margaret Dunlea and Magda Ohaga have written an article on water births for this issue *(see page 48)*. The ICM's centenary will be celebrated separately in a future issue of *WIN*.

Also in May is International Nurses Day (IND), the theme for which is 'Nurses – A Voice to Lead: Invest in Nursing and Respect Rights to Secure Global Health'.

On May 12, nurses across the world will be celebrating IND on the anniversary of Florence Nightingale's birth. This day is an opportunity for nurses to stand together and celebrate the work that nurses do in all settings, taking crucial decisions that affect the future of healthcare in Ireland and across the world.

The 2022 theme focuses on the need to invest in nursing and to respect the rights of nurses in order to build resilient, high-quality health systems to meet the needs of individuals and communities.

The Russian invasion of Ukraine on February 24 has yet again brought into sharp focus the devastation caused by war. The Ukrainian people have seen their world turned upside down, with cities turned to rubble and millions fleeing the country in search of safety and security.

It is important that we recognise and stand in solidarity with nurses and midwives who have been caught up in the conflict on the frontline, caring for the sick and injured in areas under siege, as well as those providing healthcare to refugees. The horrifying and devastating attacks on hospitals, maternity units and ambulances are deeply shocking and unacceptable. Internationally, the ICN has condemned the attack on a children's and maternity hospital in the port city of Mariupol, along with the attacks on other health facilities and healthcare workers throughout Ukraine.[1]

The *Global Strategy on Human Resources for Health: Workforce 2030*[2] report identifies working conditions as a key factor for recruitment and retention of staff. The report goes further and calls for the upholding of "the personal, employment and professional rights of all health workers, including safe and decent working environments and freedom from all kinds of discrimination, coercion and violence". This underlines the vital role that trade unions play in organising nurses and midwives as one voice to advocate and fight for improvements in working conditions.

Ireland provides an excellent example of the struggle of nurses and midwives over the past three decades to improve pay and conditions and to ensure funding for the development of the professions.

Ensuring the employment and professional rights of nurses and midwives is essential in developing countries where regulations to safeguard workers are often underdeveloped or non-existent. However, workplace rights remain an issue relevant in high-income countries, such as Ireland, where increasing work-related demands and levels of stress and burnout experienced by nurses and midwives remain unacceptably high.

Almost 70% of nurses and midwives surveyed during the pandemic said they have considered leaving the professions;[3,4] this is a worrying indicator of the state of the workforce. Of particular concern is the 25% of nurses and midwives who have indicated that they intend to leave the profession in the next 12 months.[4] The role and development of staff health and safety representatives has never been more important to ensure that the wellbeing and rights of nurses and midwives are recognised and safeguarded.

Nurses and midwives are fundamental to ensuring universal, accessible and high-quality healthcare. According to the World Health Organization and the ICN, there will be a shortage of 13 million nurses and midwives by 2030.[1,5] This shortage will be felt most acutely in developing countries that continue to expand their health services. High-income countries will experience increasing competition for nurses and midwives, while the migrant nurses and midwives who have been vital to sustaining the workforce in Ireland will be in increasing demand.

Nurses and midwives, whether educated in Ireland or elsewhere, are a precious resource and will have increasing options and employment opportunities. Action must be taken by employers to alleviate the continuous pressure experienced by our professions and to fully implement the Framework for Safe Nurse Staffing and Skill Mix.[6]

The ICN *Sustain and Retain in 2022 and Beyond*[5] report calls for a long-term global plan "to stem the tide of those leaving nursing because of the additional stresses resulting from Covid-19, and to create a new generation of nurses to grow the profession to meet increased future demands of an ageing global population".

Howard Catton, ICN chief executive, argues that "we can no longer afford to undervalue and underfund the nursing profession, not only for the sake of the health of nurses, but for the protection and sustainability of our entire global health system".[7]

Steve Pitman is INMO head of education and professional development

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Counting the cost of childcare

The cost of childcare in Ireland is the highest in the EU. The state must end its hands-off approach to this issue, writes **Laura Bambrick**

ALL European welfare systems were originally built around the assumption that women were full-time caregivers in the home while men earned a wage adequate to support the family. From the 1950s onwards, this model of work and family life began to be replaced by social policies that facilitated women, as well as men, to work outside the home.

Ireland is unusual in that this shift in official thinking began much later and gender stereotypes remain today. Nowhere is this more visible than in the state's hands-off approach to childcare.

In all other wealthy EU countries, childcare is considered an essential public service. In Denmark, Finland and Sweden, access to full-time care is guaranteed to all children aged one year or younger. A similar right exists in Germany, but state-run centres closing at lunchtime is common, making full-time employment difficult for mothers in particular.

In Austria, Belgium and France, public childcare is available for the year or two before children start primary school. In Ireland, where private for-profit businesses provide the majority of childcare facilities, there is no legal right to a childcare place. However, the right to access childcare doesn't automatically guarantee it is affordable for parents.

While all member states offer some support to reduce childcare fees, there is significant variation in the generosity of this support and the resulting out-of-pocket expense for parents.

In eight of the EU27 member states, free or low-cost publicly provided childcare is available for all children, irrespective of how much their parents earn or the family type. More typically, childcare subsidies are more generous for low-income, lone-parent and migrant families.

In Ireland, during the Celtic Tiger years, a fourfold increase in child benefit was used as a vehicle to help working parents with childcare costs in a way that ensured families caring for children in the home would benefit equally from social spending.

More recently, a new National Childcare Scheme, launched in November 2019, provides universal (paid to all) and top-up targeted (must meet certain criteria) subsidies for all children aged between 24 weeks and 15 years using a registered childcare provider. This new scheme is a landmark in Irish social policy development in giving parents a right to financial support for childcare fees for the first time.

Despite this, the cost of childcare for parents in Ireland remains one of the highest in the EU.[1] An average working couple spends 20% of their joint income on full-time fees for two pre-school children. This is a larger share of the family budget than is typically spent on housing costs (15.7%).

As a result, Ireland has one of the lowest rates of working mothers in the EU27 alongside Italy, Greece and Spain, where one-third of women aged 25-54 with children are outside the workforce. One of the main contributing factors to our crippling cost of childcare is that, unusually, fees are not subject to any regulation by the state, nor are costs capped for parents in Ireland.

Business owners often point to underinvestment by the government. Funding is comparatively low and markedly below the UNICEF recommended benchmark of investing at least 1% of GDP in early-years childcare. However, the Parliamentary Budget Office notes that it is not clear what effect the significant increased funding over the past decade has had on costs for parents.

At the same time, professionally qualified staff in the sector continue to be some of the lowest paid workers in the economy and paid far less than their EU counterparts, a longstanding fact only acknowledged by the government in the past year with a commitment to introducing agreed minimum terms and conditions for the sector's 30,000 female workforce.

It beggars belief that the state's continued absence from childcare is happening against the backdrop of having the youngest population in the EU. The crisis in childcare is not a niche issue.

The market has failed. The state must recognise childcare as an essential public service for which it is primarily responsible for delivering and resourcing. It's the European way. It's the only way to guarantee accessible and affordable childcare for families and decent pay and conditions for workers.

Laura Bambrick is the social policy officer with the Irish Congress of Trade Unions

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Bulletin Board

With INMO director of industrial relations Albert Murphy

Employment rights during parental leave

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

No, this is not the situation and your employer is incorrect. Parental leave is granted on the understanding that all of your terms and conditions of employment are protected. With this in mind, you are not considered to be a part-time worker, rather you are simply availing of a temporary reduction while on parental leave and so you are not regarded as being absent.

This means that you retain all your employment rights other than the right to remuneration and superannuation benefits. Should you have any further difficulties in this area, please get in touch with your INMO industrial relations officer who should be able to act on your behalf in this regard.

Annual leave entitlements during unpaid maternity leave

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

While on unpaid maternity leave, you are regarded as being in employment and should retain all employment rights, such as annual leave. During your 16 weeks of unpaid maternity leave, you can accrue annual leave and you should not lose any annual leave. You also accrue any public holidays that occur during this time.

Annual leave that is accrued during unpaid maternity leave can be taken at a time that is agreed between the employee and the employer and any public holidays that accrue will be added to the end of the period of unpaid maternity leave.

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

While on unpaid maternity leave or parental leave, you are entitled to continue to receive your increments and your incremental date should not change. However, as this period of time is unpaid, you do not contribute to the HSE superannuation scheme, so this period is not reckonable for pension purposes.

Interrupted breaks due to short staffing

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

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

In many wards it is common practice to record these situations in order to demonstrate the frequency of occurrence and we would advise you, if you are not already doing so, to implement this practice in your ward.

The INMO industrial relations officer for your area will meet with you and your colleagues to assist with this issue and I would encourage you to contact them with a view to having a ward meeting and progressing the matter.

Know your rights and entitlements

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

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

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

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Section focus

INMO Professional

Jean Carroll, Section Development Officer

Emergency Nurses Section meeting hears members' health and safety concerns

Outcome of emergency department taskforce meeting also discussed

A RECENT meeting of the INMO Emergency Nurses Section heard from members about the two forums that took place in March with INMO senior management regarding the serious concerns around the health and safety of patients and staff in their departments.

It is hoped that these forums will give the INMO further impetus to pursue these issues with the Minister for Health and senior HSE officials.

INMO president Karen McGowan, advanced nurse practitioner in emergency nursing at Beaumont Hospital, Dublin, also presented to the meeting on these issues.

A letter of reply from a recent Oireachtas Health Committee meeting is expected, which will be shared with members of the Emergency Nurses Section.

The emergency department agreement, safe staffing recommendations and the Prof Keane report are all tools being used to progress ED issues, the meeting heard.

Members are to be assured that issues continue to be raised at the ED taskforce, as well as with the National Joint Council and the HSE.

The ED taskforce met in March and April to raise awareness with the government and the Minister for Health of the effects on EDs and overcrowded wards of the current level of Covid-19 infection.

Members of the taskforce expressed the need to curtail elective services and increase capacity in private hospitals until this high admission rate reduces, which at the time of writing was predicted to last until at least the end of April.

Correspondence was issued to the government and Tony Holohan and public statements were made. At the time of going to press we awaited a response.

The INMO highlighted health and safety issues, delay in Covid-19 swab results and staffing issues and capacity as issues causing overcrowding in Ireland's EDs.

A member from University Hospital Limerick reported on the recent visit of the Health Information and Quality Authority (HIQA) to the hospital, stating that it was recommended that the triage department receives better staffing to improve key performance indicators. At the time of this meeting, the HIQA report had only been supplied to management and had not been seen by staff. The INMO has requested that staff see this report.

Mick Schnackenberg, section chairperson, outlined how HIQA stated via Twitter that they are to visit all EDs throughout the country.

The section is hosting its second annual webinar on June 9. See *page 66* for details.

Email jean.carroll@inmo.ie if you wish to join to the Emergency Nurses Section.

Retired Nurses Section enjoys visit to Kilmainham Gaol

The Retired Nurses Section enjoyed a tour of Kilmainham Gaol on April 5, which included a guided tour of the Gaol and lunch in the Hilton afterwards. The section is looking forward to its next trip to Killarney in May and hopes to complete a busy diary of events this year. Pictured on the day were (l-r): Myra Garahan, Mae Sanfey, Mary Giblin and Geraldine Sweeney

International Section delegation visits Nigerian embassy

A group representing Nigerian members of the INMO International Section visited the Embassy of Nigeria in Dublin in March. The group spoke with Nigeria's ambassador to Ireland Ijeoma Obiezu about the strategic importance of a close relationship between the embassy and Nigerian nurses in Ireland. The group also asked the ambassador to appeal to the Irish government to fast-track the family reunification applications of Nigerian nurses working in Ireland. Ms Obiezu praised the contribution of Nigerian nurses to the Irish healthcare system and promised the embassy's renewed support for Nigerian nurses in Ireland. On behalf of the section, the group extended an invitation to the ambassador to visit INMO HQ later in the year. Pictured at the Embassy of Nigeria in Leeson Street, Dublin on March 16 were: Grace Oduwole, INMO International Section, and Ijeoma Obiezu, Nigerian ambassador to Ireland

INMO Professional

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2022 Webinars & Conferences for Nurses and Midwives

Webinars and Conferences 2022

ONLINE AND IN-PERSON EVENTS

All conferences and webinars are Category 1 approved by NMBI

Thursday **9** JUNE — **Emergency Department Nurses Section Webinar**

Tuesday **20** SEPTEMBER — **Care of the Older Person Section Webinar**

Wednesday **28** SEPTEMBER — **Telephone Triage Nurses Section Conference**

Thursday **17** NOVEMBER — **All Ireland Midwifery Conference**

Saturday **2** JULY — **International Nurses Section Culturefest**

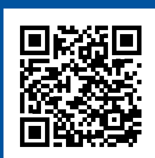
Saturday **8** OCTOBER — **Operating Department Nurses Section Conference**

Dates to be Confirmed

- **RNID Section Webinar**
- **Occupational Health Nurses Section Webinar**
- **Director & Asst. Directors Section Webinar**
- **Public Health Nurses Section Webinar**

For more Information:

Jean Carroll, Section Development Officer
jean.carroll@inmo.ie, www.inmoprofessional.ie/conference



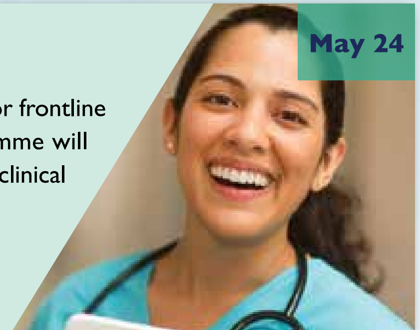
INMO Professional

Continuing professional development for nurses and midwives

INMO EDUCATION PROGRAMMES

In the pull-out this month…

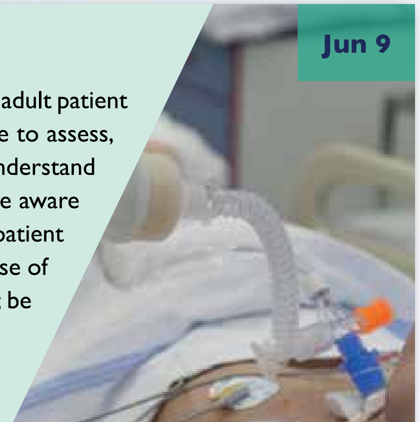
Introduction to Management and Leadership Skills



The aim of this short programme is to identify key managerial and leadership competencies for frontline nursing/midwifery managers and to explore how these are applied in practice. The programme will include management theory, effective leadership and team working, as well as delegation and clinical supervision. This programme will run from 10am to 1pm on the day.

Fee: €30 INMO members; €65 non-members

Tracheostomy Care Study Day



This programme introduces a holistic and interdisciplinary approach to the management of the adult patient with a tracheostomy. Participants will be given the necessary knowledge, skills and confidence to assess, manage and evaluate the nursing care of a patient with a tracheostomy. Learning outcomes: understand the anatomy of a tracheostomy tube; be aware of the different types of tracheostomy tube; be aware of the complications associated with a tracheostomy; communication and swallowing in a patient with a tracheostomy; how to manage tracheostomy emergencies safely; understand the purpose of humidification with a tracheostomy; manage safe suctioning of a patient with a tracheostomy; be aware of nursing care of a tracheostomy. 10am-1pm.

Fee: €30 INMO members; €65 non-members

International Yoga Day

10.00-11.00am, Richmond Education and Event Centre, Dublin

We invite all nurses and midwives to come together and celebrate the International Day of Yoga on the theme 'Yoga for Nurses' and Midwives' Health and Wellbeing'. While helping our patients, let's begin our healing through the practice of yoga asanas. The United Nations recognised yoga's universal appeal on December 11, 2014. The United Nations proclaimed June 21 as the International Day of Yoga by resolution 69/131. This day is celebrated all across the globe to raise awareness of yoga and its holistic approach to health. June 21 is also the summer solstice. On this day it is a tradition in yoga to revere the sun and draw its energy. Free for INMO members.

Steve Pitman
Head of Education and Professional Development

The Richmond set for busy summer schedule

INMO Professional welcomes members and delegates to the 103rd INMO annual delegate conference in Sligo. This will be the first in-person ADC since 2019 and will be a fantastic opportunity to meet friends and colleagues for debate and discussion. Don't forget to come and visit the INMO Professional stand at the conference.

The INMO will be commemorating Ruth Ormsby on Friday, May 6 in Dromore West. Ruth was a nurse and a member of the 15th International Brigade that travelled to Spain in 1937 as part of the fight against Francisco Franco and the rise of fascism. Ruth was born in Belville, Sligo, and trained as a nurse in Glasgow. She died tragically in Barcelona on May 4, 1938, becoming the only Irish woman to be killed during the Spanish Civil War. A wreath will be laid at the cairn constructed by the Friends of the International Brigades in Ireland in 2018.

ICN NP APN Network Conference 2022

Registration is open for the 12th ICN NP APN Network Conference that will take place in UCD on 21-24 August, 2022. This international conference will be the largest gathering of nurse and midwife practitioners in 2022. The conference is open to all advanced nurse/midwife practitioners and clinical nurse/midwife specialists. Further information is available at **www.npapndublin2022.com**

Conferences

A number of conferences, webinars and meetings are organised for INMO sections throughout 2022. The Emergency Department Nurses Section conference takes place on June 9 and the Care of the Older Person Section webinar takes place on September 20. See the *Diary* on *page 66* for a full list of upcoming section events.

