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WIN

Journal of the Irish Nurses and Midwives Organisation

World of Irish Nursing & Midwifery

Latest INMO CPD education programme
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World Ovarian Cancer Day
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International days of nurses and midwives

ADC to celebrate professions in Killarney

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On the cover
Pictured (l-r): Emergency department nurses Holly Dolan and Alan Long pictured at Letterkenny University Hospital, Donegal

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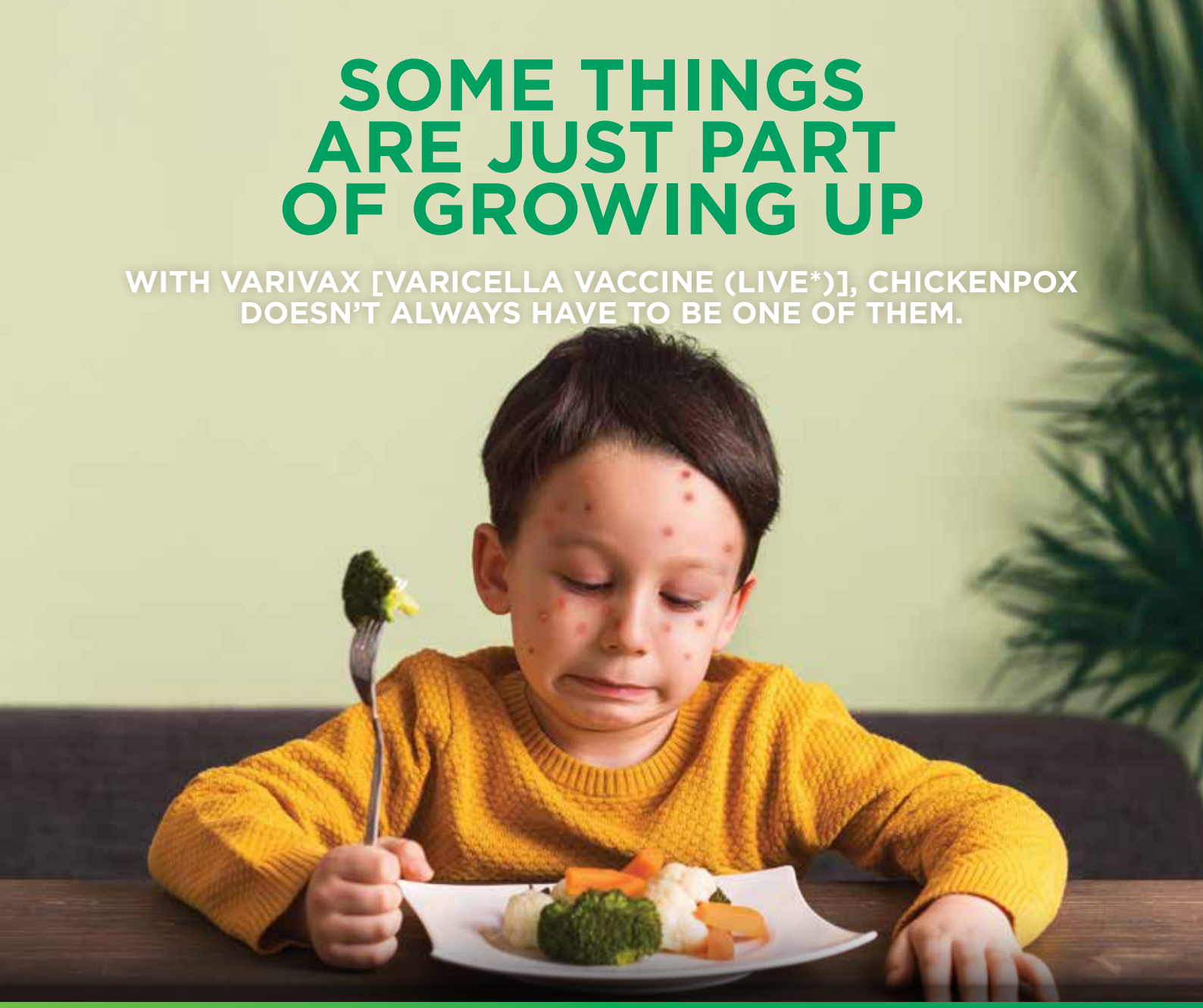

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Blood dyscrasias, leukaemia, lymphomas of any type, or other malignant neoplasms affecting the hemic or lymphatic systems. Individuals receiving immunosuppressive therapy. Severe humoral or cellular immunodeficiency. Individuals with a family history of congenital or hereditary immunodeficiency unless immune competence has been demonstrated. Active untreated tuberculosis. Any illness with fever >38.5ºC. Pregnancy. Furthermore, pregnancy should be avoided for 1 month following vaccination. **PRECAUTIONS AND WARNINGS** In order to improve the traceability of biological medicinal products, the name and the batch number of the administered product should be clearly recorded. Appropriate medical treatment and supervision should always be available in the rare event of anaphylaxis. Vaccine recipients should avoid salicylates for 6 weeks after vaccination. Vaccination may be considered in patients with selected immune deficiencies where the benefits outweigh the risks. Immunocompromised patients who have no contraindication for this vaccination may not respond as well as immunocompetent subjects; therefore, some of these patients may acquire varicella in case of contact, despite appropriate vaccine administration. These patients should be monitored carefully for signs of varicella. Transmission of varicella vaccine virus (Oka/Merck strain) resulting in varicella infection including disseminated disease may rarely occur between vaccine recipients (who develop or do not develop a varicella-like rash) and contacts susceptible to varicella including healthy as well as high-risk individuals. Vaccine recipients should therefore avoid close association with susceptible high-risk individuals for up to 6 weeks after vaccination. If varicella vaccine (live) (Oka/Merck strain) is not given concomitantly with measles, mumps, and rubella virus vaccine live, a 1-month interval between the 2 live virus vaccines should be observed. 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Common side effects: Upper respiratory infection, rash, Maculopapular rash, varicella-like rash (generalised median 5 lesions), injection site erythema, rash, pain/tenderness/soreness, swelling and varicella-like rash (injection site median 2 lesions), irritability. **Healthy individuals 12 months to 12 years of age (2 doses received ≥ 3 months apart):** The following serious side effects temporally associated with the vaccination were reported in individuals 12 months to 12 years of age given varicella vaccine (live) (Oka/Merck strain): Diarrhoea, febrile seizure, fever, post-infectious arthritis, vomiting. **Healthy individuals 13 years of age and older (majority received 2 doses 4 to 8 weeks apart):** Very common side effects: Fever ≥ 37.7°C oral, injection-site erythema, soreness and swelling. Common side effects: varicella-like rash (generalised median 5 lesions), injection-site rash, pruritus and varicella-like rash (injection site median 2 lesions). Other reported adverse events (during post-marketing surveillance) that may potentially be serious include thrombocytopenia, pneumonia, encephalitis, anaphylaxis, cerebrovascular accident, febrile and non-febrile convulsions, Guillain-Barré syndrome, transverse myelitis, ataxia, Stevens-Johnson syndrome, erythema multiforme Henoch-Schönlein purpura and herpes zoster. Varicella (vaccine strain) has been reported during marketed use of the vaccine. The vaccine virus may rarely be transmitted to contacts of vaccinees who develop or do not develop a varicella-like rash. Complications of varicella from vaccine strain, including herpes zoster and disseminated disease such as aseptic meningitis and encephalitis, have been reported in immunocompromised or immunocompetent individuals. Necrotizing retinitis has been reported post-marketing in immunocompromised individuals. For a complete list of undesirable effects please refer to the Summary of Product Characteristics. **PACKAGE QUANTITIES** Single vial of vaccine and prefilled syringe of diluent with two unattached needles. **Legal category:** POM **Marketing authorisation number:** PA 1286/057/001 **Marketing Authorisation holder:** Merck Sharp & Dohme Ireland (Human Health) Limited, Red Oak North, South County Business Park, Leopardstown, Dublin 18, Ireland. **Date of revision:** September 2022. Further information is available on request from: MSD, Red Oak North, South County Business Park, Leopardstown, D18 X5K7 or from www.medicines.ie. Adverse events should be reported. Reporting forms and information can be found at www.hpra.ie. Adverse events should also be reported to MSD (Tel: 01-2998700) II0119 (CRN00CWXK)

**Adverse events should be reported. Reporting forms and information can be found at www.hpra.ie.
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* VARIVAX is a live attenuated vaccine contraindicated in certain patients. See prescribing information.[1]
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Reference
1. VARIVAX Summary of Product Characteristics September 2022.

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medmedia publications

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

Production & news editor Tara Horan

Sub-editor Max Ryan

Designers Fiona Donohoe, Paula Quigley

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

Publisher Geraldine Meagan

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INMO
Irish Nurses and Midwives Organisation

Editor-in-chief: Phil Ní Sheaghdha

INMO editorial board:
Karen McGowan
Mary Tully and Caroline Gourley

INMO editors:
Siobhán de Paor (siobhan.depaor@inmo.ie)
Freda Hughes (freda.hughes@inmo.ie)

INMO photographer: Lisa Moyles

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

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

www.facebook.com/irishnursesandmidwivesorganisation

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ADC set to debate key issues

AS WE get ready for our 104th annual delegate conference (ADC) I want to highlight the work undertaken by branch officers and trade union representatives every day in workplaces around the country. The culmination of this work is the ability to raise important issues for nurses and midwives in their workplace at the union's conference. This is an important opportunity to publicly highlight and celebrate what we have achieved through our advocacy, collective bargaining,and workplace representation involving nursing and midwifery representatives and their union.

It provides an important opportunity for representatives to highlight the priorities for the upcoming public sector pay talks and to draw attention to the government's failure to positively answer the INMO's calls for real measures to ensure:

- Implementation of the framework for nurse and midwifery staffing ratios in line with recommended safe levels
- The increasing side effects of hospital overcrowding (burnout and increased violence and aggression in the workplace)
- The increasing lack of availability of suitable accommodation and increasing rents.

The 53 motions for debate at this year's ADC reflect the real issues, ranging from:

- Enhancing entry pathways into our professions to increase our numbers
- The requirement to improve workplace conditions, specifically staffing levels, and health and safety measures in an increasingly violent working environment
- Timely payment of agreed pay awards in the public service and the need for the employer to ensure this is upheld
- Rights of nurses/midwives at the end of their careers in an increasingly difficult and physically demanding environment.

It promises to be a wide-ranging *clár* and one that branches and professional sections are keen to have debated in the public space of the ADC.

The HSE's new chief executive, Bernard Gloster, will address delegates on his vision for the HSE on Thursday morning and Minister for Health Stephen Donnelly will address delegates on Friday morning, on the government's priorities for the health service. We will also have an exciting panel of speakers discussing significant issues to nurses and midwives both inside and outside of their workplaces. We will be joined by Elizabeth Adams, president of the European Federation of Nurse Associations, who will highlight various initiatives being brought through various European institutions that will impact our professions.

Owen Reidy, recently appointed general secretary of the Irish Congress of Trade Unions, will set out the work of ICTU at a European level and the importance of representation of the voice and interests of Irish workers. Dr Rory Hearne, housing policy expert and author of the recently published book *Gaffs*, will lead a timely discussion with our latest research showing that some nurses/midwives are spending up to 77% of take-home pay on rent.

The important issues of women's place in Irish society, the barriers that still exist to equality, how we must work to support victims of domestic violence and coercive control and bring about protections to reduce fatality statistics will be expertly set out by Sarah Benson, chief executive of Women's Aid. She will cover what we, as healthcare professionals can look out for, education programmes being piloted in this area specifically for nurses and midwives, and the need for employers to recognise this issue as a workplace issue and aid employees who are in some cases also victims.

Overall, this panel discussion will be a lively and informative one and we are delighted to have such expert and committed participants. The panel will be chaired by journalist Alison O'Connor.

A full report on the proceedings will be included in the June issue of *WIN*. We hope that members unable to attend as delegates this year, will get involved at INMO branch level in the year ahead and join the debate as a delegate next year.

Phil Ní Sheaghdha
General Secretary, INMO

Irish Nurses and Midwives Organisation
Working Together

Nurse and Midwife Representative Training 2023

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

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

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

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

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

**Please note that the dates and locations are subject to change*

CONTACT YOUR INMO OFFICIAL

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

A positive focus with the president

Karen McGowan, INMO president

Menopause on the map

IN APRIL I spoke at the Menopause Summit on the findings of the INMO questionnaire on menopause in the workplace. The results showed that 87% of respondents reported having menopause symptoms, 18% reported symptoms as being severe and debilitating and 90% reported that their menopause symptoms affected them while at work. The panel that I was part of spoke about making workplaces menopause friendly environments. The recommendations were to implement menopause at work policies, develop training to raise awareness of menopause and how to support women in the workplace. The INMO will campaign collectively with other unions to stop the stigma in relation to menstrual and menopausal issues in the workplace. This was Ireland's first national menopause conference and there is certainly a growing demand for more conferences like it. *See page 24 for a report on the event.*

Final preparations for ADC 2023 in Kerry

AS WE go to print, final preparations are being made for our annual delegate conference (ADC) which will take place in Killarney on May 3-5, 2023. ADC will give us an important opportunity to present the issues that mean the most to nurses and midwives directly to senior decision-makers in government and the HSE. As well as deciding the union's policies and priorities for the years ahead, ADC allows us to meet others within the nursing and midwifery professions to exchange ideas and make new invaluable connections.

Delegates voting at last year's ADC in Sligo

As president, I am looking forward to welcoming more than 350 delegates from across our branches and sections, particularly our delegates who are attending ADC for the first time. I am also looking forward to presenting the updated *General Guidelines for Members in Relation to Industrial Action and Strike Action*. The main objective of these guidelines is to present a clear process for strike committees to follow, while allowing the committee some discretion in local decision making. Furthermore, by following these guidelines, and by observing the invaluable work of the strike committees, all members can see, and benefit from, a fair and transparent process. This benefits all members and the people to whom they provide care, through the provision of essential services during any dispute.

The guidelines also focus on and provide a clear pathway to manage any escalation in a dispute, at local, regional and national level, and clear guidance should any industrial/strike action extend over a long period of time. The guidelines' main purpose is to ensure the maximum degree of consistency of approach when organising a national dispute, but can also be used, and adapted, during a dispute in a specific local care setting. I hope you will find these guidelines helpful and that they explain the INMO's methodology and process in relation to all industrial/strike action.

The ADC coincides with International Day of the Midwife on May 5. International Day of the Nurse will take place on May 12 (*see page 19*). These days are a wonderful way to recognise the ways in which both the midwifery and nursing professions contribute to society at large. I'm looking forward to seeing all of your pictures on both days so be sure to tag the INMO socials when you are posting.

Executive Council update

THE Executive Council met this month and discussed the final plans for ADC in Killarney. We also considered and sanctioned plans for a new website and software to support membership professionally. This is long overdue and we look forward to future changes to ensure ease of access to information and courses available through the INMO.

There were a number of requests for balloting for industrial action that the Executive Council considered and subsequently sanctioned. These situations will be monitored and any updates will be reported to the Executive Council as they progress through the stages.

First-vice president Mary Tully attended EFN general assembly in Croatia and reported back on the progress of that gathering. It is so important to be part of this European collective group. The policy statements on the European health strategy, digital health and also including a European directive on violence against women were discussed. EFN president Elizabeth Adams, former director of professional development with the INMO, has stated that this is a very important topic at EU level and is receiving enormous support politically. The next assembly will be in October.

Members of the Executive Council participated in the 'Climb with Charlie' event in the Phoenix Park. It was an extraordinary day of solidarity with Charlie Bird in the face of his motor neuron disease diagnosis.

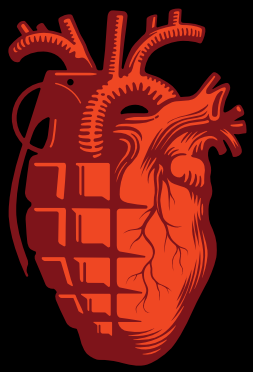
I want to thank the officers and Executive Council members for their commitment and support over this term. Their attention to detail and progression of the profession is always to the fore and I thank them for keeping the vision of INMO members high on the agenda. We look forward to meeting the delegates at ADC.

Get in touch

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

ATTR-CM
SUSPECT & DETECT
UNCOVER THE CLUES FOR DIAGNOSIS

SUSPECT ATTR-CM
(TRANSTHYRETIN AMYLOID CARDIOMYOPATHY)



A LIFE-THREATENING DISEASE THAT CAN GO UNDETECTED

Life-threatening, underrecognized, and underdiagnosed, ATTR-CM is a rare condition found in mostly older patients in which misfolded transthyretin proteins deposit in the heart.[1-7] It is vital to recognize the diagnostic clues so you can identify this disease.

CONSIDER THE FOLLOWING CLINICAL CLUES, ESPECIALLY IN COMBINATION, TO RAISE SUSPICION FOR ATTR-CM AND THE NEED FOR FURTHER TESTING

HFpEF — heart failure with preserved ejection fraction in patients typically over 60 years old[5-7]

INTOLERANCE — to standard heart failure therapies (ACEi, ARBs, and beta blockers)[8-10]

DISCORDANCE — between QRS voltage and left ventricular (LV) wall thickness[11-13]

DIAGNOSIS — of carpal tunnel syndrome or lumbar spinal stenosis[3,8,14-20]

ECHO — showing increased LV wall thickness[6,13,16,21,22]

NERVOUS SYSTEM — —autonomic nervous system dysfunction-including gastrointestinal complaints or unexplained weight loss[6,16,23,24]

LEARN HOW TO RECOGNIZE THE CLUES OF ATTR-CM AT:
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Date of Preparation: February 2021 GCMA code: PP-RDP-IRL-0105

Pfizer Rare Disease

"Ridiculously high trolley figures – the new normal"

INMO calls for multi-annual plan on overcrowding

THERE was no hospital bed available for almost 70,000 patients admitted to hospital in the period covered by the HSE's Winter Plan 2022/2023. This included 12,943 patients in March – 447 of whom were children, according to INMO TrolleyWatch.

INMO general secretary Phil Ní Sheaghdha said: "In some hospitals the level of overcrowding we have seen has been out of control and cannot be allowed to continue. Our analysis on the success of the HSE's Winter Plan has shown that more people than ever have been on trolleys during the health service's winter period (October-March) with 12,943 people on trolleys during this period.

"It is time for the HSE and the Department of Health to devise a multi-annual plan as to how we tackle overcrowding. It is clear that it is no longer just a winter overcrowding crisis but a year-long one.

"The State cannot expect nurses to bear the brunt of the crisis and work at full tilt in constantly overcrowded and understaffed wards year-round. Nurses want to be able to carry out the high quality care that they have been trained to do but cannot provide in these circumstances. There must be a change in mindset in how we approach this overcrowding crisis – from senior decision-makers, from hospital management to HSE senior management levels.

Earlier in March the INMO had warned that "runaway hospital overcrowding had become the new normal", at a point when there hadn't been a day with trolley numbers below 545 in over two weeks.

Ms Ní Sheaghdha said: "It is clear to our union that ridiculously high trolley figures have become the new normal. The INMO has long been raising concerns about the devastating impact this level of overcrowding is having on nurses and their patients with all levels of HSE management.

"The HSE and the Department of Health need to stop treating runaway hospital overcrowding as a surprise; this level of overcrowding was and is entirely predictable. Post bank holiday backlogs are not new, they happen each time and it is clear that many hospitals are not preparing properly.

"Our members have made it clear they cannot continue to work in these conditions year-round with absolutely zero reprieve.

"We have sought an urgent meeting with the new HSE CEO to discuss new approaches that can be taken in light of his recent comments on the winter plan process."

Overcrowding out of control in Cork

THE INMO was calling for a bespoke plan to tackle "out-of-control" overcrowding in Cork City as we went to press. This came on a day when overcrowding reached record levels across the city with 132 patients admitted to hospital without a bed, including 92 at Cork University Hospital and a further 40 patients admitted to Mercy University Hospital being cared for on trolleys or chairs.

INMO assistant director of IR for the Southern Region, Colm Porter said: "Overcrowding in both major hospitals in Cork has become out of hand, with records being broken in both Cork University Hospital and the Mercy. It is clear now that this warrants a national response from the HSE.

"The situation in CUH is continuing to deteriorate week on week. Our members are under significant pressure across all wards. The bed deficit that currently exists in CUH is impacting the ability of our members to carry out the safe care they have been trained to provide to patients.

"Immediate engagement is required to ensure that discharge facilities are available in the community and that all capacity that can be used from the private sector is being deployed."

INMO IRO Liam Conway said: "The conditions in the Mercy University Hospital over recent weeks have proved to be intolerable for nurses. There are real concerns for nurse safety when it comes to fire safety and infection control due to the levels of overcrowding.

"Our members are calling it for what it is inside the Mercy – dangerous. Patients are being cared for near exit doors and in areas blocking fire safety equipment, this is not acceptable.

"As well as a national response from the HSE, the hospital and the South/South-west Hospital Group is required to commence de-escalation protocols and cancellation of all non-urgent elective care."