The annual INMO and RCM Northern Ireland All-Ireland Midwifery Conference will be held in person on Thursday, November 17, 2022 at the Slieve Russell Hotel in Co Cavan. The theme for this year's conference is 'Midwives – Visible and Valued'. This will be a great networking opportunity for midwives across Ireland. The call for abstracts and posters will be published in *WIN* ahead of the event and on the INMO website in the coming weeks. See **www.inmoprofessional.ie**

The 6th Sigma Biennial European Conference will be held in Dublin at the RCSI University of Medicine and Health Sciences Dublin in June 2022. This conference will bring together nurse leaders to showcase cutting-edge research and clinical practice initiatives that demonstrate nursing and midwifery leadership in the development of sustainable health systems and services with global reach and local impact. Further information is available at **www.omegaepsilon.sigmanursing.org**

The National Nursing and Midwifery Digital Healthcare Conference takes place on Friday, May 20, 2022 at the Convention Centre in Dublin. The event will also be streamed live. The call for posters is open until May 6. Further information about registration is available at **www.smartsurvey.co.uk**

International Day of Yoga

THE RICHMOND
EDUCATION AND EVENT CENTRE

Nurses and midwives are invited to come together and celebrate International Day of Yoga with the INMO on June 21. The event will be held in the Richmond Education and Event Centre, Dublin, between 10am and 11am. The theme for the event is 'Yoga for Nurses' Health and Wellbeing'.

The United Nations (UN) recognised yoga's universal appeal on December 11, 2014. The UN proclaimed June 21 as the International Day of Yoga by resolution 69/131. This day is celebrated across the world to raise awareness about yoga and its holistic approach to health. This is also the summer solstice, and on this day it is a tradition to revere the sun and draw its energy. See **www.inmoprofessional.ie**

On-site Education

INMO Professional offers an extensive range of on-site programmes facilitated by expert practitioners. If you are interested in booking one, email marian.godley@inmo.ie or call 01 6640642.

Delivering courses and writing for *WIN*

INMO Professional is eager to offer members the opportunity to work with us in delivering education courses. If you are an advanced nurse or midwife practitioner, a clinical nurse/midwife specialist or a nurse/midwife with expertise in clinical or management practice, we would like to hear from you by email: education@inmo.ie or Tel: 01 6640642.

INMO Professional is also interested in hearing from members who would like to write professional and clinical articles for *WIN*. Email steve.pitman@inmo.ie

INMO Professional

Online Education Programmes

Tel: 01 6640641/18
Email: education@inmo.ie

All of the following programmes are category 1 approved by the NMBI and allocated continuous education units
Fee: €30 members; €65 non-members
Time: 10am-1pm

Book three online education programmes and get the fourth free
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Keep your CPD up to date • Extensive range of programmes • NMBI category 1 approved • Digital certification provided

May 10 **Risk Management and Incident Reporting**

This course outlines the principles of best practice in managing risk, enabling participants to understand terms related to risk management in healthcare, outline the stages of the risk management process based on the international standard and framework for risk management, outline the five steps of risk assessment, understand the purpose of a risk register and complete accurate records of incidents.

May 10 **Understanding and Developing Care Plans for Nurses and Midwives**

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

May 11 **Introduction to Treating and Preventing Pressure Ulcers**

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

May 12 **Telephone Assessment and Advice Skills**

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

May 12 **Best practice for Clinical Audit for Nurses and Midwives**

This programme teaches the necessary skills to implement a clinical audit in their practice and enable them to deliver evidence of improved performance for safer and better care for patients and improved quality service. Participants will be provided with an overview of clinical audit and be informed about each stage in the clinical audit cycle: topic selection, standards development, data collection, data analysis, reporting, implementing changes and re-audit. There will be an emphasis on continuous quality and safety improvement in healthcare.

May 12 **Best practice for Clinical Audit for Nurses and Midwives**

This programme equips nurses and midwives with the necessary skills to plan and implement a clinical audit in their practice and enable them to deliver evidence of improved performance for safer and better care for patients and improved quality service. Participants will be provided with an overview of clinical audit and be informed about each stage in the clinical audit cycle: topic selection, standards development, data collection, data analysis, reporting, implementing changes and re-audit. There will be an emphasis on continuous quality and safety improvement in healthcare.

May 13 **Adult Asthma Getting the Basics Right**

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

Official sponsors of the Richmond Education and Event Centre

Cornmarket

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

May 16 **Introduction to Effective Library Searching Skills**

This short online course is aimed at nurses and midwives who would like to develop valuable lifelong information seeking skills to get the most up to date information for clinical practice, reflection, or policy development. This course will assist participants who are undertaking academic programmes.

May 18 **End of Life Care in Residential Care Settings for Older Persons**

This programme outlines information specific to the care and support of residents and their families in end of life care. It aims to recognise signs and symptoms of deterioration, and will assess, monitor and review physical, psychological, social and spiritual areas of care at the end of a person's life. Participants will be able to identify effective interpersonal communication with families of a loved one at end of life during this difficult period. Furthermore, the outline of debriefing of staff and bereavement care for residents and relatives is addressed.

May 24 **Introduction to Management and Leadership Skills for Nurses and Midwives**

The aim of this programme is to identify managerial and leadership competencies for frontline managers and to explore how these are applied in practice. The course will include management theory, effective leadership and teamwork, as well as delegation and clinical supervision.

May 25 **Introduction to Wound Management for Nurses and Midwives**

Topics covered in this course will include wound healing, wound bed preparation, treatment options and dressing selections. Participants will learn about the anatomy and physiology of wound management, the factors influencing wound healing, the differences between acute and chronic wounds, implementation of a holistic assessment of individuals with wounds and different types of dressing and their application.

Jun 9 **Tracheostomy Care Study Day**

This programme introduces a holistic and interdisciplinary approach to the management of the adult patient with a tracheostomy. Participants will be given the necessary knowledge, skills and confidence to assess, manage and evaluate the nursing care of a patient with a tracheostomy. The programme will cover the anatomy, the different types of tracheostomy tubes, complications communication and swallowing in a patient with a tracheostomy, how to manage emergencies safely, the purpose of humidification, managing safe suctioning of a patient and how to be aware of nursing care of a tracheostomy.

Jun 14 **Medication Management Best Practice – Guidance for Nurses and Midwives**

This short online programme supports safe, evidence-based practice in the area of medication management thus preventing medication errors and near misses. The programme will cover key topics such as: the key principles of medication management, the medication management cycle, management of controlled drugs and medication safety. Participants will have the opportunity to update their knowledge in line with the NMBI Guidance for Registered Nurses and Midwives Administration (2020) and HIQA requirements for medication management.

Jun 15 **Navigating your Way Through Conflict**

The key learning outcome for this online interactive short course will be to help participants develop the insights and skills necessary to successfully navigate their way through conflict situations and reach satisfactory solutions.

Jun 16 **Retirement Planning Webinar**

This webinar is to help support you in planning your retirement and will briefly cover the following: superannuation and your entitlements, options for drawing down your AVC at retirement, considering lump sums and AVCs before retirement, protecting your lump sum against inflation, key steps to long term investing, top tax tips for retirement and a Covid-19 Q&A session.

Jun 21 **Overview of Nursing Assessment and Management of Stroke**

This course will give participants an overview of nursing assessment and management of stroke. At the end of the training participants will be able to: identify and discuss the two types of strokes; identify and ascertain the various treatment options; understand best practice for the nursing care of people who have suffered an acute stroke, including secondary prevention; be aware of aetiology of stroke and rationale for specific diagnostic tests.

When booking online courses please note:
Places must be booked in advance. You will need a reliable computer and internet access. Please ensure a correct email is provided when registering. Certificates for participation will be issued in digital form and sent by email. Do not hesitate to contact us at Tel: 01 6640641/18 or email: education@inmo.ie

Jun 21 **International Yoga Day**

Inviting all nurses and midwives to come together and celebrate International Day of Yoga with INMO on the theme 'Yoga for Nurses' and Midwives' Health and Wellbeing'. While helping our patients, let's begin our healing through the practice of yoga asanas. United Nations recognised yoga's universal appeal on December 11, 2014. The United Nations proclaimed June 21 as the International Day of Yoga by resolution 69/131. This day is celebrated all across the globe to raise awareness about yoga and its holistic approach to health. June 21 is also the summer solstice. On this day It is a tradition in yoga to revere the sun and draw its energy.

Jun 22 **Become More Assertive**

This short online programme is designed to help nurses and midwives develop their skills to be more assertive to help them make decisions with conviction; to deal with difficult situations and people and to influence others positively.

Jul 6 **Paediatric Asthma Understanding the Basics**

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

Jul 7 **Tools for Safe Practice** *(free for INMO members)*

This programme provides safe practice tools to protect the nurse and midwife and patient within current healthcare settings. This is an awareness session to ensure all staff have an understanding of the process involved regarding patient alerts, clinical incidents and thorough assessment, while remaining focused on patients and individual staff. The programme addresses patient safety and staff safety and provides five key tools on areas of documentation, clinical incident reporting, safety statements, best practice guidelines regarding assessment and communication practices in a complex multifaceted healthcare arena.

Sep 1 **Type 1 Diabetes Management for Nurses and Midwives**

This short online programme will provide nurses and midwives with knowledge and skills regarding Type 1 Diabetes. The literature would suggest that diabetes, chronic disease management and the self-care that is associated with it brings high incidence rates of depression, anxiety and negative thoughts. The use of different strategies, self-management, treatment options, insulin pump therapy and CGM will be looked at to improve patient self-management. The exploration of these strategies and management of Type 1 diabetes is a necessary component to help nurses/midwives try and formulate plans to look at issues that clients face.

Sep 1 **Infection Control Regulation 27: guide to thematic/focused inspections in your facility**

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

Sep 7 **Become More Assertive**

This short online programme is designed to help nurses and midwives develop their skills to be more assertive to help them make decisions with conviction; to deal with difficult situations and people and to influence others positively.

Sep 7 **'Therapeutic Use of Mindfulness' for Nurses and Midwives**

This three-day online course is for nurses and midwives who work in the area of chronic illness, mental health, maternity care, parent education, palliative care, old age care and want to support their patients by teaching them mindful breathing and meditation techniques. If you embrace the holistic aspect of nursing care and keen to explore innovative ways of providing health care with the therapeutic use of mindfulness, then this course is for you. Mindfulness cultivates a stable healing presence that benefits patients and providers alike. Mindful nurses/midwives can teach their patients how to use breath as an anchor to bring the mind home to the body and experience more peace and calm. Dates: 7, 14 and 21 September. Fee: €180 INMO members; €390 non members.

Sep 9 **Adult Asthma Getting the Basics Right**

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

Official sponsors of the Richmond Education and Events Centre
Cornmarket

Sep 13 **Best practice for Clinical Audit for Nurses and Midwives**

This programme equips nurses and midwives with the necessary skills to plan and implement a clinical audit in their practice and enable them to deliver evidence of improved performance for safer and better care for patients and improved quality service. Participants will be provided with an overview of clinical audit and be informed about each stage in the clinical audit cycle: topic selection, standards development, data collection, data analysis, reporting, implementing changes and re-audit. There will be an emphasis on continuous quality and safety improvement in healthcare.

Sep 13 **Tools for Safe Practice** *(free for INMO members)*

This programme provides safe practice tools to protect the nurse and midwife and patient within current healthcare settings. This is an awareness session to ensure all staff have an understanding of the process involved regarding patient alerts, clinical incidents and thorough assessment, while remaining focused on patients and individual staff. The programme addresses patient safety and staff safety and provides five key tools on areas of documentation, clinical incident reporting, safety statements, best practice guidelines regarding assessment and communication practices in a complex multifaceted healthcare arena.

Sep 14 **Falls Reduction, Assessment & Review**

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

Sep 14 **Wound Management for nurses and midwives**

This short online course will advise participants on wound care management. Topics covered on the day include; wound healing, wound bed preparation and treatment options, and dressing selections.

Sep 15 **Diabetes CBT and general wellbeing**

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

Venue
The Richmond Education and Event Centre, Dublin

Training, Delivery and Evaluation

September and October 2022

5 Day PROGRAMME

Day 1 **Tues 20 - Sept**
Day 2 **Wed 21 Sept**
Day 3 **Thurs 22 Sept**
Day 4 **Tues 4 Oct**
Day 5 **Wed 5 Oct**

9.30am to 5.00pm

30 NMBI CEUs

Module 6N3326 - QQI Level 6
Category 1 Approved by NMBI

FOR MORE INFORMATION CONTACT:
Tel: 01 6640641 | Email: education@inmo.ie
Please note: This training is due to take place in person, pending further review closer to the time and government's guidelines.

FREE ONLINE COURSE

Retirement Planning WEBINAR

Thursday, 16 June 2022

Online from 2.00pm - 3.30pm

Places must be booked in advance to join this webinar.

- Superannuation and your entitlements.
- Drawing down your AVC at retirement.
- Consider a lump sum AVC before retirement?
- Protecting your lump sum against inflation.
- Key steps to long term investing.
- Top tax tips for retirement.
- Covid-19 Q & A: Retirement planning in uncertain times.

BOOKING YOUR PLACE IS ESSENTIAL

FREE LIVE ONLINE WORKSHOP FOR INMO MEMBERS; €20 FOR NON MEMBERS

TO BOOK YOUR PLACE CONTACT
education@inmo.ie or 01 6640641/18

FREE ONLINE COURSE

Tools for Safe Practice for Nurses and Midwives

3 CEUs

Thursday, 7 July 2022

Online from 10.00am - 1.00pm

Practical advice on:

- **Clinical Risk**
- **Report and Statement Writing**
- **Incident Reporting**
- **Documentation**
- **Fitness to Practise Complaints**

FREE LIVE ONLINE WORKSHOP
FOR INMO MEMBERS; €65 FOR NON MEMBERS

BOOKING YOUR PLACE IS ESSENTIAL

TO BOOK YOUR PLACE CONTACT
deborah.winters@inmo.ie or 01 6640618

Celebrating our professions

May is an important month for nurses and midwives around the world as the two professions are celebrated

International Day of the Midwife

May 5, 2022

The theme of the International Day of the Midwife this year is '100 Years of Progress' – looking forward to coming together as a global midwife community to advocate for investment in high-quality midwifery care around the world, improving sexual, reproductive, maternal, newborn, child and adolescent health in the process.

International Nurses Day

May 12, 2022

The International Council of Nurses (ICN) International Nurses Day theme for 2022 is 'Nurses: A Voice to Lead – Invest in nursing and respect rights to secure global health'. Nurses continue to be challenged by the Covid-19 pandemic; yet far from backing down in the face of these challenges, they have stood up to them with incredible strength and dedication, despite difficult and even life-threatening working conditions. The daily care nurses provide in all settings is now receiving more recognition and accolades from the public, yet little in the way of serious investment from governments and health systems.

It is now time for governments and health systems to invest in nursing education, address the growing nursing shortage, provide positive practice environments and adequate remuneration, ensure gender equity and involve nurses in decision-making at all levels and in all aspects of health and healthcare.

Investment in the nursing and midwifery workforce means we can restore, transform and strengthen health systems to ensure health equity. By investing in nursing and midwifery, we can build a stronger, more resilient, competent and satisfied workforce to meet the challenges that lie ahead.

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Library services

The library has a number of services to support your practice and educational requirements, including literature searching, document supply, reference desk assistance and searching consultations. To find out more, call 016640614 or email: library@inmo.ie

Library reopens in the Whitworth building

After some remodelling and renovation, we are delighted to announce that the library has reopened in the basement of the INMO Whitworth building. The bright, spacious room houses the book, journal and thesis collections. We now have a separate quiet space for individual study, which is available to book. Contact the library on library@inmo.ie or 01-6640614 to make an appointment.

Online – Introduction to Effective Library Search Skills

Next course date: Monday, May 16, 2022

Fee: €30 INMO members; €65 non-members

This course is aimed at nurses and midwives who would like to develop their searching skills to effectively find the most relevant information for clinical practice, reflection and policy development. This course will also be of benefit to those who are undertaking, or about to commence, post-registration academic programmes.

Leadership in maternity

There are many different kinds of leadership and RCM i-learn offers a range of modules examining the key aspects of leadership for midwives

LEADERSHIP is proactive, visionary and transformative and there are many examples of excellent practice that demonstrate effective leadership. However, maternity services are under constant scrutiny, whether it relates to poor outcomes or best use of financial services.

RCM i-learn offers a range of modules on the topic of leadership. Each module offers insight into the key aspects of leadership for midwives on a broad range of topics and are very digestible only taking 10 minutes to complete.

Introduction to leadership

This introductory module sets the scene on leadership in maternity. It is based on a model of leadership which was developed for senior midwives in the 1990s. More recently there has been a greater realisation that leadership is the role of everyone and not something which should simply be the preserve of managers.

On completion of this i-learn module on midwifery leadership you will:

- Have an understanding of the leadership role at all levels
- Develop an appreciation of the difference between management and leadership and know what style is needed when
- Appreciate some of the current leadership theories and terminology
- Identify pathways for leadership development.

Leadership: promoting the profession

The word 'profession' means different things to different people. However, at its core, it is meant to be an indicator of trust and expertise. Recognising and championing the needs of women and families and supporting maternity staff highlights the value of the profession. All of the maternity staff are expected to demonstrate excellence and high-quality care, following the example of great role models and having the courage to face up to the daily challenges while striving to improve care. This module highlights aspects of promoting the profession and what it means to be a professional.

Having completed this module you will:

- Have an understanding of the maternity profession
- Understand the unique role of midwives and support workers and their value in respect of safe care
- Promote the profession locally and nationally through awareness campaigns and supporting professional organisations.

Leadership: driving results

Everyone working in maternity services has a role to play in improving care and driving results. This module looks at how working cultures can be changed to be supportive and to embrace development and evolution to help meet the needs of women and the service.

Having completed this module you will:

- Appreciate the need for practice to evolve and drive through results
- Consider the workplace culture and the impact on service
- Understand the roles and responsibilities of everyone in driving results.

Leadership: promoting learning

Women expect care from a practitioner who is knowledgeable and informed. This means that reviewing and updating knowledge and skills is a constant aspect of practice. This module looks at ways of promoting learning and how knowledge and skills can be shared within the workplace.