World news

Nurses and midwives in action around the world

Australia

- Nurses, midwives call for 24/7 onsite security after violence and threats in regional hospitals

Canada

- "We've been asking for this for 25 years" – British Columbia Nurses Union CEO on new patient-nurse ratios
- Overworked nurses worried about adding prescription training to their workload, says union

France

- Reintegration of unvaccinated caregivers: several medical and nursing organisations oppose it

Honduras

- Sexual assault on a nurse, trigger for nurses' strike

India

- Unionised private hospital nurses strike in Kerala State April 11-13

Italy

- Nurses on a war footing. Union requests urgent meeting with regional leaders in Ascoli Piceno

New Zealand

- 'Exhausted, desperate' hospital workers filed 23,000 reports warning of unsafe staffing
- Nurses to rally nationwide in 'time of absolute crisis'

Philippines

- Agony and glory: Filipino nurses in the UK struggle to adapt, face challenges

UK

- Nurses in England to stage biggest strikes yet after rejecting pay offer

US

- Proposed federal law would set nurse-to-patient staffing levels

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

Update on WRC hearings

- The INMO attended the Workplace Relations Commission on the issues surrounding Section 39 facilities and a further meeting is due to take place on May 15.
- The National Joint Council was also in WRC talks in April with the Department of Health to resolve the matter of pay restoration to Sections 39s.
- The INMO is also awaiting a draft proposal from the WRC regarding out-of-hours RNID work.

INMO industrial action pending across the country

FOLLOWING a winter of unprecedented challenges in hospitals throughout the country, a number of ballots and requests for industrial action are in process.

University Hospital Limerick: In UHL, 93.6% of nurses in the intensive care unit have voted in favour of industrial action, and the INMO Executive Council has been requested to authorise the serving of notice to sanction the commencement of this industrial action.

Cork University Hospital: Despite a longstanding issue with regard to the coronary care unit at CUH, positive progress was made at a meeting with management on Thursday, March 30, 2023. The INMO obtained commitment that a supernumerary clinical skills facilitator would be allocated to the unit, together with commitments on staffing improvements before the end of April.

University Hospital Kerry: A dispute is ongoing in UHK's very busy Aghadoe surgical ward, regarding insufficient staffing levels and a non-supernumerary CNM2 role. Members were being balloted on industrial action in this dispute as we went to press, due to the considerable risk to patient safety and staff on the ward.

Delays in payment of pay awards and pensions undermining Building Momentum

SIGNIFICANT delays in the payment of pay awards and pensions have the potential to undermine Building Momentum, according to the Public Service Agreement Group (PSAG).

This followed referral of the issue of delays in pay awards and pensions to the PSAG, which wrote to the HSE national director of HR in February 2023 pointing out that significant delays of this nature are fundamentally at odds with the spirit of the national pay agreement and have the potential to undermine the spirit of Building Momentum.

The trade unions have since received an assurance from the HSE that all outstanding arrears for 2022 would be paid to pensioners in the month of April 2023. However, following a meeting of the PSAG on April 4, 2023 it was agreed that a further letter would issue to the newly appointed HSE CEO regarding the outstanding matters.

The INMO also advised that it would be seeking compensation for the delay, considering the impact on members who were continuing to work and incur all the cost of living increases without the same benefit as other public servants who were promptly paid.

Pension buy-back

Progress has also been made on the issue of pension buy-back superannuation, as following the recent Health Service Oversight Board meeting on March 13, it has been agreed that there will be further engagement and a meeting on April 27, between the HSE and the INMO on this matter.

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

Discussions on significant changes in community without consultation

THE INMO has been in contact with the HSE regarding several concerns in relation to community matters.

The union met with HSE Community Operations and National Employee Relations on April 3, 2023 to outline its concerns that different divisions of the HSE appeared to be rolling out changes without consultation or agreement. Such concerns relate to:

- Community networks
- Chronic disease management
- Integrated care older persons
- Public health nursing
- InterRAI
- Management structures
- Reporting relationships and governance
- Additional roles and responsibilities for nurse managers
- Community support teams
- Additional structures/director of nursing position in older person services in CHO2.

Following the meeting, it was agreed that the INMO and the HSE would meet again shortly to resolve a number of these issues.

on recent national issues

Equalisation of serious physical assault scheme

National Joint Council report

A CLAIM that the Serious Physical Assault Scheme, which covers leave entitlement to eligible staff after an assault at work, should be paid to all workers is one of a number of issues currently being discussed by the National Joint Council (NJC), the joint management/union forum.

This issue has been ongoing for a considerable period but the Department of Health has now confirmed that, in principle, it agrees to the equalisation of this scheme and that it will be satisfactorily resolved shortly.

The NJC is also involved in the change of sections 38/39 status matter regarding Wicklow ID facility Sunbeam House, and the unions have confirmed that there will be no change of status of organisations without proper consultation between the unions and management side.

Further to this, the NJC is also involved in resolving outstanding issues relating to the non-inclusion of a number of groups in the pandemic bonus scheme and has requested a meeting with the Department of Health to resolve this. The unions are also requesting engagement with the Department on differences in payment timeframes for agency and directly employed staff in Section 39 facilities.

Following comments made by the new HSE chief executive, the NJC has requested engagement in relation to the potential restructuring of Regional Health Areas (RHAs), noting that in the event of this restructure, agreement needs to be reached with the unions on the issue of national-level bargaining.

A commitment was given by the HSE that this matter will be raised with the chief executive and Liam Woods, assistant national director who has responsibility for implementation of the RHAs.

No consultation on HSE finance changes

THE finance side of the HSE issued a new financial regulation without consultation with unions.

The effect of this regulation is that the right to recover money as a result of an over-payment will be increased from €200 to €500 of salary, or capped at 15% now being increased to 20%.

The HSE accepted this was issued without consultation and the unions requested that the regulation be suspended pending consultation with the unions. A letter was sent to the HSE requesting the withdrawal of this regulation pending engagement, and the HSE has since confirmed its withdrawal.

Ongoing talks on outstanding matters

WINTER surge look-back: The unions are awaiting further engagement having objected to the HSE's proposed look-back at the winter surge. The unions objected to the proposed format of the consultation and the status of the unions in the process.

Hospice Section 38 status: The union side is also awaiting a response from the Department of Health on the issue of the conversion of four hospices to Section 38 status.

Pre-retirement initiative: Meanwhile, the HSE has acknowledged that the matter of the pre-retirement initiative scheme has been dragging on for a considerable time and has committed to meeting with unions within the next four weeks on this matter.

Special leave schemes: The unions are also pursuing claims for menstrual and menopause leave and are in the process of finalising the policy regarding paid leave for staff experiencing domestic violence, with outstanding issues resulting from management seeking a stipulation that proof be provided that a person is experiencing violence. The unions have stated that this is unacceptable and have advised the HSE to seek specialist advice on domestic violence leave policies for a speedy conclusion of the matter.

Assessment of capacity under new Act

A NUMBER of parts of the Assisted Decision-Making Capacity Act were given legal effect from April 28, 2023, including assessment of capacity under Part 4 and Part 7 of the Act.

The INMO has a number of concerns regarding the approach of the HSE in relation to this legislation and the union will be engaging further on this matter.

The union believes the HSE has adopted a *laissez-faire* and unstructured approach to implementation of the new legislation.

The INMO will be seeking that there are new resources trained at the appropriate level to provide services at each CHO area. It will also be seeking that this policy applies to Section 38 and other health organisations.

Your story matters.

Share it with us

The INMO has launched a new platform currently open to members employed in the West, North-West and Mid-West regions.
If you're a member working in this region you can now **anonymously** share important stories from your working life on the INMO Sensemaker platform.

Scan the **QR code** to tell us about the experiences that matter most to you.

Only a robust interim plan will stop action at UHL ICU

IN EXCESS of 94% of INMO members working in ICU at University Hospital Limerick recently voted in favour of taking industrial action in protest at the serious staffing deficits in the intensive care unit.

There is currently a deficit of approximately 20% of nurses from the roster, as well as an accumulation of annual leave and outstanding time off in lieu (TOIL) hours totalling over 10,000 hours. The INMO first raised the staffing deficits in the unit in September 2021 when they were in the region of 10%. However, the doubling of this quantum has given rise to real concerns from ICU nurses in relation to their ability to sustain the functioning of the unit at full capacity.

A meeting with management at the time of going to press proposed remedies for the outstanding annual leave and TOIL with written proposals awaited.

In relation to the staffing deficits, the INMO members are seeking a robust interim plan pending the recruitment of replacement nurses to fill the roster deficits. If the issues are not resolved with workable solutions, notice of industrial action will be served on the hospital.

– Mary Fogarty, INMO assistant director of IR

Improved sick leave scheme at Mercy

FOLLOWING representation by the INMO to have Mercy University Hospital members' longstanding claim addressed in relation to paid sick leave applying within the first 12 months of service, the union has successfully negotiated paid sick leave for staff far beyond the new Sick Leave Act 2022 and closer aligned to the HSE's terms and conditions.

Mercy University Hospital had relied on previous sick leave arrangements, including custom and practice, to not pay staff who have less than 12 months service paid sick leave since the Sick Leave Scheme was revised in 2014.

As a result of the INMO's negotiations, all new staff now have access to limited paid sick leave under the new scheme with effect from January 2023. Management at the Mercy has committed to review the current arrangement in November 2024.

– Liam Conway, INMO IRO

Pay increases finally being paid

PAY increases due under Building Momentum are finally being paid in the Southern Region. Members in Cork and Kerry should have received their 1% increase under Building Momentum from October 2022 in April 2023, inclusive of arrears.

A further 2% increase from March 2023 will be paid in pay periods in June 2023, with arrears. This timeline also applied to members in Tipperary University Hospital.

Section 39s seek pay alignment and parity

Section 39 members in Kerry in both South Doc and Kerry Parents and Friends are seeking well-overdue pay increases to align with current HSE rates in the midst of a cost of living crisis. Reps have been active locally in organising their colleagues in pursuance of this claim over recent months. The claims have been lodged and are currently subject of local discussions.

Separate discussions are ongoing at a national level regarding pay awards for section 39 organisations (*see IR Update, page 10*).

– Liam Conway, INMO IRO

ED forums key to addressing concerns

INMO members working in emergency departments at Mercy University Hospital and University Hospital Kerry are continuing to see the ongoing benefits of ED forums in addressing key issues and concerns about unsafe staffing and overcrowding.

Under the WRC ED agreement of 2015 and 2016, the forums provide our members and reps a voice in addressing key issues within their workplace with senior hospital management in a structured format.

The ED forum has been re-established in Tipperary University Hospital for May.

– Liam Conway

Members see benefit of checking payslips

Cregg House ID Services

The INMO continues to assist members in Cregg House ID Services in CHO1 in relation to ongoing errors in pay.

The union recently escalated several individual claims seeking that HSE management administer emergency payments, which was conceded.

Members are advised to continue to link in with their INMO reps regarding any related matters of concern or to contact the INMO Galway Office.

Leitrim Older Person Services

THE INMO lodged a claim for time-and-one-sixth payment from 2017 for members in Leitrim Older Person Services. Following extensive engagement with HSE management, the union has received confirmation that currently 44 members have received their retrospective monies.

– Christopher Courtney, IRE

Onsite INMO information clinics return

THE INMO relaunched onsite information clinics in Tipperary University Hospital in March 2023. Post-Covid restrictions, this is another important step in returning services onsite for members.

Further clinics will run in May, July and August in the region. Members and prospective members are encouraged to approach the INMO stands in their workplaces with any queries or concerns.

– Liam Conway

INMO deputy general secretary **Edward Mathews** rounds up global nursing

Shortage of nurses must be treated as a global health emergency – ICN

THE worldwide shortage of nurses should be treated as a global health emergency, according to the International Council of Nurses (ICN). In a new report, the ICN stresses that health systems around the world will only start to recover from the effects of the pandemic when there is sufficient investment in a well-supported global nursing workforce.

The report, *Recover to Rebuild: Investing in the Nursing Workforce for Health System Effectiveness,* co-authored by Prof James Buchan and ICN chief executive Howard Catton, builds on the analysis in last year's ICN *Sustain and Retain* report, which highlighted the terrible impact the pandemic has had on individual nurses and the global nursing workforce.

Recover to Rebuild cites more than 100 studies which show:

- 40-80% of nurses reporting having experienced symptoms of psychological distress
- Nurses' intention to leave rates having risen to 20% or more
- Annual staff turnover rates increasing to 10% and more.

The report recounts the vital role nurses played during the pandemic, in often dangerous circumstances, and provides evidence from studies of nurses in several countries around the world, including Ireland. This evidence shows how the Covid effect has compounded already fragile health systems and the unequivocal need for substantial and sustained investment.

ICN president Pamela Cipriano noted that the report substantiates what the ICN has been saying since the start of the pandemic: "Nurses were on the front lines, and often in the firing line, and it has taken its toll. Nurses are the professionals who can lead us out of this post-pandemic slump in healthcare, but they can only do that if there are enough of them, if they are properly supported and paid, and if the fragile health systems they work in are rejuvenated with large investments from governments everywhere."

She also observed that health systems are struggling everywhere under the strain of securing a sufficient workforce, and leaders know that the workforce is key to solving the healthcare crisis. In the report, the ICN sets out what is needed, but only government leaders can make it happen. "The investments politicians make in the nursing workforce and the health systems they work in will help to bring universal health coverage within reach and repay dividends for people for decades to come. But the clock is ticking. It's time to stop ignoring the solutions and take decisive action now," Ms Cipriano said.

The report says the stress, burnout, absences from work and strikes affecting the nursing workforce are symptoms of the current perilous state of healthcare, and that they must be addressed urgently if nurses are to successfully take on their central role in the recovery of health systems globally. It goes on to say that relying on individual nurses' resilience is not an option, and that governments must take responsibility and make amends for their inadequate planning, which has created the chronic worldwide nursing shortage.

Many countries have not invested sufficiently in educating adequate numbers of nurses to meet their populations' needs, the report says, leading to overwork and additional burdens for their existing staff, and reliance on the quick fix of harmful and unsustainable international recruitment by wealthier nations.

Countries that have a long tradition of educating nurses 'for export' are now also experiencing problems, with India now seeing a big increase in demand for nurses domestically, and the Philippines, where the government now acknowledges a shortage of up to 350,000 nurses, originally identified by the Philippine Nurses Association.

Howard Catton said that the worldwide shortage of nurses needs to be considered as a global health emergency and recovery from the current situation must to be a priority for all governments. "Last year, the ICN provided evidence of the immense toll the pandemic has taken on the wellbeing of nurses, and our latest evidence shows that it is not only continuing to have a damaging effect, but its impact is getting worse. Many nurses are leaving the profession, and those who remain are so concerned about the after-effects of the pandemic on patient safety and the wellbeing of colleagues, that they are left with no choice but to take industrial action and even outright strikes."

James Buchan, who is adjunct professor at the University of Technology, Sydney, Australia, said that the current situation is a direct result of a lack of action and the absence of a long-term vision and a plan for the global nursing workforce. He warned that without sufficient numbers of nurses, the global health system will not be rebuilt. "We need to see co-ordinated policy responses, both within countries and internationally, that will protect and support the global nursing workforce so that they can be effective in their vital role of rebuilding our health systems."

The report says the remedy for the current situation is for governments to take urgent action and plan more effectively. Among the immediate actions required are updating the World Health Organization/ICN 2020 *State of the World's Nursing Report,* assessing the impact of governments' policies on the nursing workforce, supporting early access to full vaccination programmes for all nurses, and the proper implementation of safe staffing levels.

There should also be reviews of the capacity of domestic nurse education systems, monitoring each country's self-sufficiency in producing its own nurses, investment in the recruitment and retention of nurses, and improved career development opportunities for nurses.

In addition, there should be an agreement to implement and evaluate effective and ethical approaches to the managed international supply of nurses, and a commitment to investing in nursing workforce sustainability in fragile states, which were most heavily impacted by the pandemic and are most at risk of losing their nurses to international recruitment.

and midwifery news

Report reveals extent of damage caused to HCPs by pandemic

THE extent of the physical and psychological damage done to healthcare professionals (HCPs) during the Covid-19 pandemic because the health systems they worked in failed to protect them is revealed in a recent report from the World Health Professions Alliance (WHPA) and the World Health Organization (WHO).

This comprehensive report pulls together evidence of the impact of the pandemic from the WHPA's five members: the International Council of Nurses (ICN), World Medical Association, World Dental Federation, the International Pharmaceutical Federation and World Physiotherapy, which in total represent 41 million HCPs.

The report, *What the Covid-19 pandemic has exposed: the findings of five global health workforce professions*, says HCPs feared for their personal safety during the pandemic because of a lack of protective equipment. In addition, the absence of any systematic support and security left many feeling undervalued.

WHPA chair Jonathon Kruger said: "By pooling the data from surveys of their memberships conducted during the pandemic, the WHPA organisations have been able to put together a unique picture of what the pandemic looked like for health professionals on the ground. By identifying the challenges we have in common across the professions, we can work together to resolve them.

"The WHPA is also pleased to see the publication of this report as one of the first concrete outcomes of the Memorandum of Understanding signed between its members and the WHO in November 2022, and looks forward to continuing the collaboration."

ICN chief executive officer Howard Catton, who is co-author of the report, thanked fellow authors Hoi Shan Fokeladeh and Erin Downey, and said the report should be used by governments to influence their plans for the next global health emergency, and ensure that healthcare staff do not have to carry such a heavy and unfair burden in the future.

Mr Catton observed that around the world, prior underinvestment in health systems meant that they failed the health professionals and multidisciplinary teams that are the life blood, the very essence of our healthcare services. "We know what needs to be done: the challenge is making it happen. A vital first step would be to have more health professionals in the most senior leadership positions to counter the current disconnect between decision makers and healthcare professionals on the frontline," said Mr Catton.

He called on governments to honour the contribution of nurses and other HCPs during the pandemic, elevate them to positions where they can more directly influence healthcare policies, and make sure that they never again have to face a deadly pandemic without the care, support and protection that they deserve.

The report says vaccination information and training needs to be revised to address vaccination hesitancy and rejection. It also highlights the lack of mental health and psychosocial support experienced by professional staff, and the profound disruption that occurred to their education, with the closure of education centres, and postponement or cancellation of clinical placements.

It says concerted efforts are needed to protect HCPs from the chronic violence that exists in healthcare settings, and that they should have a greater say in high-level planning, strategy and decision making about the policies that they are responsible for carrying out.

The report concludes that there needs to be a greater involvement of healthcare professionals in efforts to rebuild healthcare systems after the pandemic as part of a whole society response that will contribute to global preparedness and health security.

First ICM chief midwife will lead global initiatives

THE International Confederation of Midwives (ICM) recently announced the appointment of its first chief midwife, Prof Jacqueline Dunkley-Bent from the UK.

Prof Dunkley-Bent brings to the role her vast, diverse experience of maternity services through clinical care, education, policy, strategy and healthcare management. She joins the ICM after being the first chief midwifery officer for England and an exceptional record within the field of midwifery and maternity care, influencing national and international healthcare policy and practice.

As chief midwife, Prof Dunkley-Bent will be the global figurehead for the ICM's midwifery expertise. She will represent the interests of midwives around the world and lead initiatives essential to the growth of midwifery globally.

A member of the ICM leadership team, she will be responsible for developing the organisation's regional plan to strengthen midwifery and creating leadership frameworks for midwives. Prof Dunkley-Bent will be relocating to the Netherlands to work at the ICM's head office in the Hague in May 2023.

ICM chief executive Sally Pairman said that Prof Dunkley-Bent is a fantastic addition to their team, who brings extensive experience to the ICM, to the benefit of midwives and the midwifery profession globally.

She further observed that at the ICM they lead by example – advocating for all countries and regions to appoint a chief midwife, and the appointment of Prof Dunkley-Bent is an opportunity for the ICM to model what this critical leadership role can do to elevate midwives and midwifery in the 140 member associations in 119 countries.

Evolution of a profession

Autonomy and person-centred care were at the heart of the recent All-Ireland Maternity and Midwifery Festival, reports **Freda Hughes**

THE evolution of the role of the midwife was a dominant theme at the All-Ireland Maternity and Midwifery Festival in The Helix, Dublin on April 18. The event was open to all midwives and student midwives practising in Ireland but also had an international audience as participants had the option of attending online.

In her opening address, Lynda Moore, INMO Executive Council member, spoke of her love for the profession of midwifery with passion – a passion that was echoed by many of the speakers throughout the day.

Ms Moore highlighted staff shortages in midwifery as a dangerous issue facing all midwives and directors of midwifery both in Ireland and internationally. This was reiterated by Sheila McClelland, chief executive, Nursing and Midwifery Board of Ireland (NMBI), who gave details of Irish midwifery demographics and called for updating of the figures detailed in the *State of World Midwifery Report* of 2021.

This report revealed that the world is currently short 900,000 midwives. Ireland's biggest cohort of working midwives is aged from 40 to 49 so Ms McClelland stressed the pressing need to recruit and retain midwives and to engage in evidence-based workforce planning.

Angela Dunne, infant and child development lead, National Midwifery Strategy, HSE, thanked the directors of midwifery in all 19 maternity centres around the country and asked for their support in bringing about a resumption of water births in the community. She also advocated for the urgent establishment of a National Midwifery Taskforce to keep up with the demands of an ever-changing midwifery landscape.

Education and training for midwives were pertinent themes throughout the day with an emphasis on affording as much autonomy as possible to birthing parents. Mary Brosnan, director of midwifery and nursing at the National Maternity Hospital (Holles Street), and adjunct associate professor at UCD School of Nursing and Midwifery, argued the case for such empowerment.

"It's about information and empowerment, so women can make informed decisions about how they want to give birth," she said.

Prof Brosnan also spoke of the dilemmas facing directors of midwifery as they observe the commercialisation of childbirth and a change in consumer expectations when it comes to maternity care. Societal change has led to a change in patient profile and increased demand on some parts of the maternity service. "With women over the age of 40 accounting for 12% of our births, more pregnancies are treated as high risk and we see an increase in maternal requests for induction and increased rates of Caesarean section," she said.