After completing this module you will:

- Understand the value of lifelong learning
- Appreciate the impact that professional development has on practice
- Understand the role of the leader in promoting learning
- Be able to actively encourage others to seek out development opportunities and provide support/guidance where appropriate.

RCM i-learn access for INMO midwife members

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

Spotlight on leadership

Nursing Now CHALLENGE

Personality-based leadership

TRAITS that can be described as distinguishing personal characteristics of a leader include emotional intelligence, integrity and honesty. One of the earliest research theories in leadership, the trait theory, was developed from the idea that leaders were born with certain traits or characteristics. Leaders, therefore, could not be 'made' because leadership traits were inherently part of a person's makeup from birth. This became commonly known as the 'great man theory,' attributed to a 19th-century Scottish philosopher and historian Thomas Carlyle,[1] who identified successful leaders as having a particular 'greatness' similar to a divine right to lead or rule.

Although out of touch with a contemporary view of leadership, this theory was important to the evolution of leadership theory and its association with a set of characteristics.[2] The great man theory was discredited by scholars, who found a weak link between traits and leadership success.[3]

Since then, leadership theory has expanded beyond that of the individual's traits into behavioural, situational and new leadership theories. However, research continues on what the most important characteristics for effective leadership are.

Interest in personality traits emerged again in the 1980s with the development of the 'big five' personality traits (openness, conscientiousness, extroversion, agreeableness and neuroticism).[4] This has renewed interest in the relationship between leadership and personality traits.[5] The development of the positive psychology movement over the past two decades with its focus flourishing[6] has influenced the development of approaches to leadership.

Rooted in positive psychology, strength-based characteristics have emerged as an important component of effective leadership. Character strengths are the positive parts of a person's personality that impact how they think, feel and behave and can help people to flourish in life.[7]

The VIA Institute on Character is a non-profit organisation that provides information on character strengths through the creation and validation of character surveys and the development of practical strengths-based tools.[7]

Table: The 24 character strengths[10]

Wisdom	Courage	Humanity	Justice	Temperance	Transcendence
Creativity	Bravery	Love	Teamwork	Forgiveness	Appreciation of beauty and excellence
Curiosity	Perseverance	Kindness	Fairness	Humility	Gratitude
Judgement	Honesty	Social intelligence	Leadership	Prudence	Hope
Love of learning	Zest			Self-regulation	Spirituality
Perspective					

Peterson and Seligman's study of strengths resulted in the VIA classification system, which identifies 24 universal evidence-based character strengths *(see Table)*. These strengths are grouped together under six broad virtues: wisdom, courage, humanity, justice, temperance and transcendence. Every individual possesses these character strengths on some level, and working together, they can create positive relationships and productivity in the workplace. The Institute maintains that focusing on character strengths can assist individuals in their personal development and also works for teams, groups and organisations.

Leadership is one of the 24 character strengths listed under the virtue of justice. However, it does not need to be listed in a person's top character strengths for them to be an effective leader. The key for a leader is to understand their own unique profile and to use their strengths in their own unique way through a series of interventions. Understanding the strengths that individual team members possess is also important for leaders. Developing character strengths within a team or organisation can increase collaboration, improve relationships and increase productivity.[7]

According to Kaplan and Kaiser,[8] many leaders do not understand their strengths and others that do understand their strengths can overuse one particular strength over another, thus compromising their effectiveness as a leader.

MacFarlane[6] argues that strengths must be developed more frequently and consistently to avoid this situation. Instead of focusing on the top five character strengths, exploring the middle ranking strengths is also essential.

Reflection is an essential tool in understanding the strengths of a leader and her team. Once a person has established their strengths, there is a process of developing actions to encourage their use.

Developing character strengths does not happen overnight and managers should invest time with their team to establish the most effective strengths and how to use them in practice.[9] Benefits of developing character strengths within a clinical team include creating new leaders, increasing productivity, reduced staff turnover and increased patient satisfaction.

Niamh Adams is INMO head of library services and Steve Pitman is INMO head of education and professional development

References available on request by emailing nursing@medmedia.ie (Quote Adams N, Pitman S. WIN 2022; 30(4):42)

A column by Maureen Flynn

Quality & Safety

Introducing the 'Just Culture Guide'

THIS month we are sharing information on a topic of great importance to everyone involved in healthcare – nurses, midwives, patients, services users and their families – building a 'just culture'. A just culture approach is key in gaining a shared understanding of how safety is achieved within any complex organisation.

Commitment two of the HSE's Patient Safety Strategy sets the ambition for a compassionate, just, fair and open culture in healthcare organisations and states that "staff must be actively encouraged to speak up for safety, feel psychologically safe, be involved in decisions which affect the safe delivery of care and be provided with the skills, support and time to engage in patient safety improvement initiatives".[1]

Just culture

The *HSE Incident Management Framework*[2] defines just culture as one which refers to a values based supportive model of shared accountability and proposes that individual practitioners should not be held accountable for system failings over which they have no control. It also acknowledges that there is a balance within a just culture, where staff also recognise that they are not absolved of the need to behave responsibly and with professionalism.

How it works

In a just culture, staff feel psychologically safe to report incidents, including near misses. A just culture balances the need for an open and honest reporting environment and accountability with a quality learning environment and culture. There is therefore an imperative to create an environment that encourages staff to speak up whether this involves the reporting of incidents or raising issues that pose a risk to the safety of service users, without fear of reprisal (*see box*).

Steps to facilitate a culture of safety in healthcare organisations[3]

- We need to move from looking at errors as individual failures to realising they are caused by system failures
- We must move from a punitive environment to a just culture
- We must move from secrecy to transparency
- Care must be patient centred
- We must move our models of care from reliance on independent, individual performance to interdependent, collaborative, interprofessional teamwork
- Accountability must be universal and reciprocal, not top-down

Just Culture Guide

Though many services espouse that they have a just culture, it is when incidents occur that this is tested. Avoiding an early rush to judgment is key. Rather, our response can be one of enquiry to better understand what happened, why it happened and what needs to change to reduce the risk of it happening again.

The *HSE Incident Management Framework*[2] includes a 'Just Culture Guide' (in Section 4). This can be used to guide decisions – not just support conversation – about whether a staff member involved in a patient safety incident requires specific individual support or intervention to work safely.

The 'Just Culture Guide' provides a consistent approach to the constructive evaluation of the actions of staff involved in patient safety incidents. The actions of staff involved in an incident should not be routinely examined using the 'Just Culture Guide', but it can be useful if in the course of managing or reviewing an incident there is suggestion of a concern about the actions of an individual.

The Guide includes an algorithm with accompanying guidelines and poses a series of structured questions about an individual's actions, motives, and behaviour at the time of the incident. The questions move through four sequential 'tests'. These are: deliberate harm; health test; foresight; and substitution.

The 'Just Culture Guide' concludes with a question about significant mitigating circumstances that might indicate consideration of broader issues that may explain what influenced the actions of the individual staff member. Action singling out an individual is rarely appropriate – most patient safety issues have deeper system-level causes and require wider action.

Learn more

You can read more about the *Incident Management Framework* and the Just Culture guide on the HSE National Quality and Patient Directorate website at: **www.hse.ie/eng/about/who/nqpsd/l** or by contacting Dr Samantha Hughes, project lead, QPS Incident Management Team by email to: samantha.hughes@hse.ie

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Quality Improvement forms a central focus of the newly formed HSE National Quality and Patient Safety (NQPS) Directorate led by Dr Orla Healy. We work in partnership with those who provide and access our health and social care services to build quality and patient safety capacity and capability in practice; and drive and monitor implementation of the Patient Safety Strategy 2019-2024 including reducing common causes of harm, enhancing processes for safety-related surveillance, safe systems of care and sustainable improvements. Read more at hse.ie or link with us on Twitter: @nationalQI or email @NationalQPS.ie

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Preparing for a job interview

Róisín O'Connell advises internship students on the dos and don'ts of job interviews

IN RECENT weeks I have received many queries from internship students across the country about interviews and how to prepare for them. Very few people enjoy job interviews, particularly at the start of their career. They can seem daunting and scary due to the element of uncertainty, especially if you are not prepared. It's important to remember that everyone gets nervous in the lead-up to an interview. However, if you prepare well beforehand, you will be ready on the day.

Interviews for nursing and midwifery roles are often done by panels, meaning that you could have two or three people interviewing you. There will likely be someone from HR present, as well as someone from the clinical area and a member of senior management. Usually, while one person is asking you a question, another will be documenting your answers. Try not to be distracted by this.

The questions asked are usually competency based, but some questions may be designed to let the employer know how you might fit into their organisation. It is a good idea to prepare some answers for general questions that you might be asked, eg. 'Why did you want to become a nurse or midwife?' or 'Tell me a bit about yourself'. This is your opportunity to stand out and tell the employer why they should choose you. You must familiarise yourself with your CV or application, as anything you have written can be asked about during the interview.

Before the interview

Preparation should begin well before the day of the interview. Some employers will look up candidates online before the interview. Search your name to see what comes up and if there is anything there that you would like to remove.

Researching your prospective employer is always beneficial. It helps if you can show a genuine interest in the organisation. This includes knowing about the ethos of the organisation or if it is known for its work in a particular specialty. It is very important to review the job description to see how well your skillset and CV match the role.

It is important to try to sleep well the night before, have a good breakfast and stay hydrated as these will all help you to focus and perform well. Know exactly where the interview is to take place to ensure you have allowed adequate time to get there. Aim to arrive ten minutes early and allow time for unexpected delays.

Turn your phone off, discard any chewing gum and dress appropriately. Wear smart but comfortable clothes. Some interviews may be held online, but the same principles should apply. If your interview is via a video call, be mindful of what is visible in the background.

During the interview

Make eye contact and smile when greeting your interviewers. Handshaking should be avoided in order to prevent the spread of Covid-19. Be aware of your body language and the way you communicate. Some people tend to slouch, fidget or speak too quickly when they become anxious. Similarly, some people tend to punctuate sentences with 'um' or 'ah' when nervous. Practising with friends/family beforehand and asking for honest feedback can help to make you aware of what to look out for. If you are unsure of the question, simply ask the interviewer to repeat it. This will offer you time to calm yourself down and think about your answer.

The 'STAR' technique *(see Table)* can be helpful when answering competency-based questions, as it can be used to demonstrate previous experience, eg. 'How would you prioritise your patient caseload?' or 'Tell me about a time you managed conflict on your ward'.

Some questions may be skills- or knowledge-based, eg. 'Tell me about the ISBARR', while others will focus on your professional development, eg. 'How do you keep up to date in your practice?'

'STAR' technique	
Situation	Describe the event or situation that you were in
Task	Explain the task you had to complete
Action	Describe the specific actions you took to complete the task
Result	Close with the results of your efforts

Remember that you are applying for a staff nurse/midwife position, and so you should avoid limiting yourself by using phrases like 'I can't do that as I'm only an intern'. Instead, you could say what you would do as a staff nurse/midwife.

After the interview

Interviewers will often ask candidates if they have any questions and it can be helpful to come up with a few to demonstrate your interest. Thanking your interviewers for their time will leave them with a positive impression. Whether or not the interview goes well, you can ask for feedback on the interview after you are contacted with a result. This can help you to improve your interview skills for next occasion.

Róisín O'Connell is the INMO's student and new graduate officer

Child sexual abuse and pregnancy

Hazel Katherine Larkin discusses the effects that a history of child sexual abuse can have on a woman in pregnancy and the steps that midwives and nurses can take to mitigate any related distress

CHILD sexual abuse (CSA) is a sad fact of life for thousands of people in Ireland. The only nationwide survey on the incidences of sexual violence in this country – The SAVI (Sexual Abuse and Violence in Ireland) Report – turns 20 this year.[1] The results of the survey which informed the report revealed that one women in five who responded had experienced contact sexual abuse in childhood. A further one in 10 women reported experiencing non-contact sexual abuse when they were children.

For several reasons – including the report's methodology and the explosion of the internet – these numbers can no longer be accepted as a true reflection of the levels of child sexual abuse in Ireland. What can be accepted, however, is that during your career, you will care for many pregnant and birthing women who have histories of CSA.

There is no denying that a history of child sexual abuse affects a woman's experience of pregnancy, labour, birth and breastfeeding. But how can you, as a nurse or midwife, work with a woman who has a history of CSA to ensure her experiences of healthcare are as positive, or even healing, as possible?

Levels of remembering

What I always stress to women who disclose is that it's not the level of abuse that matters, it's the effect it has on them. For many, it's not just what happens to them that affects them (the actual abuse), but what doesn't happen (the support, the belief). For midwives and nurses, the difficulty isn't necessarily when women disclose, rather it's when women don't disclose.

Given the statistics and the fact that such high numbers report (and we know that many more don't), I always suggest that practitioners treat every woman as though she has been sexually abused, whether or not they disclose, until they categorically tell you that they haven't been.

It's worth noting, however, that women who don't have conscious awareness of their histories of abuse, can have the memories triggered by stressful situations – such as pregnancy and childbirth. As dissociated memories of sexual abuse emerge, or re-emerge, they often manifest as shadowy, vague, dreams, daydreams, or feelings of panic, anxiety, snatches of memory or flashbacks.

Process of recall

While some women never forget their abuse, others suppress the memories. Women survivors are often anguished for the length of time it takes them to remember the abuse. Often, memories don't surface until the abuser has died and it feels 'safe' to remember.

Sometimes abuse memories start coming as body sensations, flashbacks or through remembered fragments of events. Even if the women themselves are not cognitively aware of their histories, their bodies will retain the memory and react as the body of an abused woman.[2,3]

Trauma

Trauma is defined as an event that is life-threatening, catastrophic, terrifying and/or accompanied by a sense of helplessness and powerlessness. Trauma can manifest in psychological symptoms such as nightmares, sleeplessness, flashbacks to the event, intrusive thoughts, feelings of panic; avoidance of anything associated with the trauma (for example, a place or people with similar features to the abuser); and dissociation.

In 2013 the Icelandic Research Centre investigated the long-term health sequelae on women who had been sexually abused as children. They found correlations between CSA and a myriad of physical diseases and disorders. All of the women reported having an eating disorder of one kind or another. Many others reported having used alcohol and/or drugs (prescription and street) to try to ease their emotional pain.[4]

CSA survivors report complex physical symptoms without clear physical aetiology. These include migraines, digestive issues, cardiac arrhythmia, angina and hypertension, dizziness, fainting, glandular dysfunction, problems with the lymphatic

and nervous systems, chronic fatigue and fibromyalgia.

Impact of CSA on pregnancy

It may seem extraordinary, but the earliest piece of research I came across linking CSA with difficulties during childbirth was published in 1994.[5] The author referred to her work as "exploratory research" because the literature revealed no "association between a woman's history of incest and her subsequent childbirth experiences". Thankfully, more work has been done in the area since, and we know a lot more about the impact of CSA on pregnancy. I highlight a few of these issues below.

Becoming pregnant

Pregnancy is a time of monumental change for women. It is a time when past, present and future collide in our bodies and minds. It's a time of great vulnerability for every woman, but especially so for women who have histories of sexual abuse.

Past

For every woman, pregnancy brings up memories of their own childhoods and of their own mothers. For women with histories of child sexual abuse, these memories are often very painful. Even if their mothers did not sexually abuse them, their mothers were often guilty of ignoring obvious signs, of disbelieving their daughters or of neglecting them, or both. The experience of not being loved and cared for can frighten some women into believing that they can't possibly be good parents themselves. Fear that her child will be similarly abused can plague a woman during and after pregnancy. This is particularly true if she has a daughter.

Present

The present – being and staying pregnant – can be fraught with difficulties, too. Being pregnant can bring up anxieties about keeping her baby safe from the kind of dangers she herself encountered as a child. A woman may be fearful of the idea of bringing a child into the world. Some women also feel a huge burden of responsibility associated with keeping her child safe. She may feel a lack of control over her own body and what happens to it – yet again. It is also not uncommon for survivors to feel that their bodies are broken, abnormal, dirty or damaged.

They may also feel concerned about their babies passing through their birth canals because they feel they are 'unclean', and their babies will be 'dirtied' by passing through their vaginas. A conviction that their bodies don't work 'properly' can mean that women with a history of abuse worry excessively that they will miscarry, deliver early or have a baby that is 'damaged' in some way.

Survivors are also more likely to conceal their pregnancies, through either a denial that their bodies are being 'used' by another person again or through concern that their bodies will be poked and prodded by strangers (medical professionals) because they are pregnant, meaning that their bodies will, once again, not 'belong' to them.

Future

Pregnancy makes everyone think about the future in ways that most other life experiences don't. Survivors think about all the same things as other women, the type of buggy they'll use, cloth or disposable nappies, co-sleeping, etc, but can also become riddled with anxiety. They may also worry that they won't be able to protect their children from harm, particularly abuse. In addition, they may have intrusive thoughts wherein they visualise themselves or their partners harming the baby. They may begin to worry about respectful nappy changing and bathing and may also be worried about sharing these fears in case there is an adverse response.

Issues of control

Here's where you and your skills come in – presenting an opportunity to have a very positive impact on the women you care for. Some survivors can be intimidated by medical personnel and the medical system. For them, healthcare providers may represent authority, power and control in a way that is similar to the authority figures of their childhood – the same authority figures who abused her or who didn't protect her.

Pregnancy may bring a variety of abuse issues to the surface. If recognised and handled appropriately, there is great potential for healing. Respectful, individualised treatment by a nurse or midwife is something everyone wants. For survivors of child sexual abuse however, such treatment is one of the most effective ways to avoid re-traumatisation and to mitigate the harm that has already been done to them.

It's worth noting that you and your patient may have different views of what it means to be treated with respect. This might be rooted in differences between you and her regarding things other than, or in addition to, her experience of abuse. These differences might include country of origin, ethnicity, class, background, religion, age or disability (seen or unseen).