Obstetric violence and birth trauma were discussed in detail in the first plenary session of the day. Dr Hazel Keedle, academic programme advisor and senior lecturer of midwifery at Western Sydney University in Australia, discussed the findings from the Birth Experience Study, which surveyed 12,000 women about their experiences of maternity and birthing care. Some 991 of those interviewed said that they had experienced some form of mistreatment or obstetric violence from a health professional during their maternity journey.

Dr Keedle stressed that obstetric violence is a gendered form of violence that requires a trauma-informed response. She outlined three key steps towards eradicating it: reflection on practice, respect-based education and obstetric legislation, and highlighted the International Council of Nurses' respectful maternity care workshops. She ended her presentation saying: "I believe all women deserve respectful maternity care, free from harm, abuse and disrespect."

Ursula Nagle, a PhD candidate at Trinity College Dublin and a registered advanced midwife practitioner at the specialist perinatal mental health service at the Rotunda Hospital in Dublin, discussed her PhD study. Ms Nagle's research, entitled *Birth Trauma – The Experience of Women,* has undertaken to quantitatively look at the factors affecting birth trauma. Irish data in this area had not previously been collected and her study has found that 18% of women surveyed (n=209) had experienced a traumatic birth, with 4% of the sample meeting the diagnostic criteria for post-traumatic stress disorder (PTSD).

She said that it was time to recognise child-birth related PTSD as a subcategory of post-traumatic stress.

"We need targeted interventions for people with a history of depression and increased supports for people who have experienced traumatic births. Trauma informed care is the way forward," she said.

The afternoon was filled with breakout talks and workshops on a wide range of topics. The All-Ireland Maternity and Midwifery Forum Trailblazers Awards also took place at the festival with Katherine Robinson winning the Midwifery Practice Leader Trailblazer award, Rhona O'Connell winning the Midwife Education Trailblazer award, Tegan Kavanagh winning the Student Midwife Trailblazer award, and Helen McLoughlin and Bernadette Keogh winning the Leadership Trailblazer award.

Pictured at the All-Ireland Maternity and Midwifery Festival in The Helix, Dublin, were: Ursula Nagle, a PhD candidate and advanced midwife practitioner; Dr Hazel Keedle, academic programme advisor and senior lecturer of midwifery at Western Sydney University in Australia; Sheila McClelland, chief executive of the NMBI; and Lynda Moore, INMO Executive Council member

Pictured at the All-Ireland Maternity and Midwifery Festival in The Helix, Dublin, were: Steve Pitman, INMO head of education and professional development; Sheila McClelland; Prof Mary Brosnan, director of midwifery and nursing at the National Maternity Hospital, Dublin; and Lynda Moore

Prof Mary Brosnan, Lynda Moore and Angela Dunne; infant and child development lead, National Midwifery Strategy, HSE

Caitlín McCormack, Ivana Petrovik, Carragh McAleenan and Natene Gaughran, all midwifery students from Dundalk Institute of Technology

Kate Byrne, Leah McGealy, Rapaelle Dio and Leah Lesage, midwifery students from Dundalk Institute of Technology; and Róisín O'Connell, INMO student officer

Women and the trade union movement

Workplace violence was among the issues highlighted at the recent ICTU Women's Seminar in Dundalk. **Beibhinn Dunne** reports

THE 2023 Irish Congress of Trade Union (ICTU) Women's Seminar, held over two days in March in Dundalk, highlighted a number of issues affecting women in the workplace, in society and within the trade union movement, including workplace and domestic violence, the gender pay gap and childcare responsibilities.

The INMO delegation attending included Executive Council members Lynda Moore and Eilish Corcoran, former INMO first-vice president Eilish Fitzgerald, director of professional services Tony Fitzpatrick, industrial relations officer Gráinne Walsh and industrial relations executive Kathryn Courtney.

The seminar heard from SIPTU deputy general secretary and member of the ICTU executive Ethel Buckley on the importance of a gender-sensitive approach to organising. Ms Buckley noted the need for a unified right-to-organise campaign to improve access to unions and the importance of making women's issues more visible within the trade union movement.

The seminar, which was opened by Margaret Coughlan and Maxine Murphy-Higgins, joint chairs of the ICTU women's committee, heard an opening address from ICTU assistant general secretary Gerry Murphy, who noted the timely nature of the event given the impact of the current cost-of-living crisis for women in low-paid and precarious work.

A powerful presentation was delivered by Lisa Wilson and Paul MacFlynn from the Nevin Economic Research Institute on the gender pay gap in Ireland and Northern Ireland. Ms Wilson discussed the significant role of sectoral segregation on suppressing women's pay as well as the gendered impact of the inadequate supports for career progression, development and high-quality work when women undertake part-time or flexible work to meet caring responsibilities.

A session was hosted by ICTU's David Joyce and Clare Moore regarding International Labour Organization Convention 190 on the elimination of violence and harassment at work. Their presentation highlighted the importance of recognising the world of work as broader than the workplace, noting impending legislation on paid domestic violence leave, which recognises domestic violence as a work-related issue.

Pictured at the 2023 ICTU Women's Seminar were (l-r): Kathryn Courtney, INMO IRE; Lynda Moore, INMO Executive Council member; Eilish Fitzgerald, former INMO first-vice president; and Eilish Corcoran, INMO Executive Council member

Attendees of this session also noted a significant need for training for managers to ensure the adequate implementation of up-to-date legislation, including the development of clear policies in workplaces.

Attendees also heard from Dublin City Councillor and alternate member of the European Committee of the Regions, Alison Gilliland, on climate action and gender equality. Ms Gilliland discussed the governance structures around international climate policy-making and the gendered impact of climate change.

ICTU general secretary Owen Reidy addressed day two of the seminar before Jenny Liston from Pavee Point and peer researcher Vanessa Paszkowska gave a presentation on the Roma community in Ireland and the right to fair work. This presentation focused on a research project conducted in association with NUI Maynooth regarding the effects of discrimination on the ability of members of the Roma community to access and maintain work, and the health inequalities experienced in this community.

A discussion about ways to grow union membership among women and facilitate organising women in workplaces also took place, drawing a broad range of insights into the obstacles to organising women, such as the time pressures of caring responsibilities and the need for a legal right to access workplaces. Attendees also highlighted the need for childcare to be facilitated by unions and the need to organise on issues that affect women directly.

Other social issues highlighted and discussed at the seminar included the campaign to maintain the West Belfast Regina Coeli women's hostel and domestic violence refuge, and the plight of women under oppressive regimes in Afghanistan and Iran, as well as the ongoing struggle for rights, equality and freedom in Palestine.

A video on the rise of the far right in trade unions, workplaces and communities was also shown, highlighting the role of trade unions in showing solidarity with migrant communities, as well as resisting attempts to divide workers by scapegoating migrants and asylum seekers for social issues that require a cohesive response from the trade union movement.

Celebrating nurses and midwives everywhere

This year's **International Day of the Midwife** and **International Nurses Day** celebrations are opportunities to increase the recognition that members of both professions receive worldwide

IN MAY the INMO joins the International Council of Nurses (ICN), the International Confederation of Midwives (ICM) and hundreds of organisations around the world in celebrating International Nurses Day and International Day of the Midwife. These days represent a vital opportunity for nurses and midwives to draw global and national attention to their role in healthcare leadership and to the challenges that face their professions and the future of healthcare.

International Day of the Midwife

Falling on May 5, this year's International day of the Midwife 2023 is themed '*Together again: From evidence to reality*'. This theme is a nod to the upcoming 33rd ICM Triennial Congress, where the global midwife community will come together for the first time in more than five years to share global experiences in maternity care and promote social and clinical advances in midwifery services.

The theme also honours the efforts of midwives and their associations to action critical evidence like the *State of the World's Midwifery 2021* report towards meaningful change for the midwifery profession and the women and families who midwives care for.

In Ireland, May 5 is an opportunity for us to highlight the issues facing midwives and maternity care across the country, and to draw attention to the need to develop women-centred care, including midwifery-led care that maintains clinical excellence. It is also a time to highlight the need for urgent recruitment and retention measures in midwifery. According to the 2022 Nursing and Midwifery Board of Ireland (NMBI) *State of the Register* report, approximately 27% of practising midwives are over the age of 55, with much lower numbers of new entrants to the profession, highlighting the need to increase capacity in maternity services in line with the National Maternity Strategy, as well as to develop community midwifery care across the country to ensure real choices and positive experiences in maternity care for women in all regions of the country. It is essential for women, future generations and the profession of midwifery that we dramatically increase the numbers in training and retain midwives currently practising.

International Nurses Day

On May 12, the anniversary of Florence Nightingale's birth, nurses across the world will celebrate International Nurses Day under the theme of '*Our Nurses – Our Future*'. 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. It is also a chance to highlight the challenges that emerge in a national context as well as those that affect the profession globally.

The ICN's 2023 report *Recover to Rebuild: Investing in the Nursing Workforce for Health System Effectiveness*, drawing attention to the post-Covid horizon in nursing and healthcare, shows that unless there are enough nurses who are well motivated, educated and supported, the global health system will not be rebuilt. What is needed are co-ordinated policy responses, both within countries and internationally, that will protect and support the global nursing workforce in their vital roles in rebuilding health systems that were damaged by the pandemic.

In Ireland, the post-Covid experiences of nurses in acute and community services have been heavily affected by issues in staffing and capacity as well as the significant and lingering mental health and burnout effects that continue to impact on much of the nursing and midwifery workforce. This must be addressed as a structural issue in the Irish health service.

In line with this, the 2023 International Nurses Day theme is part of a year-long campaign that sets out what nursing needs now and in the future in order to address global health challenges and improve global health for all.

ICN president Dr Pamela Cipriano described the intent of the campaign: "Nurses provide care and leadership to address global health challenges everywhere, often at great personal risk. They are the essential life force for health, yet our healthcare systems worldwide have fallen short and failed to value, protect, respect and invest in this precious resource.

"The world has mistakenly taken nurses for granted, treating them as an invisible and inexhaustible resource. That must now stop for the sake of nurses and global health," Dr Cipriano continued.

– Tony Fitzpatrick, INMO director of professional services

Pressing issues in ID nursing

The recent RNID Section annual conference heard from experts on women's health, advocacy and industrial relations

The RNID Section committee pictured outside the Richmond Education and Event Centre (l-r) (standing): Pauline O'Gorman and Michael Whyte; (seated): Patricia McCartney, Ailish Byrne, Colin Redmond, Anne Marie O'Reilly and Elizabeth Egan

INCREASED life expectancy among people with intellectual disabilities means there is an increased requirement for training in the management of post-menopausal service users, including improvements in the provision of accessible, sensitive and appropriate care.

This was outlined by INMO president and ANP in gynaecology Karen McGowan, when addressing the INMO's RNID Section's annual conference.