It might be a good idea to tell the woman that you want to treat her with respect and consideration and then ask her what that means to her. We need to bear in mind that if we do not treat women with respect, tenderness and patience, we are adding another layer of mistreatment.

When conducting examinations, it is my experience that survivors find it very helpful if the nurse/midwife names the elements that might remind her of the abuse. This helps the woman to prepare, or try to, for the emotions that may surface. It can also be useful to ask the woman how she reacts to her triggers, and letting her know that if she's triggered, the examination will stop.

It's also useful to remind her that the key difference between the abuse and what you're doing is that you have her best interests at heart. You are taking care of her, while her abuser was doing the opposite.

Finally, I am aware that many readers of this piece will be both healthcare workers and survivors of child sexual abuse. As such, your patient's disclosure of CSA might be triggering for you. It's important to respect your own feelings and reactions and to practise gentle self care.

Conclusion

A history of child sexual abuse can have a profound impact on a pregnant, birthing and breastfeeding woman. Feeling empowered every step of the way cannot only prevent further emotional and psychological damage to the woman, it can also assist in her attenuation of the trauma she has suffered. As nurses and midwives, you are uniquely placed to offer that kindness, support and space for healing. We all remember our birth experiences for the rest of our days; and facilitating a CSA survivor's remembrance of birth fondly and as occasions of empowerment, healing and growth is one of the most profoundly generous gifts you can give a woman in your care.

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See: www.traumarecovery.ie for more

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The case for water birth

Margaret Dunlea, Jeannine Webster and **Magda Ohaja** review the evidence in favour of water birth and urge the HSE to lift the restrictions on access to this safe and effective birthing method

ON MAY 5 we celebrate the International Day of the Midwife. As part of this celebration we wish to reiterate the central role midwives play in ensuring a high-quality, safe maternity service.

The convincing evidence of the benefits of midwife-based strategies to best protect women and babies worldwide was compiled and presented in the 2014 *Lancet* series that focused on the improvement of maternal and newborn health through midwifery care.[1] This was later showcased by the World Health Organization as the strategy that is at the core of securing the safety of women and babies globally.[2] Central to this is matching the right healthcare provider with the right childbearing woman, in the right birth setting.

Midwives play a pivotal role in providing safe birth options for women. One such option is a water birth. Use of a birthing pool is now considered a safe alternative to medicalised birth for those women who have a low-risk pregnancy.[3,4]

Background

There are 19 maternity units and hospitals in Ireland. Traditionally, Ireland's maternity services are highly medicalised and risk averse; over 99% of women give birth in a consultant-led hospital unit, despite 60% of women being healthy, with no identified risks at the start of labour.[5]

Where are water births available?

In 2004 two co-located midwife-led units (MLUs) were established in Cavan General Hospital and Our Lady of Lourdes Hospital, Drogheda.[6] This gave women in these areas more control over their birthing options, including access to a birthing pool.

The HSE Home Birth Services were established in 2008 when the HSE contracted the Self-Employed Community Midwives (SECM) to provide homebirth services. According to the HSE, a planned home birth is an acceptable and safe option for low-risk women.[7]

Six of the other 17 maternity hospitals around the country have a birthing pool available on request:

- Coombe Women and Infants University Hospital
- The National Maternity Hospital
- Cork University Maternity Hospital
- University Maternity Hospital Limerick
- University Hospital Waterford
- Wexford General Hospital.

Units that have future plans to install a birthing pool include:

- Portiuncula University Hospital
- Midland Regional Hospital Mullingar
- University Hospital Kerry.

While the Rotunda has a birthing pool in situ, it will only become operational once midwifery training programmes are completed.

Benefits of a water birth

Some women like to labour in water because it helps them cope with the contractions.[3,4] It also protects and supports physiological processes.[8] This is particularly true in the medicalised/hospital birth setting where medical intervention is the norm. It also contributes to a positive and safe maternity care experience.[3]

Mothers generally want to stay in the water for the birth because warm water immersion during the pushing stage can be comforting.[4] The alternative for pain management is epidural anaesthesia, which can negatively effect the physiological birth process and is not without risk.[9]

Who can use a birthing pool?

Using the birthing pool for labour is a viable and safe option for women who are healthy and well with no known problems at the start of labour.[3,4]

Attending the mother during a water birth

Midwives attend the birthing mother during a water birth. Women interested in having a home birth should contact a designated midwifery officer or the SECM directly via the HSE website. Similarly, midwives employed by the HSE/voluntary hospitals will attend the mother should she give birth in the MLU or the consultant-led hospital setting. With a home birth, women have the added advantage of knowing the midwife who attends them in labour.

Evidence on water birth safety

The largest study so far into the safety of water births conducted in the US by Bovbjerg et al[4] compared 17,530 water births and 17,530 non-water births in a healthy, low-risk pregnant population. The two groups were similar in age, education and pregnancy characteristics. There was a lower risk of several maternal and neonatal outcomes, including postpartum haemorrhage, fewer perineal lacerations and hospitalisation soon after birth, and no increase in neonatal death in women who gave birth in water.

Importantly, there was no difference in the number of neonatal deaths between babies born underwater and those born 'on land'. Neonatal hospital admissions were also reduced in babies delivered in water. The risk of uterine infection did increase by 3:5,000 and the risk of the umbilical cord snapping before it could be clamped increased to 20:5,000. However,these events did not have any long-term effects on safety outcomes.

Access restrictions

If women are interested in using a birthing pool at home, they should discuss this with their midwife. To be eligible to access home birth in the first instance, women need to meet a restrictive, low-risk obstetric criteria agreed by the HSE. These eligibility criteria are not fully compatible with international best standards and exclude women who would otherwise have access to a home birth in other jurisdictions.

The most recent combined HSE and NPEC audit revealed that 734 registered home births occurred in the period 2012-2014.[10] Many women accessing a home birth choose water immersion for labour and birth. In 2018, 38% of women giving birth at home opted to use immersion in water for the birth. In 2020, up to September when birthing in the pool was pulled by the HSE, 33% of women opted to stay in the pool for the birth.[11]

Currently there is a limited number of SECMs to support a home birth service on behalf of the HSE, with only 20 registered SECMs for the year 2017. Part of the reason for this is the requirement by the HSE that midwives must have worked three out of the preceding five years in an acute hospital setting in order to be eligible to work as a SECM.

No other professional group, having successfully completed an undergraduate programme and being accepted onto their professional register, have their scope of practice limited in such a way. No such restrictions exist on community midwifery work elsewhere in Europe.

It is proposed that a pilot mentorship programme for midwives who wish to work in the community be established, including an educational component to develop the necessary skills. Another restriction to women accessing home birth – and by implication water birth – is the reluctance on the part of some GPs to provide shared care to women who choose to give birth at home. Some 30 refusals are recorded in the *Planned Home Births in Ireland Annual Report 2017*.[10]

For some GPs, indemnity insurance does not cover the care for a woman wishing to have a home birth. The reasons for GPs refusing to accept women needs to be explored by the Irish College of General Practitioners to determine what further supports GPs feel they need.

Conversely, if availing of a water birth in the hospital setting, most maternity units have only one plumbed-in birthing pool available for use. This makes birthing pools a scarce commodity, and gaining access to the birthing pool is not always guaranteed. As mentioned, the criteria are strict and are based on restrictive obstetric definitions of risk.

Even the most tenuous condition can exclude women from being eligible to access the pool. If women manage to navigate all of these hurdles and are eventually deemed suitable – and prior notice is given of their wish to use the pool – it is allocated on a first-come, first-served basis.

There is currently a temporary ban imposed by the HSE on women availing of a home water birth. So while labour in water is allowed, women are encouraged to exit the pool for birth. Given the evidence of the safety of water birth internationally, we ask that the HSE lift this ban with immediate effect.

Conclusion

Water birth is not appropriate for everybody, but for some people it is a totally viable option. International evidence has demonstrated that water birth can be safely managed in and out of the hospital setting.[3] Restrictions on access to water birth in Ireland must be addressed as a matter of urgency.

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Next month we will hear from midwives who facilitate water birth, as well as from women who have given birth using a birthing pool, about their experiences

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Inclusion:

Key to quality of life in disability

For people with disabilities, full social inclusion is one of the most crucial components of quality of life, write **Julie Bourke** and **Angela Flynn**

PRIMARY care nurses often feel under-equipped or unprepared to handle the unmet needs of people with disabilities. Increasingly, primary care services are recognised as being vital to the essential healthcare for people with disabilities.[1]

The term 'quality of life' refers to the physical, social, psychological and functional components of happiness.[2] Being healthy is important for one's quality of life, personal growth and community involvement. While health is a basic human right, not everyone enjoys the same degree of health and happiness.[3] Maintaining quality of life is extremely important for people living with disabilities.

Having a good quality of life can be linked to the amount of social inclusion or exclusion a person with a disability feels in their everyday life. There are different definitions of social exclusion, but it typically refers to the condition of disadvantage experienced by specific groups who are perceived to be marginalised in society and unable to fully engage in regular life.[4]

This article will discuss the factors that affect the quality of disabled people's lives, as well as the importance of social inclusion in the context of health inequalities. In addition, it will specifically discuss the experiences of nurses with self-identified sensory disabilities.

Models of disability

When talking about quality of life and the social inclusion of disabled people, the models of disability are important and relevant. There are two main models of disability: the medical model and the social model. People with disabilities are defined and classified in the medical model based on their disability. It portrays the person as a 'victim' or a 'problem'. A disabled person is framed as having to adapt to the demands of society and the environment in which they live. In terms of growth and functioning, there are 'norms' against which the individual is measured. It becomes more about what people can't do rather than what they can do. The focus becomes attempting to 'cure' or 'repair' the disabled person.[5] The medical model can be seen to be damaging to a disabled person's quality of life and can affect their image of themselves.

Alternatively, according to the social model, it is the unfavourable attitudes of society, social institutions, organisations and individual people that create obstacles inhibiting people with disabilities from obtaining services and resources. In this approach, society must adapt to enable people with disabilities to participate in society.[5] The social model is far more effective in boosting disabled people's self-esteem and improving their quality of life.

Intellectual disability

Intellectual disability (ID) can have a significant effect on people's lives. It has been argued that there is a gap in ID nursing research, which may be due to the ID nurse's limited visibility among the community of healthcare workers. Traditionally, people with intellectual disabilities have been excluded from mainstream society, leaving them with restricted opportunities and independence. They typically don't get the chance to choose what happens in their own lives as much as those without an ID.[9]

This societal attitude is ludicrous and affects immensely the general health and happiness of individuals with intellectual disabilities. Only Ireland and the UK provide direct-entry specialty undergraduate ID nursing education programmes.[6] As a consequence, this influences the quality of life of people with intellectual disabilities as there may be a related deficit of specialised care and treatment in this area in many countries.

Health inequalities

Health inequalities in people with intellectual disabilities are triggered by a range of causes. Individual features include the degree of impairment and any accompanying hereditary disorders. Secondary health issues, as opposed to personal/biological risk factors, are other variables that contribute to lower health status in those with intellectual disabilities.[3]

These health inequalities have a major effect on the quality of life of people with intellectual disabilities. The secondary health issues, although for the most part treatable, still cause major disruption to one's life. Individuals with intellectual and developmental impairments appear to have more difficulty accessing and using healthcare services than the general population.[3] The unfortunate irony here is evident, as this population requires far more healthcare and support than average.

People with disabilities were named as a groups in society which faces the most social exclusion during a debate of the links between social exclusion and health ahead of the 2008 WHO Commission on Social Determinants of Health. The Social Exclusion Knowledge Network, a subgroup of this commission, was formed in 2006 to explore and report on this link.

This network's final report found that inequalities in access to resources (means to satisfy human needs), capacities (the relative power people must employ to access the resources available to them) and rights characterise social exclusion processes, resulting in a continuum of inclusion/exclusion.[4]

Inequities in health arise as a result of this continuum. Social exclusion has a direct impact on health through its expressions in the health system, as well as an indirect impact on health through altering

economic and other social inequities. These inequities exacerbate social isolation, resulting in a vicious spiral.[4] It is important to talk about social inclusion and exclusion in the context of healthcare because the sector of basic healthcare is a critical location to observe evidence of social exclusion and its impact on health.[4]

Nurses with disabilities

Recent research on registered nurses with impairments has shown that nurses with sensory disorders are resigning or are on the verge of leaving the profession.[7] This is most notably due to the discrimination and lack of social inclusion they face in the workplace. Healthcare workers experience being pushed out by co-workers and management who believe they are unable to operate properly or do not 'lift their weight'.[7]

Despite cultural and educational disparities, physicians and nurses' experiences as healthcare workers with self-identified persistent sensory disability have been found to be very similar. Both groups revealed that career options and trajectories were narrowed as a result of disability and that deciding whether or not to disclose their condition at work could be difficult.

They also spoke about how they were affected by a wide range of emotions as a result of their disability-related professional issues. Nurses and physicians felt that the interactions that they had with colleagues reflected the culture around disability in the workplace and as a result they seldom asked for workplace modifications.[7] This type of social exclusion in the workforce can leave people with disabilities feeling like outcasts in their working lives, which is extremely damaging for their self-esteem.

Healthcare professionals often experience a loss of self-confidence and self-worth as a result of attempting to compensate for what they couldn't accomplish effortlessly. Anger, contempt and sadness were frequently expressed as a result of their frustration at others not being able to grasp that they could still think critically and act safely.[7]

This sadness and frustration can lead to a lower quality of life for the person with an impairment. These experiences can also cause people's self esteem and self image to lower drastically. Lower self image and self esteem can lead to poor mental health and even mental illness, such as depression and anxiety.

This demographic is recognised to be more vulnerable to mental health risks. Those who are deaf and hard of hearing, for example, are more prone to experience feelings of isolation and poor self worth and are more vulnerable to the adverse effects of domestic violence, both in childhood and adulthood.[8]

Conclusion

There are many different factors that impact quality of life for people with a disability. They may face prejudice while seeking healthcare or while working in the healthcare sector. Communication may have an effect on their experiences and their inclusion in society by influencing perceptions and models of disability.[5]

For those with impairments, social inclusion is equally critical. When someone with a disability seeks employment, they can be discriminated against and can find themselves socially ostracised. There are various definitions of social inclusion and exclusion in use, and their extent varies substantially. While numerous instruments have been created to measure these ideas in healthcare settings, they are not primarily focused on healthcare. In primary care settings, the need is there for the creation of a method for analysing social inclusion or exclusion.[4]

There is still more work to be done to ensure that all people in our communities have equitable access to healthcare services, including the pursuit of research to inform access, use and quality of healthcare services, as well as the continued implementation of systemic initiatives.[3] Only when these kinds of initiatives are achieved will we see full social inclusion for people with disabilities – a crucial component to ensuring quality of life.

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The human need for social inclusion

The pandemic has been more than just a threat to our physical health – we need a greater awareness of the effects of loneliness and isolation writes **James White**

SOCIAL integration is the established process by which a society facilitates the harmonious induction of a new member to that society.[1] Social inclusion, or rather, lack thereof, correlates with distress, dysphoria and suicidal ideation.[2] This article will examine Émile Durkheim's theories on social integration and suicide, discuss them in the context of Covid-19 and relate them to contemporary nursing practice.

Émile Durkheim

French sociologist, Émile Durkheim was instrumental in shaping the modern sociological viewpoint on suicide. Societal functioning was a key theme of his work and he was the first to introduce the concepts of mechanical and organic solidarity.[3] *Suicide: a study in Sociology*[4] is a key influence in understanding the sociological components of suicide and forms the basis of this examination. The concept of egoistic suicide identified by Durkheim in this work, presents a view of suicidality from outside of the traditional medical and psychiatric models.

Egoistic suicide is said to arise when an individual has chronic feelings of non-belonging and of being an outsider who is not fully integrated into, or accepted in society. Social integration is a core component of developing and sustaining positive mental health and well-being.[5]

Social integration

The social and community opportunities profile (SCOPE), originally developed in the UK, shows efficacy cross culturally as a measure for social inclusion.[6 7] Only when culture is carefully considered and understood can the full impact of social integration on suicide be understood.[8] Social integration can be measured and this is key to better understanding its relationship with suicide.

This relationship is deeply rooted within the sociocultural norms and values to which the individual belongs. Moreover, an application of Durkheim's conceptualisation which underpins this work – ie, that poor social integration leads to mental ill-health and suicide – is highlighted in a 2019 study[9] which found that humanitarian migrants experienced high levels of both mental and general health problems in the first three years of adaptation. Difficulty surrounding social integration was identified as a precipitating factor.

Turning to the Irish context, the harrowing echoes of the asylums, a social product of Irish society's willingness to cast aside the mentally-ill still resonate today. It has been suggested that these asylums were social creations, just as much as medical ones, "if not more so".[10] In the absence of definitive, evidence-based psychiatric treatments and professional regulation, the sociocultural view of mental illness was very much one of fear and misunderstanding.

Despite the marked attitudinal transformation towards mental health and illness in recent times, there is still a definite presence of discomfort surrounding the topic. Although psychiatric inpatient admission is now often short-term, as opposed to the life-long institutionalisation of the past, the way society views the physical confinement of those with mental ill-health, through a prism of the past, can have a very significant effect on the patient socially. This has been, perhaps most concerningly, observed among health professionals in the workplace.[11]

Effects of Covid-19

It has been suggested that the Covid-19 pandemic presents two key issues. These are the physical illness and incapacity caused by the virus itself and also the psychological distress and fear associated with it.[12] Moreover, many of the healthcare providers treating the physical illness caused by the virus do not have education in mental healthcare to offer this support in this domain.[13]

Notwithstanding the attempts to combat the social isolation that results from the measures used to combat the spread of Covid-19; the reshaping of how people lived their lives presents an interesting realisation for many. This is, the traditional liberties concomitant with social integration and their products, eg. meeting with family and friends, were ceased in order to protect public health. However, it is inescapable that these measures have damaged the psychological resilience of so many, both the public and healthcare providers.[14]

Nursing practice

Although seemingly anachronistic, Durkheim's work is by no means irrelevant today. The biopsychosocial model aims to take a more holistic view of human health.[15] There are indeed realms of truth in all the biological, psychological and the social, in terms of understanding psychological distress, mental illness and suicide. Although the social sciences are ostensibly

removed from nursing practice, in a profession that involves engaging with individuals from such a broad range of social and cultural backgrounds; a broadening of the sociological imagination will undoubtedly contribute to more holistic and informed nursing care.[16]

By committing to a deeper understanding of the social sciences that shape nursing practice, professionals are better equipped to recognise and support individuals experiencing distress that comes as a result of not only social isolation, but a variety of sociologically influenced circumstances.

Conclusion

The foundations laid by Durkheim in his studies on suicide should continue to be a sub stratum for the synthesis of new knowledge. The aforementioned concept of egoistic suicide, when combined with modern understandings of mental health and illness could shape even broader and superior treatments and approaches. Through looking back, advancements in awareness and attitudes may progress.

The pandemic has placed an unprecedented strain on the healthcare sector and the dedicated individuals who staff it. The revocation of activities and expressions of social inclusion has brought to light the need for a much greater awareness of the effects of loneliness and isolation.

Finally, it is incumbent on the nursing profession to strive for a broader knowledge of the social sciences and the development of a sociological imagination to promote, sustain and enhance societal attitudes towards inclusion and fortify both their own psychological resilience and that of those in their care.

James White is at Stage 3 studying for a BSc in general nursing at Dundalk Institute of Technology

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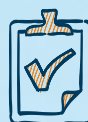

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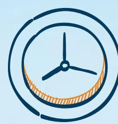

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No re-titration is required after initial titration. If patients miss a dose, the next dose should be taken as soon as possible. If it is close to the time for their next dose, the missed dose should not be taken and the next dose should be taken at the regular time. Patients with severe renal impairment: The dose of OTEZLA should be reduced to 30mg once daily in patients with severe renal impairment (creatinine clearance of less than 30mL per minute estimated by the Cockcroft-Gault equation). For initial dose titration in this group, it is recommended that OTEZLA is titrated using only the AM doses and the PM doses be skipped. Paediatric population: The safety and efficacy of OTEZLA in children aged 0 to 17 years have not been established. No data is available. **Contraindications:** Hypersensitivity to the active substance(s) or to any of the excipients. OTEZLA is contraindicated in pregnancy. 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Patients and caregivers should be instructed to notify the prescriber of any changes in behaviour or mood and of any suicidal ideation. If patients suffered from new or worsening psychiatric symptoms, or suicidal ideation or suicidal attempt is identified, it is recommended to discontinue treatment with OTEZLA. Severe renal impairment: See dosage and administration section. Underweight patients: OTEZLA may cause weight loss. Patients who are underweight at the start of treatment should have their body weight monitored regularly. In the event of unexplained and clinically significant weight loss, these patients should be evaluated by a medical practitioner and discontinuation of treatment should be considered. 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Focus on: Psoriatic arthritis

Brona Dineen and **Gerry Wilson** discuss a case involving a patient with psoriatic arthritis who presented with a history of back pain

A 30-year-old female with a background of psoriatic arthritis presented to clinic with a six-month history of back pain. This patient was on 25mg methotrexate weekly, folic acid 5mg weekly and etoricoxib 90mg daily. The pain was insidious in onset, worse in the early morning, awakening her from sleep. She reported roughly 45 minutes of early morning stiffness with relief from non-steroidal anti-inflammatory drugs (NSAIDs) and mobilising.

On examination there was no active psoriasis or psoriatic nail changes. Joint disease was well controlled without any active synovitis, dactylitis or enthesitis. Spinal movements were normal and there was no tenderness over the sacroiliac joints. Having run bloods FBC, U&E and LFTS were normal, however both ESR (21) and CRP (10) were slightly elevated.

Sacroiliac joints x-ray showed grade 3 sacroiliitis on the right. MRI of sacroiliac joints showed signs of active inflammation with subchondral bone marrow oedema.

Figure: Sacroilitis and bilateral sacroiliac joint ankylosis

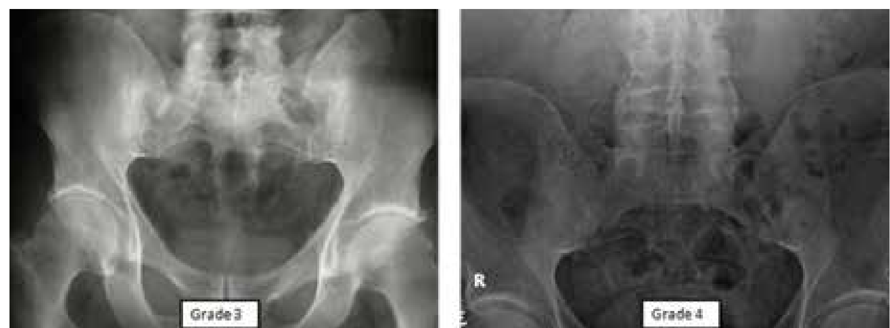

Figure: Left image shows sacroiliitis and right image shows bilateral sacroiliac joint ankylosis, on plain x-rays of sacroiliac joints (reproduced from Bennett PH, Burch TA. Population studies of the Rheumatic Disease. Excerpta Medica Foundation 1968:456-457)

Link between psoriatic arthritis and axial disease

Spinal involvement can occur in up to a quarter of psoriatic arthritis patients; this is known as psoriatic spondylitis. Patients who are HLA-B27 positive are more likely than others to have involvement of the spine. Unilateral sacroiliitis is seen more frequently in this patient cohort. Isolated axial disease occurs in only 2-5% of all psoriatic arthritis patients. Axial symptoms occur later during psoriatic arthritis and often radiographic changes can be seen before the patient becomes symptomatic.

Treatment options for psoriatic spondylitis

As per the European guidelines on the management of psoriatic arthritis with pharmacological therapies, in patients with predominantly axial disease, which is active and has insufficient response to NSAID therapy after four weeks, a biologic disease modifying anti rheumatic drug (bDMARD) should be considered.

The European League Against Rheumatism (EULAR) currently recommends a TNF inhibitor as a first-line agent however if there is psoriasis present, an IL-17 inhibitor may be preferred. In patients who have an inadequate response or are intolerant to a bDMARD, switching to another bDMARD or a targeted synthetic (ts) DMARD should be considered, including one switch within a class.[1]

Role of targeted synthetic DMARDs in psoriatic arthritis

Targeted synthetic DMARDs include phosphodiesterase inhibitors and janus kinase inhibitors (JAKi). Unlike the bDMARDS these are small molecules given orally. Apremilast is a phosphodiesterase-4 (PDE4) inhibitor which decreases pro-inflammatory cytokine production and has an anti-inflammatory effect.[2] In patients with mild disease and an inadequate response to at least one conventional synthetic DMARD and in whom JAKi or bDMARDs are not appropriate, a PDE4 inhibitor may be considered. JAKi block the JAK-STAT signalling pathway.[3] This pathway controls production of pro-inflammatory cytokines.

European guidelines recommend that in patients with peripheral arthritis and an inadequate response to at least one conventional synthetic (cs) DMARD and at least one bDMARD, or when a bDMARD is not appropriate, a JAKi should be considered.

Brona Dinneen is a specialist registrar in rheumatology and Prof Gerry Wilson is a consultant rheumatologist at the Mater University Hospital, Dublin

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As monotherapy for the treatment of adult patients with metastatic gastric cancer including adenocarcinoma of the gastroesophageal junction, who have been previously treated with at least two prior systemic treatment regimens for advanced disease. **DOSAGE AND ADMINISTRATION*:** Recommended starting dose: 35 mg/m²/dose taken orally twice daily on Days 1 to 5 and Days 8 to 12 of each 28-day cycle, within 1 hour after completion of the morning and evening meals (20mg/m²/dose for patients with severe renal impairment). Dosage calculated according to body surface area, not exceeding 80 mg/dose. Possible dosing adjustments based on individual safety and tolerability: permitted dose reductions to a minimum dose of 20 mg/m² twice daily (15mg/m²/dose for patients with severe renal impairment), dose escalation not permitted after a dose reduction. **CONTRAINDICATIONS*:** Hypersensitivity to the active substances or to any of the excipients. **WARNINGS *:** *Bone marrow suppression*: Complete blood cell counts must be obtained prior to initiation of therapy, prior to each cycle and as needed. Treatment must not be started if absolute neutrophil count < 1.5 x 10^9/L, if platelet counts < 75 x 10^9/L, or if unresolved Grade 3 or 4 non-haematological clinically relevant toxicity. Patient should be monitored closely for infections, appropriate measures should be administered as clinically indicated. *Gastrointestinal toxicity*: anti-emetic, anti-diarrhoeal and other measures should be administered as clinically indicated, dose modifications should be applied as necessary. *Renal impairment*: not recommended if end-stage renal disease. Patients with renal impairment should be monitored closely; patients with moderate or severe renal impairment should be more frequently monitored for haematological toxicities. *Hepatic impairment*: not recommended if baseline moderate or severe hepatic impairment. Proteinuria: monitoring by dipstick urinalysis recommended prior to starting and during therapy. *Excipients*: contain lactose. **INTERACTIONS*:** *Precautions:* medicinal products that interact with nucleoside transporters CNT1, ENT1 and ENT2, inhibitors of OCT2 or MATE1, human thymidine kinase substrates (e.g. zidovudine), hormonal contraceptives. **FERTILITY*. PREGNANCY AND BREASTFEEDING*:** Not recommended. **CONTRACEPTION*:** For women and men, highly effective contraceptive measures must be used during treatment and for 6 months after stopping treatment. **DRIVE & USE MACHINES*:** Fatigue, dizziness or malaise may occur. **UNDESIRABLE EFFECTS*:** *Very common*: Neutropenia, leukopenia, anaemia, thrombocytopenia, decreased appetite, diarrhoea, nausea, vomiting, fatigue. *Common*: Lower respiratory tract infection, febrile neutropenia, lymphopenia, hypoalbuminaemia, dysgeusia, neuropathy peripheral, dyspnoea, abdominal pain, constipation, stomatitis, oral disorder, hyperbilirubinaemia, Palmar-plantarerythrodysaesthesia syndrome, rash, alopecia, pruritus, dry skin, proteinuria, pyrexia, oedema, mucosal inflammation, malaise, hepatic enzyme increased, blood alkaline phosphatase increased, weight decreased. *Uncommon*: Septic shock, enteritis infectious, lung infection, biliary tract infection, influenza, urinary tract infection, gingivitis, herpes zoster, tinea pedis, candida infection, bacterial infection, infection, neutropenic sepsis, upper respiratory tract infection, conjunctivitis, cancer pain, pancytopenia, granulocytopenia, monocytopenia, erythropenia, leukocytosis, monocytosis, dehydration, hyperglycaemia, hyperkalaemia, hypokalaemia, hypophosphataemia, hypernatraemia, hyponatraemia, hypocalcaemia, gout, anxiety, insomnia, neurotoxicity, dysaesthesia, hyperaesthesia, hypoaesthesia, syncope, paraesthesia, burning sensation, lethargy, dizziness, headache, visual acuity reduced, vision blurred, diplopia, cataract, dry eye, vertigo, ear discomfort, angina pectoris, arrhythmia, palpitations, embolism, hypertension, hypotension, flushing, pulmonary embolism, pleural effusion, rhinorrhoea, dysphonia, oropharyngeal pain, epistaxis, cough, enterocolitis haemorrhagic, gastrointestinal haemorrhage, pancreatitis acute, ascites, ileus, subileus, colitis, gastritis, reflux gastritis, oesophagitis, impaired gastric emptying, abdominal distension, anal inflammation, mouth ulceration, dyspepsia, gastrooesophageal reflux disease, proctalgia, buccal polyp, gingival bleeding, glossitis, periodontal disease, tooth disorder, retching, flatulence, breath odour, hepatotoxicity, biliary dilatation, skin exfoliation, urticaria, photosensitivity reaction, erythema, acne, hyperhidrosis, blister, nail disorder, joint swelling, arthralgia, bone pain, myalgia, musculoskeletal pain, muscular weakness, muscle spasms, pain in extremity, renal failure, cystitis noninfective, micturition disorder, haematuria, leukocyturia, menstrual disorder, general physical health deterioration, pain, feeling of body temperature change, xerosis, discomfort, blood creatinine increased, electrocardiogram QT prolonged, international normalised ratio increased, activated partial thromboplastin time prolonged, blood urea increased, blood lactate dehydrogenase increased, protein total decreased, C-reactive protein increased, haematocrit decreased. *Post-marketing experience*: interstitial lung disease. **OVERDOSE*. PROPERTIES*:** Trifluridine is an antineoplastic thymidine-based nucleoside analogue and tipiracil hydrochloride is a thymidine phosphorylase (TPase) inhibitor. Following uptake into cancer cells, trifluridine, is phosphorylated by thymidine kinase, further metabolised in cells to a deoxyribonucleic acid DNA substrate, and incorporated directly into DNA, preventing cell proliferation. However, trifluridine is rapidly degraded by TPase and readily metabolised by a first-pass effect following oral administration, hence the inclusion of the TPase inhibitor, tipiracil hydrochloride.**PRESENTATION*** Pack of 20 or 60 film-coated tablets. **Marketing Authorisation Holder** LES LABORATOIRES SERVIER**,** 50 rue Carnot, 92284 Suresnes cedex France. www.servier.com. **Marketing Authorisation**: EU/1/16/1096/001-006. **Legal Classification for Supply**: POM. **Further information available from**: Servier Laboratories (Ireland) Ltd., Second Floor, 19 Lr. George's Street, Dun Laoghaire, Co. Dublin A96 ER84, Ireland, Tel (01) 6638110, www.servier.ie.

***For complete information, please refer to the Summary of Product Characteristics available on medicines.ie. Date of last revision of text: January 2021 (Date of last approved SmPC: December 2020)**

Reference: 1. Lonsurf SmPC December 2020

Date of preparation of item September 2021. 2122c1LNPressAd A4

Early detection key in bowel cancer

With delays in presentation due to the pandemic, it is more important than ever that people are aware of the warning signs for bowel cancer

DESPITE a 10% increase in the uptake of BowelScreen at home FIT (faecal immunochemical test) kits in 2021, cases of colorectal cancer are running at about 20%[1] lower than what would normally be expected. This is thought to be due to people with symptoms not presenting during the Covid-19 pandemic.

Colorectal cancer, or bowel cancer, is the second largest contributor to cancer death in Ireland, accounting for 12% of cancer deaths in men and 10% in women, totalling over 1,000 deaths annually, according to the most recent figures from the National Cancer Registry of Ireland (NCRI).[1] However, when caught early colorectal cancer is very treatable and five-year survival rates stand at just over 65%.[1]

Warning signs

During Bowel Cancer Awareness Month, which ran throughout April, the national bowel cancer screening programme BowelScreen and charities such as the Marie Keating Foundation were proactive in encouraging people to get to know the early warning signs of bowel cancer so that when they notice a change, they present to their GP without delay. Signs and symptoms include:

- Blood in or on the stool
- A change in normal bowel movements
- Unexpected weight loss
- A pain in the abdomen or bowel
- A feeling that the bowel is not totally emptying.

Consultant medical oncologist, Dr Gregory Leonard from Galway University Hospital said that more can be done to improve survival rates. "Bowel cancer, when detected early is very treatable. Unfortunately, many people don't know or ignore the warning signs of bowel cancer until it's too late. In my experience with diagnosing and treating bowel cancer, the earlier we see patients the better the outcome."

Bowel cancer is the third most common cancer in Ireland, affecting over 2,690 people each year. The number of new cases is expected to increase significantly over the next 10 years, due mainly to an increasing and ageing population. Bowel cancer accounts for over 12% of the 200,000 cancer survivors living in Ireland today.[1]

An important tool in improving the early detection and prevention of bowel cancer is encouraging members of the public to take part in BowelScreen when they turn 60. Uptake of the BowelScreen at home FIT kits rose by almost 10% in 2021 (January to September), with over 51.5% of those invited to complete a FIT test, returning testable samples. However, due to the impact of the pandemic restrictions, those eligible for BowelScreen are now looking at an additional year wait for screening, meaning the interval to be sent a FIT kit has increased from every two years to every three.

With these delays it is more important than ever that the public are aware of the symptoms to look out for, according to Bernie Carter, assistant director of nursing services at the Marie Keating Foundation. "During the course of the pandemic we know lots of people were afraid to visit their GP. Cancer screening was also impacted. The recent NCRI Annual Report is the first evidence of the impact of Covid on cancer cases and the figures are frightening. If bowel cancer cases are down by about 20% on what would normally be expected pre the Covid pandemic, then it is possible that those cancers may be diagnosed at a later stage."

Recent research from BowelScreen has identified fear of finding something wrong as the most common reason for people not taking part in the free test. However, the majority of changes in the bowel found by screening are discovered at an early stage when they are easier to treat, and therefore have a better chance of recovery.

Screening

Screening offers the chance for early detection – before cancer develops or when there are no symptoms – which means treatment is often more effective than if diagnosed later. Every year over 3,000 people have precancerous polyps removed as a result of bowel screening.

BowelScreen invites men and women aged 60-69 to use a simple, free, home test FIT kit that looks for blood in the stool, not visible to the human eye. People with a FIT test that is positive for a level of blood are invited for a colonoscopy in one of 15 hospital-based screening colonoscopy units. On average only about 5% need to be referred for a colonoscopy.

International evidence shows that screening in the eligible age groups is effective at reducing the number of deaths from bowel cancer.

"We're making people aware of the easy and potentially life-changing action they can take to reduce their risk of bowel cancer. The more people who take up the invitation, the more effective a tool bowel screening becomes to help prevent bowel cancer," said Prof Pádraic Mac Mathuna, interim clinical director of BowelScreen.