Ms McGowan highlighted issues in women's health within ID settings, presenting on rapid access pathways for post-menopausal bleeding. She also spoke about the importance of continuity of care and the role RNIDs play in ensuring accurate patient histories in the theatre setting.

The conference, which was held at the Richmond Education and Event Centre in March, heard from experts from within the specialty on topics such as challenging behaviours, assisted decision-making and the menopause. The conference was also updated on industrial relations matters of relevance to RNIDs, including wage bargaining, delays to implementation of pay increases, and the pay parity claim for nurses and midwives.

Section chair Ailish Byrne addressed the conference on the importance of RNIDs championing the specialty and advocating for people with intellectual disabilities (IDs), while INMO director of professional services Tony Fitzpatrick noted the particular challenges in ID nursing and current issues being undertaken by the INMO regarding the specialty. Mr Fitzpatrick also highlighted the importance of INMO sections for sharing insights and peer expertise in a specialist forum. He encouraged members to continue their active participation in their sections.

Clinical challenges

Anne Marie Martin, RNID and lecturer in ID nursing, University College Cork, presented on 'Collaboration and Partnership for Person-Centred Healthcare'. Dr Martin discussed the role of the RNID in bringing expert knowledge and skills to the care of patients in this setting. Research demonstrates how the specialist knowledge of RNIDs leads to improved person-centred care and positively impacts individuals and systems, according to Dr Martin, who described a module involving collaborative education for people with IDs on nutrition and lifestyle choices.

Maurice Healy, an RNID and ANP in behaviour, gave a presentation that

focused on centring people's personal stories in providing appropriate care and the importance of understanding the reasons for certain behaviours in the development of individualised behaviour management plans. During his presentation, which was titled 'A Human Rights Approach to Positive Behaviour Support', it was noted that the number of ANPs in ID nursing has grown significantly and continues to grow, and Mr Healy emphasised the importance of staffing numbers in maintaining best practice in positive behaviour support and avoiding a regression to potentially dehumanising or abusive models of care.

Caoimhe Gleeson, national programme manager in the National Office for Human Rights and Equality Policy, HSE, continued the theme of rights-based approaches to care. Ms Gleeson discussed assisted decision-making, noting the foundation of rights-based care legislation in principles of consent. She spoke about the criteria for reduced decision-making capacity and their implications for advanced planning. She also discussed some of the elements of the legislation, including the individual decision-making support roles specified in the legislation and the protections that these roles afford.

Attendees also heard a presentation by Rebecca Wyes, CNS and candidate ANP, on autism, trauma and post traumatic stress disorder in the ID setting, while Juliet McMahon and Caroline Murphy, both senior lecturers at the University of Limerick, hosted a session on research and the implications for the nursing profession presented by workplace bullying.

Seffie O'Donnell, nurse manager at Brothers of Charity, Limerick, presented on 'Morbidity and Mortality Due to Respiratory Tract Infections in Adults with an Intellectual Disability', while Wexford cANP Anne Power gave a presentation entitled 'Preventing and Managing Chronic Illnesses in People with Intellectual Disabilities'.

Industrial relations update

INMO general secretary Phil Ní Sheaghdha updated the conference on structural and national issues affecting the RNID specialty and nurses and midwives generally, including wage bargaining, delays to implementation of pay increases and the pay parity claim for nurses and midwives. Ms Ní Sheaghdha also discussed the issue of staffing and the INMO's pursuit of the implementation of the Framework for Safe Staffing and Skill Mix across all health services, including ID services.

Ailish Byrne, chair, RNID Section

Karen McGowan, INMO president

Seffie O'Donnell, nurse manager, Brothers of Charity, Limerick

Caoimhe Gleeson, HSE national programme manager, National Office for Human Rights and Equality Policy

Anne Power, cANP, Wexford

Phil Ní Sheaghdha, INMO general secretary

Anne Marie Martin, RNID and lecturer in ID nursing, University College Cork

Maurice Healy, RNID and ANP in behaviour

When a complaint is made against you

The INMO is an invaluable ally when navigating the long and often complex fitness to practise process

THE FITNESS to practise process refers to the investigation carried out by the Nursing and Midwifery Board of Ireland (NMBI) in the event of a complaint being made about a registered nurse or midwife on any of the grounds laid out under the Nurses and Midwives Act 2011, including grounds of alleged professional misconduct and/or allegedly being unfit to practise. Any nurse or midwife can be the subject of a complaint, and any person can make a complaint, including patients, relatives, colleagues, management or even the NMBI itself.

The INMO's fitness to practise team comprises: Edward Mathews, INMO deputy general secretary; David Miskell and Joseph Hoolan, professional and regulatory services officers; and Noeleen Smith, co-ordinator and administration support of regulatory services.

In the event that you are notified by the NMBI that a complaint has been made against you, INMO members have access to a wide range of supports from the Organisation, including advice on how to prepare for a fitness to practise hearing, and expert and experienced representation at the hearing provided by one the union's regulatory services staff. INMO members should always contact the INMO before responding to any complaints.

Recently we spoke to some INMO members to find out what had been valuable to them in dealing with the process. One INMO member said: "The INMO was amazing from the get-go. When I first had to make that call, their support was immeasurable. There was a representative in the district where I was based who worked with me initially. He was non judgemental and did the best he could for me. Then the INMO's fitness to practise team took charge. I don't think I would have got through it without them. I felt reassured after talking to them."

Another member outlined some of the practical supports provided: "I immediately contacted the INMO when I was suspended from work. They took the reins straight away and accompanied me throughout the lengthy process. They were with me at all interviews and meetings after that. They also made sure I still received my premium pay and allowances while I was suspended from work."

Referral to the NMBI

The NMBI process has two stages. The Preliminary Proceedings Committee (PPC) is the first stage of the process. This is a committee that considers the complaint and makes a recommendation as to whether or not a full inquiry should take place. Where a hearing is to take place, this finding then leads to the inquiry stage, where a nurse or midwife is presented with evidence ahead of the hearing and subsequently will participate in a public hearing to determine fitness to practise. When matters are referred to a full hearing for adjudication they then come before the Fitness to Practise (FTP) Committee.

One member said: "When I first received the correspondence about the referral, the INMO was very quick to respond and I was assured that my issue would be dealt with promptly. The INMO helped me through the process, asking me the questions I would need to prepare, getting my statements ready and preparing me for the process."

Another member said: "The INMO was important in helping me realise what went wrong. At the same time they provided me with emotional support and reassured me that everything would be okay."

Grounds to make a complaint

Any person can make a complaint regarding a nurse or midwife's fitness to practise, based on professional misconduct, poor

professional performance, a relevant medical disability, non-compliance with the code of professional conduct and a number of other headings set out in section 55 of the Act. Our experience shows that complaints may emerge from patients, their family, other professionals, employers, regulatory bodies such as the Health Information and Quality Authority (HIQA) or nursing/midwifery officers from the Department of Health. Indeed the NMBI itself may initiate a complaint where it becomes aware of matters it believes to be of concern.

Stages of the process

Once the complaint is made to – or initiated by – the NMBI, the nurse or midwife concerned will then receive correspondence from the NMBI. This correspondence will explain that a complaint has been made, who made the complaint, and the process involved in dealing with the complaint, including the option of submitting a statement to the committee to assist it in its deliberations as to whether or not the matter should proceed to a full inquiry. Attached to that correspondence will be a copy of the complaint, as well as a copy of the procedures of the PPC. At this stage it is imperative that the nurse or midwife concerned obtains representation prior to responding to the complaint. Any response made will be used by the committee to assist it in determining whether a full inquiry should take place or if another form of action should be taken.

One INMO member said: "When the complaint came through, I couldn't believe it. I was traumatised. I'd never had a complaint made about me in my entire career. I told nobody so I felt very alone; I didn't want to talk about it at work or at home. The only people I spoke to about it were the INMO who were very supportive."

A copy of any statement submitted by the nurse or midwife at this stage will be available to the team presenting the case against the nurse or midwife before the Fitness to Practise Committee if an inquiry later takes place and may be considered by the committee itself. Therefore, at this stage, there are two key reasons for having representation: first, in many cases, a comprehensive, properly worded and well-informed statement by a registrant may assist the PPC in determining that there is no cause for a full inquiry to take place, and this may end the matter. Where an inquiry is directed, you want to make sure that the contents of your statement do not prejudice you at a later inquiry.

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

One member said: "It is scary when you find yourself referred to the NMBI because if you lose your registration, you lose your job too. As registrants we are so vulnerable. Working as a nurse or midwife and not joining a union is like driving a car without insurance. I joined the union because I come from a family where trade union membership is important, but I never knew how much I would come to rely on it."

> "Working as a nurse or midwife and not joining a union is like driving a car without insurance"

Another said: "The cost of trying to get through the fitness to practise process without my union membership would have made it impossible for me. Instead, my monthly union dues afforded me access to informed advisors, a solicitor and a barrister. It would be very difficult to access a legal team with such in-depth knowledge of this process without being a member of the INMO."

Thankfully, only a relatively small number of registrants are subject to a fitness to practise hearing in a given year. However, more do have complaints made against them and the stress, strain and financial expense involved in dealing with even the most minor of matters make this an essential topic to understand.

The hearing

On the day of the hearing, members will meet with the INMO team approximately one hour before the hearing, which generally takes place in the NMBI headquarters. The hearing begins with an opening statement from the chief executive's representative setting out the nature of the allegations and a summary of the proposed evidence. This is generally followed by a brief statement by the registrant's representative outlining the case of the nurse or midwife.

The advent of public hearings before the FTP committee has fundamentally changed the experience of members in this arena. Members are now subject to intense, lurid and speculative media coverage, which makes preventative elements of practice all the more important to avoid a referral to the committee. In addition, it makes the availability of expert assistance essential to obtaining a desirable and just outcome throughout the entire process.

One member said: "I was somewhat naïve; in this process it felt like you have to prove to the NMBI that you are innocent. It seemed like the burden of proof in relation to these allegations was on me. It was terrifying.

"I would not have been able to afford the legal representation without the union providing it for me. Many solicitors and barristers would not have the same understanding of the unique mechanisms of the NMBI that the INMO does. The Organisation also ensured that my name would not be published in the public domain as there was no evidence of wrongdoing," the member continued.

Complex process

This is a complicated process that can take many turns on the road to conclusion. The essential point is that expert representation at this stage has the potential to either prevent a complaint from proceeding any further or, where it does, to ensure that a nurse or midwife's career is not prejudiced by poor decisions at this stage.

An INMO member said: "One thing that I have learned through this process is that we are all vulnerable. You have to be so careful and conscious in your practice and code of ethics, but you're always multitasking and, no matter how careful you are, there is still a risk of being referred to the NMBI."

The fitness to practise process is a complex and inherently legalistic one. Not only does it require navigation of the legal rules ahead of and during the hearing, but also an astute appreciation of the profession and proceedings when preparing for the process and selecting experts to give evidence on your behalf. This is a service that is inherent to your membership of the INMO.

Menopause masterclass

Menopause Summit aims to arm attendees with 'best in class' knowledge to negotiate the challenge of menopause

DESCRIBED as a masterclass in menopause, the recent National Menopause Summit laid bare the 'no filter reality' of the challenges presented by perimenopause and menopause. The summit called for the introduction of inclusive, compassionate and sympathetic work policies to ensure women feel supported in their careers and to stem the flow of women exiting the workforce and not availing of opportunities to advancement, as a result of the lack of support through this life stage.

The National Menopause Summit took place in The Round Room at The Mansion House, Dublin on Thursday, March 23. INMO president Karen McGowan joined a panel of leading clinicians, facilitators and professionals that aimed to shift the narrative on menopause by debunking myths and taboos and providing fact-based information. The summit advocated for support across both the personal and professional arenas, and provided a platform of understanding and respect to ensure no one suffers needlessly at this oftentimes highly challenging and transitional stage of life.

In 2021 the INMO conducted an online survey of its members to gain an understanding or nurses and midwives' experiences of menopause in their workplaces. More than 90% of respondents reported that their menopausal symptoms affected them while at work. Some 17% indicated that they had missed work due to their menopause symptoms, with 43% of these reporting they had missed approximately five days due to symptoms. The majority (63%) did not tell their employer why they took time off.

The overwhelming majority (82%) of respondents said that they had considered leaving their job or reducing their hours of work due to their menopause symptoms. Just under one-third (31%) were 'not very confident' about discussing menopause in the workplace and 37% did not feel confident discussing menopause with their line manager. An overwhelming number of respondents (88%) would like to see their organisation introduce menopause awareness and training for staff. A similar number (87%) would like to see their workplace implement a menopause at work policy.

Pictured at the National Menopause Summit were (l-r): Gráinne Seoige, broadcaster and presenter; Fania Stoney, business development strategist, Great Place to Work; Paula Maher, researcher with the IADT; Kay McCarthy, founder/ CEO, MCCP The Independent Strategy Agency; and Karen McGowan, INMO president (Photo: Long Lost)

According to the Central Statistics Office there are nearly 350,000 women employed in Ireland aged 45-64. The average age of a woman's menopause is 51 years, so a significant number of women will be working throughout their menopause transition. With women representing 90% of active NMBI registrants, menopause in the workplace is an important issue for the INMO. With this in mind the INMO launched a position paper in 2019 designed to encourage discussions and lift taboos around menopause at work. Its key recommendations include:

- Development of workplace policies that promote support of women during menopause
- Education and training on menopause.

Speaking about menopause in the workplace, the INMO president outlined the union's belief that the profile of menopause in the workplace needs to be acknowledged, recognised as an important occupational issue, and for resources to be invested in supporting women.

"We call on all healthcare employers, in both the public and private sectors, to develop menopause-friendly workplaces that recognise the importance of menopause. This includes the development of clear policies, training and dedicated resources to support women experiencing the menopause at work. The workplace can affect women going through the menopause in various ways, especially if they cannot make healthy choices at work. The Menopause Summit provides an important platform for us to discuss these issues and advocate for change," Ms McGowan said.

The event was moderated by journalist and broadcaster Gráinne Seoige and featured a speaker panel of leading clinicians, facilitators and professionals in the area, including broadcaster Davina McCall, whose advocacy around perimenopause and menopause is well known. Speakers and panellists included nurses, doctors, nutritionists, physiotherapists, educators, campaigners and people working in human resources. The INMO *Menopause at Work Position Statement and Guide* is available to download at: **www.inmo.ie**

– Freda Hughes

Q and A Bulletin Board

With INMO director of industrial relations Albert Murphy

Qualification allowance – do I qualify?

Q. I recently began working in the HSE and a colleague told me that I might be entitled to a qualification allowance because of a course I did while working abroad. What is involved in applying for a qualification allowance?

There are two criteria for staff nurses/midwives and grades up to and including CNM/CMM2 to meet to receive the specialist qualification allowance. The first is having a postgraduate qualification that is recognised by the NMBI as being category II or equivalent. If you are unsure if your qualification is recognised, you can apply for verification with the NMBI directly. The second criteria is that the employer must deem that the employee is engaged in specialist duties in a specialist area using this qualification, ie. be using the qualification as part of their duties. I advise contacting your employer if you think you meet this criteria and come back to us if you have further issues.

Enhanced practice scale increments

Q. I am a staff nurse in the public health sector and have applied for the enhanced nurse/midwife practice contract. I have been on point 12 (maximum of scale) of the staff nurse/midwife salary scale for two years. I have been told that on signing the enhanced practice contract I will move to point 8 (maximum of scale) of that scale and will have to remain on point 8 for three years before moving to the long service increment. Is this correct?

This is not correct – you should achieve your long service increment (LSI) after three years on the maximum of scale. Nurses/midwives who reach the maximum of the scale must remain on this point for three years before obtaining the LSI. If you are currently on point 12 (maximum of scale) of the staff nurse/midwife scale, at your next incremental date, you progress normally towards achieving the LSI. As you have been on point 12 for two years, on signing the enhanced practice contract, you will move to point 8 of the enhanced practice scale for just one more year before moving to the LSI, as your existing level of service will transfer with you. Nurses/midwives currently on point 12 of the staff nurse/midwife scale who have the required service to achieve the LSI on that scale are eligible for the LSI on the enhanced practice scale.

Annual leave entitlement

Q. I have been promoted to a CMM1 post having been a senior enhanced midwife in the HSE. I have been told by HR that my annual leave entitlement will be 25 days as I have no prior experience as a CMM1, is this correct?

This is not correct. The service requirement for annual leave refers to cumulative service in the publicly funded health services in Ireland, so your previous service as a midwife should be taken into account. As you were a senior enhanced midwife and so have over 10 years' service, this would mean your annual leave entitlement as a CMM1 is 28 days per annum. If you encounter further difficulties, please contact your INMO official.

1999 strike action and your pension

Q. I have recently sought information in respect of my pension as I am due to retire shortly. The superannuation department has advised me that the nine days that I partook in the 1999 national nurses' dispute are being deducted as part of my service record. I thought this had been negotiated and that we would not lose these dates for pension purposes. Can you please clarify this?

You are correct. The INMO argued that this time should be considered service and the matter was heard by the Labour Court in 2006 and the Court issued a recommendation on November 9, 2006 that any period of absence, without pay, due to the industrial action from October 19-27, 1999, would be reckonable for pension purposes. The Labour Court recommended the service would be reckonable subject to the payment of the appropriate superannuation contributions in respect of the days being reckoned. Contributions would be calculated based on pensionable remuneration at the date of retirement. The only exception to this would be nurses and midwives who already exceeded the maximum reckonable service permitted under the superannuation scheme. The HSE issued a circular following this recommendation in 2007 setting out the terms on which this particular issue is to be dealt with. This period, in accordance with the recommendation, can now be considered time worked and the superannuation that would have been due, had it been worked, is to be calculated at the rate of remuneration that applied for the nurse/midwife at that time.

Minding your mental health

Róisín O'Connell reminds students that they need to look after their mental health

THE past three years have been particularly stressful for student nurses and midwives. It is important to take time to check in with ourselves and evaluate how our mental health has been affected by our circumstances. With this in mind, I would like to explore some ways that we can all use to improve our mental health.

While we are frequently told that we need to 'mind our mental health', it is worth noting that mental health is not simply the absence of mental illness. The WHO defines mental health as "a state of wellbeing in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community".

One in four people will struggle with their mental health at some point in their lives. Our mental health can be challenged for any number of reasons, be it events at work or at home, relationship difficulties or pressures from meeting academic requirements. Accepting that both good and bad days are a normal part of life can make it easier to manage the bad days. Taking steps to protect and strengthen our mental health when we are feeling well can help us to cope when we are having a difficult day.

Develop good habits

Some of the little things that we can do to protect our mental health include ensuring that we get enough sleep (seven to eight hours per night), reducing alcohol consumption, eating regular nutritious meals and keeping active.

Limiting social media exposure and moderating caffeine, tobacco and drug intake has also been linked with improved mental health. Some studies indicate that there can be benefits to gratitude journalling – writing down a few things that we are grateful for regularly can have a positive effect on our satisfaction with life, particularly used in conjunction with other stress management techniques.

One of the most important ways that we can mind our mental health is by connecting with other people. Whether it be by joining a new sports team or participating in a club activity, these can help us feel valued within our community. Having a strong support network by maintaining relationships with friends and family can be crucial to contributing positively to our mental health.

It is important that we look out for each other, if you notice that a friend or classmate seems quiet or just not themselves, check in with them. Providing a listening ear can make the world of difference.

Seek support

While you are providing care to others, you must also care for yourself. Speaking to someone about what you are going through can prove to be invaluable, but that doesn't mean that it is easy to do. A good way to start is to simply say how you are feeling, be honest and use words that feel comfortable to you. There may be times you feel you want support but don't feel able to speak to friends or family. Above is a list of some organisations that you may find useful.

INMO members also have access to a 24-hour counselling helpline service **(Tel: 1850 670407 or 01 8818047)**, which provides confidential counselling over the phone, including where appropriate, onward referral to relevant voluntary and/or professional services.

Colleges also offer support such as link lecturers, student unions and student counselling services. There is also support in clinical placement sites through your CPCs. Remember that no matter how you are feeling, you are not alone. If you are concerned about your mental health, help and support are available.

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

Table 1: Organisations offering support or information

Organisation	Website	Contact details	Service provided
Samaritans Ireland	www.samaritans.org/ireland/samaritans-ireland/	Freephone: 116 123 Email: jo@samaritans.ie	24/7 Listening service and emotional support for people experiencing distress
Aware	www.aware.ie	Freephone: 1800 804848 Email: supportmail@aware.ie	Support and information for people experiencing stress, depression, bipolar disorder and mood related conditions
Pieta House	www.pieta.ie	Freephone: 1800 247247 Text: HELP to 51444	Free therapy to those engaging in self-harm, experiencing suicidal ideation, or bereaved by suicide
Jigsaw	www.jigsaw.ie	Email: info@jigsaw.ie	Support and information for people ages 12-25
Spun Out	www.spunout.ie	Text: HELLO TO 50808	Provide information on health and wellbeing
BodyWhys	www.bodywhys.ie	Tel: 01 2107906 Email: alex@bodywhys.ie	Support and information for people affected by eating disorders
LGBT Ireland	www.lgbt.ie	Tel: 1890 929539 Email: info@lgbt.ie	Support and information for members of the LGBTQI+ community
Women's Aid	www.womensaid.ie	Freephone: 1800 341900	Advice and practical support for women and children experiencing physical, emotional and/or sexual abuse
HSE	www.yourmentalhealth.ie	Freephone: 1800111888	Information and advice on mental health

Know the signs

Ahead of World Ovarian Cancer Day, **Anne Murphy** encourages women to familiarise themselves with ovarian cancer symptoms

WORLD Ovarian Cancer Day is a global movement bringing women living with ovarian cancer, their families and supporters, patient advocacy organisations, medical practitioners and researchers together each year on May 8 to raise awareness of ovarian cancer and improve outcomes of this disease.