BowelScreen offers home bowel screening tests to approximately 250,000 people each year in Ireland. For further details and to check the register, see www.bowelscreen.ie or Freephone 1800 45 45 55.

– Tara Horan

Reference

1. National Cancer Registry Ireland (2021) Cancer in Ireland 1994-2019: Annual report of the National Cancer Registry. NCRI, Cork, Ireland

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In treating a broad range of women with HR+/HER2- mBC:[1]

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Indications:

IBRANCE® is indicated for the treatment of HR+/HER2- locally advanced or mBC:[1]

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- In combination with **fulvestrant in women who have received prior ET**
- In **pre- or peri-menopausal women**, the ET should be combined with an LHRH agonist

For more information visit www.pfizerpro.ie/product/ibrance

IBRANCE® (PALBOCICLIB) PRESCRIBING INFORMATION:

Please refer to the Summary of Product Characteristics (SmPC) before prescribing IBRANCE 75 mg, 100 mg or 125 mg. **Presentation:** Hard capsules or film-coated tablets containing 75 mg, 100 mg or 125 mg palbociclib. **Indications:** Treatment of hormone receptor (HR) positive, human epidermal growth factor receptor 2 (HER2) negative locally advanced or metastatic breast cancer: in combination with an aromatase inhibitor; or in combination with fulvestrant in women who have received prior endocrine therapy. In pre- or perimenopausal women, the endocrine therapy should be combined with a luteinizing hormone releasing hormone (LHRH) agonist. **Dosage:** Therapy should be initiated and supervised by a physician experienced in the administration of anti-cancer medicinal products. The recommended dose is 125 mg of palbociclib once daily for 21 consecutive days followed by 7 days off treatment (Schedule 3/1) to comprise a complete cycle of 28 days. When coadministered with palbociclib, the aromatase inhibitor should be administered according to the dose schedule reported in the SmPC. Treatment of pre/perimenopausal women with the combination of palbociclib plus endocrine therapy should always be combined with an LHRH agonist (see SmPC section 4.4). Capsules and tablets should be swallowed whole (should not be chewed, crushed, split or opened prior to swallowing). Capsules should be taken with food, preferably a meal to ensure consistent palbociclib exposure (see SmPC section 5.2). Tablets may be taken with or without food. Palbociclib should not be taken with grapefruit or grapefruit juice (see SmPC section 4.5). Dose modification of IBRANCE is recommended based on individual safety and tolerability. Management of some adverse reactions may require temporary dose interruptions/delays, and/or dose reductions, or permanent discontinuation. For dose reduction guidelines for management of adverse reactions, haematologic and non-haematologic toxicities, refer to SmPC section 4.2. IBRANCE should be permanently discontinued in patients with severe interstitial lung disease (ILD)/pneumonitis. For patients who experience a maximum of Grade 1 or 2 neutropenia in the first 6 cycles, complete blood counts for subsequent cycles should be monitored every 3 months, prior to the beginning of a cycle and as clinically indicated. No dose adjustments of IBRANCE are required for patients with mild or moderate hepatic impairment (Child-Pugh classes A and B). For patients with severe hepatic impairment (Child-Pugh class C), the recommended dose of IBRANCE is 75 mg once daily on Schedule 3/1 (see SmPC section 5.2). No dose adjustments of IBRANCE are required for patients with mild, moderate or severe renal impairment (creatinine clearance [CrCl] ≥15 mL/min) (see SmPC section 5.2). No dose adjustment of IBRANCE is necessary in patients ≥65 years of age (see section 5.2). **Contraindications:** Hypersensitivity to the active substance or to any of the excipients (see SmPC section 6.1), use of preparations containing St. John's Wort (see SmPC section 4.5). **Warnings and Precautions:** Ovarian ablation or suppression with an LHRH agonist is mandatory when pre/perimenopausal women are administered IBRANCE in combination with an aromatase inhibitor, due to the mechanism of action of aromatase inhibitors. Palbociclib in combination with fulvestrant in pre/perimenopausal women has only been studied in combination with an LHRH agonist. Dose interruption, dose reduction, or delay in starting treatment cycles is recommended for patients who develop Grade 3 or 4 neutropenia. Appropriate monitoring should be performed (see SmPC sections 4.2 and 4.8). Severe, life-threatening, or fatal ILD and/or pneumonitis can occur in patients treated with cyclin dependent kinase 4/6 (CDK4/6) inhibitors, including IBRANCE when taken in combination with endocrine therapy. Across clinical studies (PALOMA-1, PALOMA-2, PALOMA-3), 1.4% of IBRANCE-treated patients had ILD/pneumonitis of any grade, 0.1% had Grade 3, and no Grade 4 or fatal cases were reported. Additional cases of ILD/pneumonitis have been observed in the post-marketing setting, with fatalities reported. Patients should be monitored for pulmonary symptoms and IBRANCE treatment should be immediately interrupted in patients suspected to have developed ILD/pneumonitis, see SmPC section 4.2, 4.4 and 4.8. Since IBRANCE has myelosuppressive properties, it may predispose patients to infections. Infections have been reported at a higher rate in patients treated with IBRANCE in randomised clinical studies compared to patients treated in the respective comparator arm. Grade 3 and Grade 4 infections occurred respectively in 5.6% and 0.9% of patients treated with IBRANCE in any combination (see SmPC section 4.8). Patients should be monitored for signs and symptoms of infection and treated as medically appropriate (see SmPC section 4.2). Physicians should inform patients to promptly report any episodes of fever. Strong inhibitors of CYP3A4 may lead to increased toxicity (see SmPC section 4.5). Avoid concomitant use of strong CYP3A inhibitors during treatment with palbociclib. Coadministration should only be considered after careful evaluation of the potential benefits and risks. If coadministration with a strong CYP3A inhibitor is unavoidable, reduce the IBRANCE dose to 75 mg once daily. When the strong inhibitor is discontinued, the dose of IBRANCE should be increased (after 3–5 half-lives of the inhibitor) to the dose used prior to the initiation of the strong CYP3A inhibitor (see SmPC section 4.5). Coadministration of CYP3A inducers may lead to decreased palbociclib exposure and consequently a risk for lack of efficacy. Therefore, concomitant use of palbociclib with strong CYP3A4 inducers should be avoided. No dose adjustments are required for coadministration of palbociclib with moderate CYP3A inducers (see SmPC section 4.5). Women of childbearing potential or their male partners must use a highly effective method of contraception while taking IBRANCE (see SmPC section 4.6). IBRANCE capsules contain lactose. Patients with rare hereditary problems of galactose intolerance, the Lapp lactase deficiency, or glucose-galactose malabsorption should not take this medicinal product. Palbociclib tablets do not contain lactose. **Drug Interactions:** The concomitant use of strong CYP3A inhibitors including, but not limited to: clarithromycin, indinavir, itraconazole, ketoconazole, lopinavir/ritonavir, nefazodone, nelfinavir, posaconazole, saquinavir, telaprevir, telithromycin, voriconazole, and grapefruit or grapefruit juice, should be avoided (see sections 4.2 and 4.4). No dose adjustments are needed for mild and moderate CYP3A inhibitors. The concomitant use of strong CYP3A inducers including, but not limited to: carbamazepine, enzalutamide, phenytoin, rifampin, and St. John's Wort should be avoided (see SmPC sections 4.3 and 4.4). No dose adjustments are required for moderate CYP3A inducers. The dose of sensitive CYP3A substrates with a narrow therapeutic index (e.g., alfentanil, cyclosporine, dihydroergotamine, ergotamine, everolimus, fentanyl, pimozide, quinidine, sirolimus, and tacrolimus) may need to be reduced when coadministered with IBRANCE as IBRANCE may increase their exposure. Based on in vitro data, palbociclib is predicted to inhibit intestinal P-glycoprotein (P-gp) and breast cancer resistance protein (BCRP) mediated transport. Therefore, administration of palbociclib with medicinal products that are substrates of P-gp (e.g., digoxin, dabigatran, colchicine, pravastatin) or BCRP (e.g., rosuvastatin, sulfasalazine) may increase their therapeutic effect and adverse reactions. Based on in vitro data, palbociclib may inhibit the uptake transporter organic cationic transporter OCT1 and then may increase the exposure of medical product substrates of this transporter (e.g., metformin). **Pregnancy & Lactation:** Females of childbearing potential who are receiving this medicinal product, or their male partners should use adequate contraceptive methods (e.g., double-barrier contraception) during therapy and for at least 3 weeks or 14 weeks after completing therapy for females and males, respectively (see SmPC section 4.5). There are no or limited amount of data from the use of palbociclib in pregnant women. Studies in animals have shown reproductive toxicity (see SmPC section 5.3). IBRANCE is not recommended during pregnancy and in women of childbearing potential not using contraception. Based on male reproductive organ findings (seminiferous tubule degeneration in testis, epididymal hypospermia, lower sperm motility and density, and decreased prostate secretion) in nonclinical safety studies, male fertility may be compromised by treatment with palbociclib (see SmPC section 5.3). Thus, men may consider sperm preservation prior to beginning therapy with IBRANCE. **Driving and operating machinery:** IBRANCE may cause fatigue and patients should exercise caution when driving or using machines. **Side Effects:** The most common (≥20%) adverse reactions of any grade reported in patients receiving palbociclib in randomised clinical studies were neutropenia, infections, leukopenia, fatigue, nausea, stomatitis, anaemia, diarrhoea, alopecia, and thrombocytopenia. The most common (≥2%) Grade ≥3 adverse reactions of palbociclib were neutropenia, leukopenia, anaemia, fatigue, infections, alanine aminotransferase (ALT) increased and aspartate aminotransferase (AST) increased. Dose reductions or dose modifications due to any adverse reaction occurred in 38.4% of patients receiving IBRANCE in randomised clinical studies regardless of the combination. Very common adverse events (≥1/10) are neutropenia, infections, leukopenia, fatigue, anaemia, asthenia, pyrexia, nausea, stomatitis, alopecia, diarrhoea, thrombocytopenia, vomiting, rash, decreased appetite, dry skin, AST increased and ALT increased. Commonly reported adverse events (≥1/100 to <1/10), are dysgeusia, epistaxis, ILD/pneumonitis, lacrimation increased, vision blurred, dry eye, febrile neutropenia. Refer to section 4.8 of the SmPC for further information on side effects, including description of selected adverse reactions. **Legal Category:** S1A. **Marketing Authorisation Numbers:** EU/1/16/1147/001 – 75 mg (21 capsules); EU/1/16/1147/003 – 100 mg (21 capsules); EU/1/16/1147/005 – 125 mg (21 capsules), EU/1/16/1147/010 – 75 mg (21 tablets), EU/1/16/1147/012 – 100 mg (21 tablets) and EU/1/16/1147/014 – 125 mg (21 tablets). **Marketing Authorisation Holder:** Pfizer Europe MA EEIG, Boulevard de la Plaine 17, 1050 Bruxelles, Belgium. For further information on this medicine please contact: Pfizer Medical Information on 1800 633 363 or at medical.information@pfizer.com. For queries regarding product availability please contact: Pfizer Healthcare Ireland, Pfizer Building 9, Riverwalk, National Digital Park, Citywest Business Campus, Dublin 24 + 353 1 467 6500.

Last revised: 01/2022.

Ref: 10_0.

References: **1.** IBRANCE® Summary of Product Characteristics. **2.** Taylor-Stokes G, et al. Breast. 2019;43:22-27. **3.** Rugo HS, et al. Ann Oncol. 2018;29(4):888-894.

AI = aromatase inhibitor; **ET** = endocrine therapy; **HR+/HER2-** = hormone receptor-positive, human epidermal growth factor receptor 2-negative; **LHRH** = luteinising hormone releasing hormone; **mBC** = metastatic breast cancer; **SmPC** = summary of product characteristics.

PP-IBR-IRL-0505
Date of preparation: March 2022

Triple negative breast cancer

Specialist cancer nurse Antonia Tierney discusses the benefits of neoadjuvant treatment in patients with triple negative breast cancer

A 46-YEAR-OLD woman presented to her GP with a painless right breast lump and was referred to the symptomatic breast clinic. On examination there was a definite palpable lump in the upper medial quadrant of the right breast with no adenopathy or organomegaly. She had a past medical history of hypertension, was a non-smoker and a non-drinker. There was no family history of cancer. The patient was married with two children.

A bilateral mammogram and an ultrasound of the right breast and axilla showed an ill-defined 16mm solid mass typical of an invasive tumour and one morphologically abnormal node in the right axilla. Right breast core biopsy revealed invasive ductal carcinoma with foci of lymphovascular invasion (LVI). The presence of LVI is known to be associated with an increased risk of axillary lymph node involvement and distant metastases.[1]

In this case, a fine-needle aspiration biopsy of right axilla was positive for carcinoma cells. Immunohistochemistry analyses revealed the tumour was oestrogen receptor negative (Allred score 0), progesterone receptor negative (Allred score 0) and HER2 negative by FISH test (fluorescence in situ hybridisation).

The patient went on to have bilateral breast MRI which showed the tumour was larger than it appeared on conventional imaging, the primary right tumour measured 51mm. Full radiological staging, including CT thorax/abdomen/pelvis (TAP) and bone scan, were done due to the size of the tumour which revealed no distant metastases.

In summary, this patient had a high grade, locally advanced triple negative breast cancer (TNBC) and the treatment plan was for dose dense neoadjuvant adriamycin and cyclophosphamide (A/C) for four cycles followed by paclitaxel for four cycles and she was referred to cancer genetics.

Her treatment was discontinued after two cycles of A/C due to the Covid-19 pandemic as there were strong concerns of contracting the virus and developing serious complications from chemotherapy. She was referred to surgery and a wide local excision was performed. There was significant residual disease present and extensive lymphovascular invasion (LVI) with foci of LVI < 1cm from the anterior, superior and lateral margins. Two further surgical attempts to achieve negative margins failed and the patient went on to have a completion right mastectomy and right axillary clearance.

As neoadjuvant chemotherapy was discontinued early due to Covid-19, the patient went on to have two further cycles of adjuvant A/C and four cycles of paclitaxel. Chemotherapy was complicated only by grade II peripheral neuropathy. Due to the significant residual disease post neoadjuvant chemotherapy, the patient was commenced on adjuvant capecitabine 1,250mg/m^2 for eight cycles – acknowledging that the patient only had two cycles of neoadjuvant chemotherapy and therefore was unlikely to have had a pathologic complete response (pCR).

No dihydropyrimidine dehydrogenase (DPYD) gene variants were found. During cycle four of capecitabine the patient noted a nodule at the right mastectomy site. Ultrasound showed a 14mm ill-defined hypoechoic lesion within the dermis and subsequent punch biopsy revealed skin with dermal invasion by invasive carcinoma morphologically similar to the previously diagnosed breast cancer.

After discussion at the multidisciplinary team (MDT), a CT TAP and brain were carried out. The scans showed a 7mm enhancing nodule in the lateral right chest wall with no other evidence of distant metastases. PET CT was also done and revealed hilar, mediastinal and mammary lymph nodes, which excluded her from further surgery.

Genetic testing was expedited and she had no BRCA gene mutation. Her tumour also has PDL1 low status which rules out participation current available clinical trials. The patient has commenced treatment for metastatic triple-negative breast cancer (TNBC) with carboplatin and gemcitabine and will have a repeat PET CT in three months to assess treatment response.

Triple-negative breast cancer

TNBC is a heterogeneous disease and is simply characterised by the absence of oestrogen receptor (ER) and progesterone receptor (PR), as well as human epidermal growth factor receptor-2 (HER2), it accounts for 12-15% of breast cancer.[1] TNBC is typically characterised by ductal histology, high grade and high proliferation rates. It is associated with poor prognosis, a high risk of recurrence and poor disease free survival.[1,2,3] The risk of developing TNBC varies with age, race, genetics and breastfeeding patterns.[1,2]

Several population-based studies have found that TNBC often presents at a younger age and is more common in African American women and black ethnicities.[4,5] TNBC is more common in premenopausal women than postmenopausal women.[4,5] Additionally, breastfeeding, a longer duration of breastfeeding and an increasing number of children breastfed all reduced the risk of developing TNBC.[5]

There is a well-established link between BRCA mutation status and TNBC. BRCA genes are tumour suppressor genes that are involved in double strand DNA break repair. BRCA1 deficiency results in higher genomic instability and tumour genesis.[9] Approximately 11% of TNBC are associated with BRCA1 and BRCA2 mutations. Patients younger than 50 years diagnosed with TNBC but lacking familial predisposing history are carriers of BRCA mutations in 10-30% of cases.[5]

Relapse rates in TNBC are higher than in other phenotypes with a peak recurrence risk three years post-surgery. The risk reduces with each year after this, median survival of patients with metastatic triple

negative breast cancer is approximately 18-24 months.[5,10]

Neoadjuvant chemotherapy in TNBC

Neoadjuvant chemotherapy (NACT) in breast cancer refers to systemic treatment administered prior to definitive surgery. Originally neoadjuvant therapy was used to downstage unresectable tumours and decrease the extent of surgery. Neoadjuvant therapy offers several advantages over adjuvant therapy. It facilitates real time assessment of tumour response and therefore allows prompt discontinuation of ineffective treatment.[1,5]

Identifying patients who have a poor response to NACT is important as it identifies those who have an increased risk of developing loco regional recurrence and may benefit from additional adjuvant chemotherapy.[1] A complete pathological response pCR is associated with a reduced risk of recurrence in all breast cancer subtypes including TNBC.[7] Approximately one-third of patients with TNBC achieve a pCR.[7,8]

A study examining the association between TNBC and response to several neoadjuvant chemotherapy regimens as well as overall survival in 1,118 patients found that the poor overall survival of TNBC is derived from the portion of patients with chemoresistant disease which represent > 50% of TNBC.[7]

The Capecitabine for Residual Cancer as Adjuvant Therapy (CREATE-X) trial recruited patients with HER2 negative breast cancer who did not have pCR after NACT with an anthracycline or taxane or both, and randomised them to receive capecitabine versus standard therapy alone.[7]

The trial was terminated early as the rate of disease free survival was significantly improved in the capecitabine group with improvement in overall survival at three and five years. The subset of TNBC patients demonstrated the most benefit in the CREATE-X trial.[7]

Anthracycline-based chemotherapy is the standard of care for neoadjuvant treatment in TNBC. However, long-term cardiovascular complications and secondary malignancies have prompted exploration of the use of anthracycline-free regimes in the treatment of triple-negative breast cancer.[2]

Antonia Tierney is an advanced nurse practitioner in medical oncology at St James's Hospital in Dublin

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Experiencing difficulties paying?

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

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- Cheque payable to INMO
- Postal order payable to INMO
- Bank draft payable to INMO
- Online via our website (using your unique quick payment code available from the INMO).

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

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TALZENNA is a proven alternative to chemotherapy* that provides patients with greater efficacy in a convenient, once-daily oral dose[1]

LONGER MEDIAN PROGRESSION-FREE SURVIVAL (PFS)
TALZENNA significantly prolonged median PFS vs chemotherapy: 8.6 months vs 5.6 months (HR=0.54 [95% CI: 0.41-0.71]; P<0.0001)[1]

DOUBLED OBJECTIVE RESPONSE RATE (ORR)
ORR for TALZENNA was 62.6% (95% CI: 55.8-69.0) vs 27.2% (95% CI: 19.3-36.3) with chemotherapy (OR=4.99 [95% CI: 2.93-8.83]; P<0.0001)[1]†‡

CONVENIENT DOSING
TALZENNA provides convenient, once-daily oral dosing, with or without food[1]

Indication: TALZENNA is indicated as monotherapy for the treatment of adult patients with germline *BRCA1/2*-mutations, who have HER2-negative locally advanced or metastatic breast cancer. Patients should have been previously treated with an anthracycline and/or taxane in the (neo)adjuvant, locally advanced or metastatic setting unless patients were not suitable for these treatments (see section 5.1 of full SmPC). Patients with hormone receptor (HR)-positive breast cancer should have been treated with a prior endocrine-based therapy, or be considered unsuitable for endocrine-based therapy.

CI=confidence interval; gBRCA=germline breast cancer susceptibility gene;
HER2-=human epidermal growth factor receptor 2 negative;
HR=hazard ratio; **HR+**=hormone receptor-positive;
OR=odds ratio;
RECIST=Response Evaluation Criteria in Solid Tumors.

* Capecitabine, eribulin, gemcitabine, or vinorelbine.
† Conducted in the intent-to-treat population with measurable disease at baseline. Per RECIST v1.1, confirmation of response was not required.1
‡ ORR is the proportion of patients who have a partial or complete response to treatment.

Reference: 1. TALZENNA Summary of Product Characteristics.

PRESCRIBING INFORMATION

▼This medicinal product is subject to additional monitoring. This will allow quick identification of new safety information. Healthcare professionals are asked to report any suspected adverse reactions. Refer to section 4.8 of the SPC for how to report adverse reactions.

Talzenna®▼ 0.25 mg and 1 mg hard capsules IE Prescribing Information:

Before prescribing Talzenna (talazoparib) please refer to the full Summary of Product Characteristics (SmPC). **Presentation:** Each 0.25 mg hard capsule contains talazoparib tosylate equivalent to 0.25 mg talazoparib. Each 1 mg hard capsule contains talazoparib tosylate equivalent to 1 mg talazoparib. **Indications**: Talzenna is indicated as monotherapy for the treatment of adult patients with germline BRCA1/2 mutations, who have HER2-negative locally advanced or metastatic breast cancer. Patients should have been previously treated with an anthracycline and/or a taxane in the (neo)adjuvant, locally advanced or metastatic setting unless patients were not suitable for these treatments. Patients with hormone receptor (HR)-positive breast cancer should have been treated with a prior endocrine-based therapy, or be considered unsuitable for endocrine-based therapy. **Dosage and Administration:** Treatment should be initiated and supervised by a physician experienced in the use of anticancer medicinal products. Patients should be selected for the treatment of breast cancer with Talzenna based on the presence of deleterious or suspected deleterious germline BRCA mutations determined by an experienced laboratory using a validated test method. Genetic counselling for patients with BRCA mutations should be performed according to local regulations, as applicable. The recommended dose is 1 mg talazoparib once daily. Patients should be treated until disease progression or unacceptable toxicity occurs. Complete blood count should be obtained prior to starting Talzenna therapy and monitored monthly and as clinically indicated. To manage adverse drug reactions, interruption of treatment or dose reduction based on severity and clinical presentation should be considered (see SmPC section 4.2). Special populations: Hepatic impairment: See SmPC section 4.2. No dose adjustment is required for patients with mild, moderate or severe hepatic impairment. Renal impairment: See SmPC section 4.2. No dose adjustment is required for patients with mild renal impairment. For patients with moderate renal impairment, the recommended starting dose of Talzenna is 0.75 mg once daily. For patients with severe renal impairment, the recommended starting dose of Talzenna is 0.5 mg once daily. Talzenna has not been studied in patients with CrCL < 15 mL/min or patients requiring haemodialysis. Elderly: No dose adjustment is necessary in elderly (≥ 65 years of age) patients. Paediatric population: The safety and efficacy of Talzenna in children and adolescents < 18 years of age have not been established. **Method of administration:** Talzenna is for oral use. To avoid contact with the capsule content, the capsules should be swallowed whole, and must not be opened or dissolved. They can be taken with or without food (See SmPC section 5.2). **Contra-indications:** Hypersensitivity to the active substance or to any of the excipients. Breast-feeding. **Special Warnings and Precautions:** Myelosuppression: Myelosuppression consisting of anaemia, leucopenia/neutropenia, and/or thrombocytopenia, have been reported in patients treated with talazoparib (see section 4.8). Talazoparib should not be started until patients have recovered from haematological toxicity caused by previous therapy (≤ Grade 1). Precautions should be taken to routinely monitor haematology parameters and signs and symptoms associated with anaemia, leucopenia/neutropenia, and/or thrombocytopenia in patients receiving talazoparib. If such events occur, dose modifications (reduction or interruption) are recommended. Supportive care with or without blood and/or platelet transfusions and/or administration of colony stimulating factors may be used as appropriate. Myelodysplastic syndrome/Acute myeloid leukaemia: Myelodysplastic syndrome/Acute Myeloid Leukaemia (MDS/AML) have been reported in patients who received poly (adenosine diphosphate-ribose) polymerase (PARP) inhibitors, including talazoparib. Overall, MDS/AML has been reported in < 1% of solid tumour patients treated with talazoparib in clinical studies. Potential contributing factors for the development of MDS/AML include previous platinum-containing chemotherapy, other DNA damaging agents or radiotherapy. Complete blood counts should be obtained at baseline and monitored monthly for signs of haematologic toxicity during treatment. If MDS/AML is confirmed, talazoparib should be discontinued. Contraception in women of childbearing potential: Talazoparib was clastogenic in an in vitro chromosomal aberration assay in human peripheral blood lymphocytes and in an in vivo bone marrow micronucleus assay in rats but not mutagenic in Ames assay (see section 5.3), and may cause foetal harm when administered to a pregnant woman. Pregnant women should be advised of the potential risk to the foetus (see section 4.6). Women of childbearing potential should not become pregnant while receiving Talzenna and should not be pregnant at the beginning of treatment. A pregnancy test should be performed on all women of childbearing potential prior to treatment. A highly effective method of contraception is required for female patients during treatment with Talzenna, and for at least 7 months after completing therapy. Since the use of hormonal contraception is not recommended in patients with breast cancer, two non-hormonal and complementary contraception methods should be used. Male patients with female partners of reproductive potential or pregnant partners should be advised to use effective contraception (even after vasectomy), during treatment with Talzenna and for at least 4 months after the final dose. **Interactions:** Talazoparib is a substrate for drug transporters P-gp and Breast Cancer Resistance Protein (BCRP) and it is mainly eliminated by renal clearance as unchanged compound. Concomitant treatment with inhibitors of P-glycoprotein (P gp): Strong inhibitors of P gp may lead to increased talazoparib exposure. Concomitant use of strong P gp inhibitors (including but not limited to amiodarone, carvedilol, clarithromycin, cobicistat, darunavir, dronedarone, erythromycin, indinavir, itraconazole, ketoconazole, lapatinib, lopinavir, propafenone, quinidine, ranolazine, ritonavir, saquinavir, telaprevir, tipranavir, and verapamil) during treatment with talazoparib should be avoided. Co-administration should only be considered after careful evaluation of the potential benefits and risks. If co-administration with a strong P gp inhibitor is unavoidable, the Talzenna dose should be reduced to 0.75 mg once daily. When the strong P-gp inhibitor is discontinued, the Talzenna dose should be increased (after 3 5 half lives of the P-gp inhibitor) to the dose used prior to the initiation of the strong P gp inhibitor. No talazoparib dose adjustments are required when co administered with rifampin. However, the effect of other P-gp inducers on talazoparib exposure has not been studied. Other P-gp inducers (including but not limited to carbamazepine, phenytoin, and St. John's wort) may decrease talazoparib exposure. BCRP inhibitors: The effect of BCRP inhibitors on PK of talazoparib has not been studied in vivo. Co-administration of talazoparib with BCRP inhibitors may increase talazoparib exposure. Concomitant use of strong BCRP inhibitors (including but not limited to curcumin and cyclosporine) should be avoided. If co administration of strong BCRP inhibitors cannot be avoided, patient should be monitored for potential increased adverse reactions. Effect of acid-reducing agents: Population PK analysis indicates that co-administration of acid-reducing agents including proton pump inhibitors and histamine receptor 2 antagonists (H2RA), or other acid reducing agents had no significant impact on the absorption of talazoparib. Systemic hormonal contraception: Drug-drug interaction studies between talazoparib and oral contraceptives have not been conducted. **Fertility, pregnancy and lactation:** Fertility: There is no information on fertility in patients. Based on non-clinical findings in testes (partially reversible) and ovary (reversible), Talzenna may impair fertility in males of reproductive potential. Women of childbearing potential should not become pregnant while receiving Talzenna and should not be pregnant at the beginning of treatment. A pregnancy test should be performed on all women of childbearing potential prior to treatment. Women of childbearing potential must use highly effective forms of contraception prior to starting treatment with talazoparib, during treatment, and for 7 months after stopping treatment with talazoparib. Since the use of hormonal contraception is not recommended in patients with breast cancer, two non-hormonal and complementary contraception methods should be used. Male patients with female partners of reproductive potential or pregnant partners should be advised to use effective contraception (even after vasectomy) during treatment with Talzenna, and for at least 4 months after the final. Pregnancy: There are no data from the use of Talzenna in pregnant women. Studies in animals have shown embryo foetal toxicity. Talzenna may cause foetal harm when administered to a pregnant woman. Talzenna is not recommended during pregnancy or for women of childbearing potential not using contraception. Breast-feeding: It is unknown whether talazoparib is excreted in human breast milk. A risk to breast-fed children cannot be excluded and therefore breast-feeding is not recommended during treatment with Talzenna and for at least 1 month after the final dose. **Undesirable Effects:** The overall safety profile of Talzenna is based on pooled data from 494 patients who received talazoparib at 1 mg daily in clinical studies for solid tumours, including 286 patients from a randomised Phase 3 study with germline BRCA-mutated (gBRCAm), HER2-negative locally advanced or metastatic breast cancer and 83 patients from a non-randomised Phase 2 study in patients with germline BRCA-mutated locally advanced or metastatic breast cancer. The most common (≥ 25%) adverse reactions in patients receiving talazoparib in these clinical studies were fatigue (57.1%), anaemia (49.6%), nausea (44.3%), neutropenia (30.2%), thrombocytopenia (29.6%), and headache (26.5%). The most common (≥ 10%) Grade ≥ 3 adverse reactions of talazoparib were anaemia (35.2%), neutropenia (17.4%), and thrombocytopenia (16.8%). Dose modifications (dose reductions or dose interruptions) due to any adverse reaction occurred in 62.3% of patients receiving Talzenna. The most common adverse reactions leading to dose modifications were anaemia (33.0%), neutropenia (15.8%), and thrombocytopenia (13.4%). Permanent discontinuation due to an adverse reaction occurred in 3.6% of patients receiving Talzenna. The median duration of exposure was 5.4 months (range 0.03-61.1). Very common adverse reactions (>1/10) are Thrombocytopenia, Anaemia, Neutropenia, Leucopenia, Decreased appetite, Dizziness, Headache, Vomiting, Diarrhoea, Nausea, Abdominal pain, Alopecia and Fatigue. Commonly reported adverse reactions (>1/100 to <1/10), are Lymphopenia, Dysgeusia, Stomatitis and Dyspepsia. Refer to SmPC section 4.8 for further information on side effects. **Legal Category:** Product subject to prescription which may not be renewed (A): S1A. **Marketing Authorisation Number:** Talzenna 0.25 mg hard capsules – EU/1/19/1377/001-004; Talzenna 1 mg hard capsules – EU/1/19/1377/005-006. **Marketing Authorisation Holder:** Pfizer Europe MA EEIG, Boulevard de la Plaine 17, 1050 Bruxelles, Belgium.

For further information on this medicine please contact: Pfizer Medical Information on 1800 633 363 or at medical.information@pfizer.com. **For queries regarding product availability please contact:** Pfizer Healthcare Ireland, Pfizer Building 9, Riverwalk, National Digital Park, Citywest Business Campus, Dublin 24 + 353 1 4676500.

Date of Preparation: 11/2021.

Ref: TE 3_0.

▼This medicine is subject to additional monitoring. This will allow quick identification of new safety information. You can help by reporting any side effects you may get to HPRA Pharmcoviglance, Earlsfort Terrace, Dublin 2, IRL. Tel: +353 1 676 4971, Fax: +353 1 676 2517, Website: www.hpra.ie, E-mail: medsafety@hpra.ie

PP-TAL-IRL-0045
Date of Preparation January 2022

Pfizer Oncology

Keep calm and do yoga

Aparna Shukla looks at some yoga poses that can help to minimise the back issues often faced by nurses and midwives

AS NURSES and midwives we know the importance of a healthy back and one of the main beneficiaries of yoga is the spine. With regular and safe yoga practice, it is possible to manage, minimise or avoid many back issues.

The United Nations recognised yoga's universal appeal when in December 2014 it adopted resolution 69/131 and proclaimed June 21 as the International Day of Yoga. This day is now celebrated across the globe, raising awareness of yoga and its benefits to health.

This article will look at four different asanas, or poses, designed to move the spine in all of the six possible ways.

- Neck and torso flexion
- Neck and torso extension
- Torso lateral flexion
- Neck lateral flexion
- Neck rotation
- Torso rotation.

Together the four asanas detailed here complete the six movements of the spine.

According to an article from the Harvard Medical School, yoga can be particularly beneficial for lower back pain: "Yoga can be especially helpful to the muscles that support the back and spine, such as the paraspinal muscles that help you bend your spine, the multifidus muscles that stabilise your vertebrae, and the transverse abdominis in the abdomen, which also helps stabilise your spine."[1]

Nursing and midwifery both require a healthy body, and a healthy spine is the foundation of our skeletal system. By mindfully practising yoga or other back stretching exercises, we can improve our spinal health.

Precaution: It is always best to learn any yoga asana under the guidance of an experienced live yoga teacher. If you have any health condition, it is advised to consult your doctor before beginning any yoga training.

The INMO is celebrating UN International Yoga Day on June 21. For details, check **www.inmoprofessional.ie**

Aparna Shukla is a nurse and certified yoga teacher

References

1. www.health.harvard.edu/staying-healthy/the-safe-way-to-do-yoga-for-back-pain

Cat pose/Marjarayasana

This asana brings neck and torso flexion

Steps to perform: Begin by coming on to all fours in a tabletop position. Keep hands directly under the shoulder joint and both hands flat on the mat with all fingers wide apart. Both knees remain hip-width apart and hips over knees. Exhale and round spine, bring the chin towards the chest and lower the tailbone towards the floor. Pull the navel in and up so that you engage your abdominal muscles. To release the pose, return to a neutral tabletop.

Cow pose/Bitilasana

This asana is a counter pose for Marjarayasana and brings neck and torso extension

Steps to perform: Begin from a neutral tabletop position. Inhale and arch back, lower belly, lift your tailbone, and look up. Keep the back of the neck long while looking up. To release return to neutral spine. You can alternate five to 10 repetitions of the cat and cow pose.

Benefits: These two asanas, cat and cow, together helps with warming up the spine, and are considered good preparatory poses for more rigorous yoga poses such as sun salutation.

Seated side bend/Parsva sukhasana

This asana includes two movements of the spine, one is torso lateral flexion and another is neck lateral flexion.

Steps to perform: Sit on a soft cushion or a folded blanket to raise the hips so that the knees come down. Start by sitting in sukhasana or cross-legged pose. Keep the spine straight. Place right hand down on the mat. As you start to inhale, raise your left arm up towards the ceiling. Exhale and side bend to the right. Keep 'drishti' by keeping your gaze on the left hand and take five deep conscious breaths in complete awareness. Inhale, return to the centre and exhale both hands, fingertips on the mat. Repeat the movement on the other side.

Benefits: Parsva sukhasana, or seated side bend, stretches the upper body, opens the heart centre and creates more space for the lungs, thus helping respiration.

Half lord of the fishes pose/Ardha Matsyendrasana

This asana allows neck rotation and torso rotation.

Steps to perform: Begin seated in sukhasana or cross-legged pose. Bend the right knee and step it across the left leg, placing the sole flat on the floor. Bend the left knee and place the outer edge of the left foot beside the right hip. Place the right hand on your mat behind the right hip. Inhale, sit tall with the spine. Exhale, twist towards the right and turn to look over the right shoulder. Repeat on the other side.

Benefits: Half lord of the fishes pose should only be done after the initial warm-up or towards the end of the practice. This is a good asana for stretching your outer hips and thighs and lengthening your spine. It helps to stimulate digestion.

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Take a break with

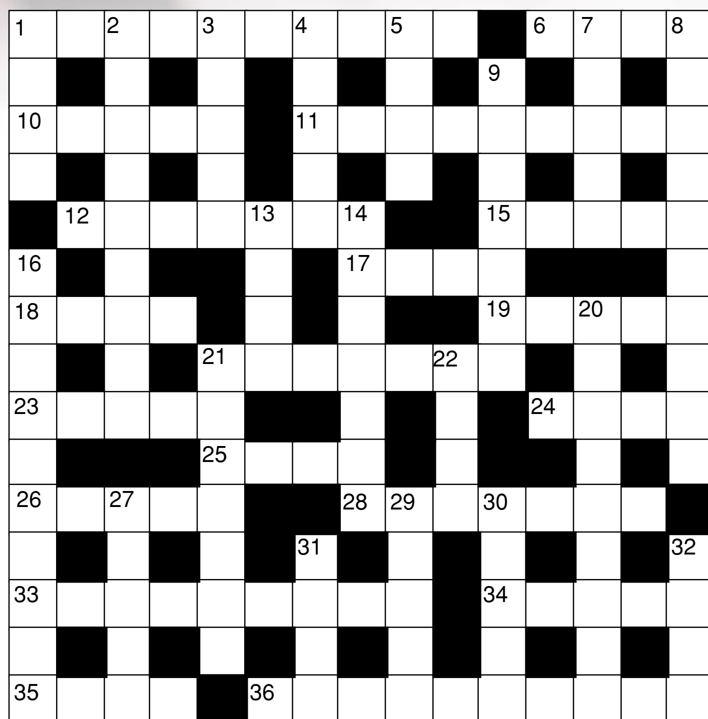
CROSSWORD Competition

Across

1 Some poor bakery provides a collection of words to say to God (6,4)
6 Reaction of shock or disbelief (4)
10 West African country formerly known as the Gold Coast (5)
11 This American state wins coins for a change (9)
12 Pays no attention to something or someone (7)
15 Name of the first pope (5)
17 Ornamental sunken ditch (2-2)
18 Mediocre (2-2)
19 Damascus is its capital city (5)
21 Colourful tropical birds (7)
23 With perfect timing, where the snooker chalk goes (2,3)
24 A drink of tea made with spices (4)
25 The top of a building (4)
26 & 28 Predatory plant that can be spun very flat (5,7)
33 The secretion of milk from the body (9)
34 Herb? Mr Fawlty to you! (5)
35 Topmost point (4)
36 Moved information from the internet to one's computer hard disk (10)

Down

1 Porcine creatures (4)
2 Relating to pain relief, as I glance around (9)
3 The Muse of love poetry (5)
4 David, 'Ziggy Stardust' creator (5)
5 This river flows through York (4)
7 Something worth having (5)
8 Accept Iran disruption, related to an enzyme producer (10)
9 Direction-finding instrument (7)
13 Hear about a flightless bird (4)
14 Law enforcement officer in the Wild West (7)
16 Soccer club based in Birmingham (5,5)
20 Practised for a play or concert (9)
21 Breed of cat that upsets a sniper (7)
22 Member of the British Conservative party (4)
27 Mother-of-pearl from a moving crane (5)
29 Russian premier from 1917 to 1924 (5)
30 Strictly forbidden (5)
31 Alcoholic down-and-out (4)
32 Happy, pleased (4)



Name: ....

Address: ....

....

You can email your entry to us at nursing@medmedia.ie by taking a photo of the completed crossword with your details included putting *'Crossword Competition'* in the subject line. Closing date: **Friday, May 20, 2022.** If preferred you can post your entry to: WIN Crossword, MedMedia Publications, 17 Adelaide Street, Dun Laoghaire, Dublin, A96E096

April crossword solution

Across: 1 Jules Verne 6 Paid 10 Edith 11 Resection 12 Herb tea 15 Ulnar 17 Fuji 18 Acts 19 Route 21 Cezanne 23 Porch 24 Edna 25 Opal 26 Appal 28 Eastern 33 Spearmint 34 Rhone 35 Adds 36 Percolator

Down: 1 Jeer 2 Leicester 3 Sahib 4 Eerie 5 Nose 7 Asian 8 Doner kebab 9 Acquire 13 Tore 14 Affable 16 Caspian Sea 20 Undercoat 21 Cholera 22 Naas 27 Plead 29 Aztec 30 Tyrol 31 RICE 32 Fear

The winner of the April crossword is: Liezl Lumbres, Cork

In-Person EVENT

FREE for INMO Members

International Nurses Section
CULTUREFEST 2022

The Richmond Education and Event Centre, Dublin

11am - 2pm

Saturday 2 JULY

Booking your place is essential

www.inmoprofessional.ie/conference or email: **education@inmo.ie**

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Thursday 9 JUNE

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- **Nightingale set up**
- **Research presentations from members**
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ICN condemns criminalisation of medical errors following US verdict

Nurse who administered incorrect drug faces six-year sentence

THE International Council of Nurses (ICN) has condemned the criminalisation of medical errors after a US nurse was found guilty of causing criminally negligent homicide by administering an incorrect drug which led to the death of a patient.

Former intensive care nurse RaDonda Vaught from Tennessee, whose drug administration error in 2017 resulted in the death of 75-year-old patient Charlene Murphey, faces up to six years in prison. She will be sentenced in May.

Instead of administering the sedative midazolam, Ms Vaught administered vecuronium bromide, a skeletal muscle relaxant used in anaesthetics.

Speaking after the ruling, ICN president Pamela Cipriano said: "The ICN has worked closely with the World Health Organization on developing the current Global Patient Safety Action Plan, which recognises that a safe organisation is one where there is a no-blame culture of openness and transparency.

"It is vital to recognise the effects of system failures whenever such tragic errors occur, because patients will not be made safer by criminalising nursing errors and scapegoating individuals.

"This ruling risks being a significant backward step for the advancement of patient safety globally and could also drive nurses to leave the profession given the fear of prosecution for an honestly declared mistake," Dr Cipriano continued.

"Patient safety is about learning and continuous improvement and this ruling potentially stands in the way of that. You can't build a culture of trust in healthcare while nurses have the threat of individual criminal prosecution hanging over them if they were to make an honest error."

The American Nurses Association (ANA) issued a statement describing its distress at the verdict and what it called the "harmful ramifications of criminalising the honest reporting of mistakes".

The ANA said the verdict sets a dangerous precedent and that there are more effective and just mechanisms to examine errors and take corrective action. It said the ruling could have a negative impact on the profession, which is already short staffed and under intense strain.

Oireachtas warned of 'serious' shortage of neurology nurse specialists

PRESENTING to the Joint Oireachtas Committee on Health in March, the Neurological Alliance of Ireland (NAI) said there is a shortfall of more than 100 nurse specialists in neurology in the Irish healthcare system.

The alliance, which comprises 30 non-profit organisations and advocates for the rights of the 800,000 people in Ireland living with a neurological condition, is seeking investment to tackle this shortage.

Nurse specialists in neurology provide many services to people with neurological conditions, including nurse-led clinics, rapid-access clinics, telephone advisory services and outreach services. They can improve the quality of care at lower cost, primarily by preventing unnecessary admissions through advice, information, support, counselling and adjustments in medication.

Speaking in advance of the presentation, Magdalen Rogers, NAI executive director, said: "In October 2021, the NAI launched our 'Patients Deserve Better' campaign to highlight the need for more nurse specialists in neurology. According to the model of care for neurology services in Ireland, we have an overall shortfall of 100 nurse specialists across neurology services," Ms Rogers continued.

"This means that four-fifths of Irish people living with Parkinson's disease, for example, do not have access to a nurse specialist, because of the absence of nurse specialists in adult neurology services for complex neurological conditions while there are no specialist nurses for rare complex conditions such as Huntington's disease.

"Investing in nurse specialists in neurology services is critical to reducing waiting lists and improving patient care. Latest figures show 23,815 people on waiting lists for a neurology appointment. This compares to 13,218 on the waiting list in 2015. We have clear evidence within our own health system of the role of nurse specialists in waiting list reduction and prevention of hospital admission.

"We are calling on the Joint Oireachtas Committee on Health to support our call to significantly increase the number of nurse specialists in neurology by up to 20 additional nurses per year over the next five years in line with the model of care for neurology services."

CTI to host 'cancer retreat' in May

TO mark International Clinical Trials Day on May 20, Cancer Trials Ireland (CTI) will host a cancer retreat for the clinical oncology community.

The purpose of the half-day event is to bring the cancer trials community, including research nurses, together to discuss common goals, how best to address current issues, as well as identify future challenges and opportunities.

The event will take place in the Royal College of Surgeons, Dublin, from 9am to 1pm, and will also be streamed live online. It will feature a number of Irish and international speakers, including from the US National Cancer Institute, CTI and other leading medical oncologists.

The primary focus of the retreat will be the recruitment of patients to trials. It will also cover the development of the new molecular tumour board and the growing area of public and patient involvement, with participants developing a shared understanding of the issues affecting patient accruals to trials.

The conference is part of the 'Just Ask' initiative, which promotes public awareness and understanding of clinical trials. To register, visit **www.cancertrials.ie**

May

Saturday 14
School Nurses Section meeting. 10.30am Midlands Park Hotel, Portlaoise

Thursday 19
SALO networking group meeting. 12pm via Microsoft Teams

Saturday 28
Special Schools Section meeting. 10am via Zoom

June

Wednesday 8
Orthopaedic Section meeting. 4pm via Zoom

Thursday 9
ED Section webinar. Contact the INMO to book your place

Friday 10
Third Level Student Health Nurses Section meeting. 10am. Richmond Education and Event Centre

Saturday 11
PHN Section meeting. 10.30am via Zoom

Wednesday 29
CPC Section meeting. 11am via Microsoft Teams

July

Saturday 2
International Nurses Section CultureFest. 11am. Richmond Education and Event Centre

Library reopening

❖ After some remodeling and renovation, the library staff are delighted to announce that the library has reopened in the basement of the INMO Whitworth Building. The bright spacious room houses the collections of books, journals and theses. There is now a separate quiet space available for individual study, which is available for members to book. If you wish to visit, please send an email to: library@inmo.ie or Tel: 01-6640614 to make an appointment.

Condolences

❖ The INMO extends our deepest sympathies to staff member Catriona O'Donnell on the recent passing of her beloved father Thomas Lacey. Our thoughts are with his extended family and friends at this difficult time. May he rest in peace.

❖ The Cork Office, COOP Section, HSE Southern Branch and all at the INMO send our sincere condolences to the family and friends of Catriona O'Sullivan, who recently passed away. Catriona will be sorely missed by her colleagues at Caherciveen District Hospital and by all who knew her. May she rest in peace.

INMO Professional Library Opening Hours

May
Monday-Thursday: 8.30am-5pm
Friday: 8.30am-4.30pm
by appointment

For further information on the library, please contact
Tel: 01 6640 625/614
Fax: 01 01 661 0466
Email: library@inmo.ie

INMO Membership Fees 2022

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

Clarification

❖ An article published in the March issue of *WIN* included a list of registered advanced midwife practitioners (RAMP), which included Usha Daniel from the National Maternity Hospital. Ms Daniel has now retired. Yvonne Tier from University Hospital Limerick is a RAMP in supported care and vaginal birth after Caesarean section.

www.nurse2nurse.ie

WIN Recruitment & Training

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- Tuesday, May 24, 2022 6.30pm-9.30pm at the Viking Hotel, Waterford
- Wednesday, May 25, 2022 6.30pm-9.30pm at Bon Secours Hospital Cork
- Thursday, May 26, 2022 2pm-6pm at Aisling Hotel, Dublin

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Further enquiries to: **021-4801664** or email **recruitment@bonsecours.ie**

Irish Cancer Society Nurses

The Irish Cancer Society are seeking registered nurses who can provide a minimum of two nights per week and have some palliative experience. Training will be provided.

- Job description on **www.cancer.ie**
- Email CV to **recruitment@irishcancer.ie**
- Informal enquiries to 01-231 0524 or **mferns@irishcancer.ie**

Irish Nurses Rest Association

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

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

WIN

Don't forget to mention *WIN* when replying to advertisements

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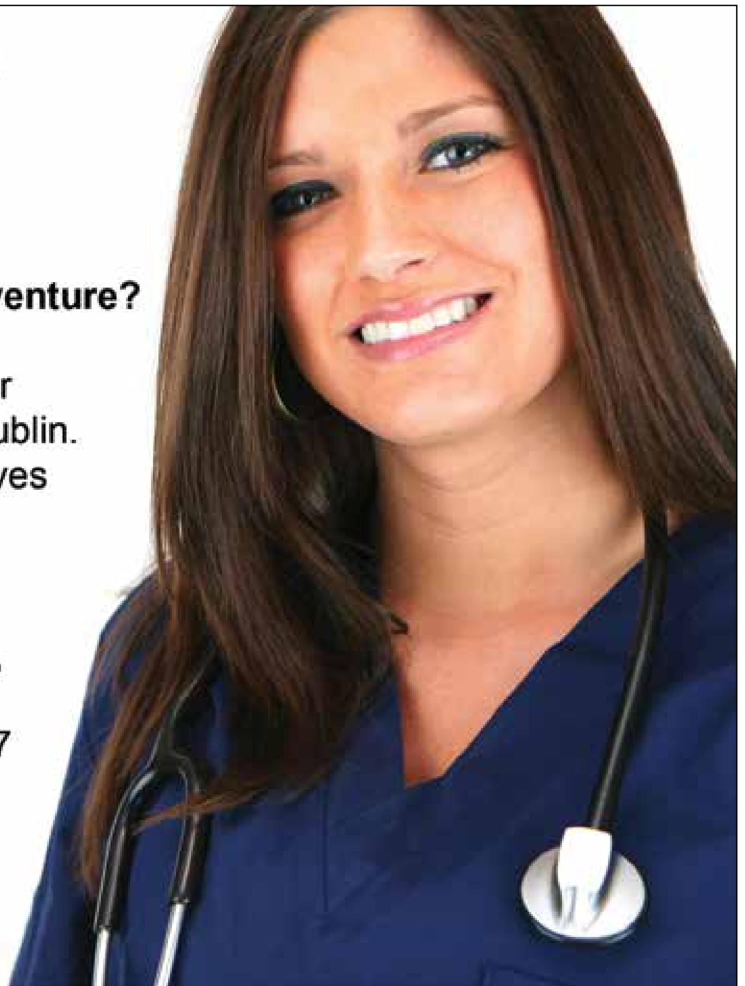

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Eagraíocht Cúram Sláinte Pobail
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Community Healthcare Organisation
Dublin North City & County

Nursing positions available

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

Our services
Primary care; older persons; disabilities; mental health and wellbeing; quality, safety and service improvement

Our current vacancies
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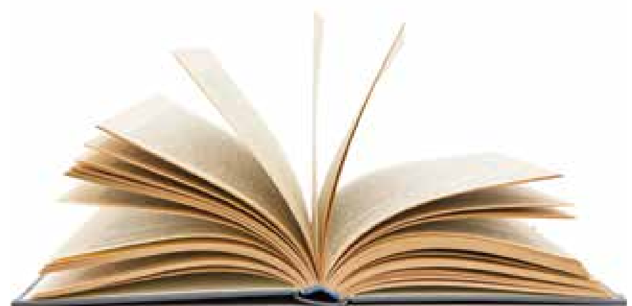
We welcome applications from all qualified individuals who meet the eligibility criteria for these roles. Further information is available in the Job Specification for each position. Search 'Rezoomo CHO DNCC Jobs' or visit **Rezoomo CHO DNCC Jobs** for all our current vacancies.

Read a good book recently? Write a review for *WIN*

Every month we publish a book review written by one of the *WIN* team or by an INMO member. It doesn't have to be nursing/midwifery related, but if you have read something that you found helpful to your practice, please consider writing a review for an upcoming issue of *WIN*.

Submit your review to nursing@medmedia.ie

Word count: 400



Advanced Practice Nursing Shaping the Future of Healthcare

The INMO is delighted to be collaborating with the IAANMP in hosting the 12th International Council of Nurses, Nurse Practitioner / Advanced Practice Nurses Network Conference in University College Dublin from 21st to 24th August 2022. This year marks 26 years of Advanced Nursing / Midwifery practice in Ireland, and the conference will showcase and celebrate advancements in nursing and midwifery practice from around the world

Who attends?

Who attends? Nurse/ Midwife Practitioners • Advanced Practice Nurses and Midwives • Clinical Nurse and Midwife Specialists • Registered Nurses and Midwives • Those on the pathway to Advanced Practice • Educators • Policy Makers and Managers • Industry Partners • Media

Conference Themes

- Advancing nursing practice to address inequality
- Leading innovation in advanced practice nursing
- Health and Wellbeing
- Global Health and Climate Change
- Building a NP/APN workforce for health
- Evidencing the impact of advanced practice nursing

Call for abstracts now open until 14th March 2022
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Access the award-winning training at: www.Tork.ie/WorldHandHygieneDay

*World Health Organization, World Hand Hygiene Day 2021 Facts and Figures, https://www.who.int/campaigns/world-hand-hygiene-day/2021/key-facts-and-figures

**Survey among 1017 healthcare professionals in five markets: United States, United Kingdom, Sweden, Germany and Poland. The survey was conducted between 23 November to 7 December 2018 by United Minds on behalf of Tork and in collaboration with the panel provider CINT

Think ahead.