Ovarian cancer is the sixth most common women's cancer in Ireland. Just over 400 women are diagnosed with it each year. According to the National Cancer Registry Ireland, approximately 300 women will die each year from this disease.[1] It is the fourth leading cause of death in women in Ireland after lung , breast and colorectal cancer. Ireland ranks among the highest in Europe and the world in terms of mortality from the disease.

Often referred to as 'the silent disease', this description is untrue. Ovarian cancer has signs and symptoms and more recently is referred to as a disease 'that whispers', with ovarian cancer survivors advocating that women 'listen to their bodies', acknowledge the subtle changes and get it checked out by their GP.

Early diagnosis

Early diagnosis can significantly improve survival. Some 83% of patients diagnosed with stage one ovarian cancer are alive five years after diagnosis, whereas only 16% of patients diagnosed with stage four ovarian cancer are alive five years after diagnosis.[1]

One of the key ways to improve our terrible outcomes with this disease is raising awareness and providing information that will help women be diagnosed at an earlier stage of disease which improves overall survival. There is no screening tool for ovarian cancer. Cervical screening does not detect ovarian cancer. Women's own vigilance is the best way but knowing the symptoms of ovarian cancer is essential if women are to present in a timely manner to their GPs for investigation.

Study

Last year, a study commissioned by the Irish Network for Gynaecological Oncology and supported by Breakthrough Cancer Research and carried out by independent research consultants Behaviours & Attitudes, showed that four out of five women in Ireland are not confident in noticing a symptom of ovarian cancer. This is the first significant study ever done in Ireland that demonstrates the knowledge in Ireland on ovarian cancer.

- 94% of those surveyed could not name change or loss of appetite as a symptom
- 97% did not recognise frequent trips to the bathroom/needing to urinate (changes in toilet habits) more often as a symptom
- 57% did not think that changes in bowel habit could be a sign of ovarian cancer
- Only one in two think persistent pain and bloating are signs of ovarian cancer.

Fieldwork on the ovarian cancer research study ran from March 13 to March 25, 2022. The identity of the commissioning client was not disclosed to enhance objectivity.

The sample interviewed used quota controls to ensure it was representative of all women over the age of 40. Quota parameters (gender, age group, region and area) were established based on the latest census of population as well as industry-agreed estimates in respect of socio-economic class. Participants are members of Behaviour & Attitudes Acumen online panel. At a sample size of 400, the data can be deemed accurate to within a margin of error of +/- five percentage points.

BEAT campaign

The BEAT Ovarian Cancer Campaign focuses on knowing your body, knowing the signs and getting help at an early stage if you have any of the symptoms *detailed in the box above* for three weeks or more.

Women should listen to their bodies and consult with their GP if they have:

- Bloating, abdominal or pelvic pain
- Changes in urination, bowel or eating habits, including eating less and/or feeling full more quickly.

Symptoms of ovarian cancer can often be confused with other conditions such as irritable bowel syndrome. This is why it is important to seek help if you notice persistent changes.

Women with a family history of breast or ovarian cancer should also be particularly vigilant. Studies have shown that nearly 20% of ovarian cancer patients have an inherited genetic mutation that was likely the cause of their disease including: BRCA1, BRCA2, Lynch Syndrome or a family history of ovarian cancer.[2] Talk to your GP, describe new symptoms which are not going away and mention any family history.

Nurses are in a unique position to have a positive impact on improving outcomes for ovarian cancer patients as early detection is key.

The Irish Network for Gynaecological Oncology is a voluntary co-ordination body and consists of more than 30 of Ireland's foremost gynaecological cancer campaigners, researchers and patient advocates. Its aim is to raise awareness of gynaecological cancers across Ireland. The group participates in two major international events annually, World Ovarian Cancer Day on May 8 and World Gynaecological Cancer Day on September 20.

BEAT – ovarian cancer

- **B**loating that is persistent and doesn't come and go
- **E**ating less and feeling full more quickly
- **A**bdominal and pelvic pain you feel most days
- **T**oilet changes in urination or bowel habits

Anne Murphy is a cancer support nurse, Sláinte an Chláir, Clare Cancer Support and a member of the Irish Network for Gynaecological Oncology

References
1. National Cancer Registry Ireland (2022) Cancer in Ireland 1994-2020, Annual statistical report of the National cancer registry. www.ncri.ie
2. http://targetovariancancer.org.uk/about-ovarian-cancer/genetic-genomic-testing/hereditary-ovarian-cancer

New section holds inaugural meeting

ICN NP/APN conference sparked interest in Advanced Practice Section

A NEW INMO section of advanced practice nurses and midwives has been established, with more than 25 founding members meeting for the first time at the Richmond Education and Event Centre and online in March.

The Advanced Practice Section will focus primarily on supporting registered advanced nurse/midwife practitioners (ANPs/AMPs), as well as candidate ANPs, AMPs and clinical nurse/midwife specialists (CNS/CMS).

The section was formed following renewed interest at the International Council of Nurses NP/APN Network Conference in University College Dublin last year. The conference demonstrated the expertise within the professions, and the aim of the section is to continue to highlight this.

Speaking at the section's inaugural meeting, INMO president and ANP in gynaecology Karen McGowan said: "We are proud of our health service in Ireland. We are highly critical of it as well, and rightly so in terms of access, overcrowding and delays.

"However, we take an approach to healthcare that envisions the healthcare system as an essential service of general interest to our society, one which is delivered by the public service and one which is available based on need and not the ability to pay," Ms McGowan continued.

"As part of that vision we must have the right professionals in the right place at the right time, with the right skills and resources.

Pictured at the inaugural Advanced Practice Section meeting at the Richmond in March were (left, l-r) Fiona Colbert, section chair and ANP, Beaumont Hospital, Dublin; Karen McGowan, INMO president and ANP in gynaecology; and Oliver Allen, section vice chair and ANP, Mater Hospital, Dublin and (above, l-r): Abi Mani, Fiona Colbert, Aiden Foley, Oliver Allen and Dona Romard

"Never before has it been more important to recognise and advocate for the value of our professions and to recognise and further develop the role of advanced practice in realising universal healthcare and in particular bringing health benefits to patients".

The section's next meeting will take place on Monday, June 12 at the Richmond Education and Event Centre, with online attendance available for members who are unable to travel.

Contact section development officer Jean Carroll at jean.carroll@inmo.ie with any queries or email membership@inmo.ie if you wish to be aligned to this new section.

All smiles at the RNID Section conference

(See pages 20-21 for full coverage)

The INMO RNID Section held its annual conference at the Richmond Education and Event Centre in March. Pictured at the conference were (l-r): Anne Marie O'Reilly; Elizabeth Egan; Colin Redmond; Karen McGowan, INMO president; Ailish Byrne; Michael Whyte; Pauline O'Gorman; and Patricia McCartney

Pictured (l-r) are students Amy Hickey and Mary Kenneally with Chloe McGuire and Lorna Hoare, SETU fourth-year interns

Pictured (l-r) are Edwina Gilroy and Reece Ylanan, both student RNIDs, and Caroline Lynch, RNID

Anne Marie O'Reilly, education officer, RNID Section and Helen Farrelly, St Michael's House

INMO Professional

Continuing professional development for nurses and midwives

INMO EDUCATION PROGRAMMES

In the pull-out this month…

Competency-based interview skills for nurses and midwives

May 15

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

Master your communication skills

May 17

When good communication is practiced, it improves client care, staff morale and working relationships. It also decreases workplace conflict caused by gaps in communication, inactive listening or cultural differences. This online training will help you develop your interpersonal and communication skills at all levels in the organisation. It focuses on your key competencies for face-to-face and written communications to ensure you can understand what is being communicated to you; how to respond and how to communicate clearly and with purpose. Learn these practical skills to ensure more effective and impactful communications.

Risk management and incident reporting

May 24

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

INMO Professional

Looking ahead to an important month

Steve Pitman
Head of Education and Professional Development

MAY is an important month for the INMO with the annual delegate conference (ADC) and the international days of the nurse and midwife. May 1 is also International Workers Day, celebrated by trade unions across Ireland and internationally.

The ICN theme for International Nurses Day 2023 – *'Our Nurses. Our Future'* – emphasises the importance of governments and health services across the globe taking actions for the future that ensure nurses are protected, respected and valued. This year's International Day of the Midwife focuses on togetherness, a nod to the first ICM in-person Triennial Congress in five years taking place in Bali from June 11-14. The theme for the 2023 International Day of the Midwife, held on May 5, is *'Together again: from evidence to reality'*. The focus is on critical evidence that can bring about meaningful change for the midwifery profession, as well as for women and families generally.

INMO Professional sends greetings to all delegates and members attending this year's ADC in Killarney. If you are attending, don't forget to look out for our stand at the conference.

Undergraduate digital health standards

The Nursing and Midwifery Board of Ireland (NMBI) has completed a public consultation on the draft Digital Health Competency Standards and Requirements for Undergraduate Nursing and Midwifery Education Programmes. The NMBI is expected to produce a final document over the coming months.

The increasing importance of digital health in managing and delivering health services will require nurses and midwives to develop and maintain their skills in using technology. The standards will provide guidance on digital health competencies for education providers delivering undergraduate education programmes. This will ensure that the development of digital health skills is introduced early in the professional career of nurses and midwives.

HSE professional development plan (PDP)

The HSE Office of the Nursing and Midwifery Services Director (ONMSD) is planning to launch the PDP for nurses and midwives in early May. The PDP framework was first introduced in 2017 as a tool to support nurses and midwives to identify professional goals for their own benefit, the benefit of the service user and the benefit of their workplace. In 2020 the HSE introduced the performance achievement process as a mandatory process for all staff in the HSE. However, it was agreed that nurses and midwives would use the ONMSD PDP framework for the HSE performance achievement process.

The introduction of the PDP as a mandatory process for all nurses and midwives will require nurse and midwife line managers to meet with each team member at least once every year. Line managers will inevitability meet with a member of their team frequently. The INMO has raised concerns that the mandatory process could introduce an additional workload, particularly in CNM2 grades. This highlights the importance of ensuring that the recommendation of the Department of Health Framework for Safe Staffing and Skill Mix are fully implemented to ensure the successful implementation of the PDP. One of the key recommendations of the framework was the need to ensure that the role and function of CNM2 grades are in a supervisory capacity.. This enables the CNM2 role to be safeguarded, allowing CNM2s to fulfil their supervisory and leadership roles in the clinical environment. This is critical to patient safety, staff wellbeing and retention.

The INMO recognises the importance of supporting and investing in the education and continuing professional development of nurses and midwives and calls for further investment. This improves retention and ensures the development of skills to meet the current and emerging patient and population health needs. The INMO supports the introduction of the PDP but believes that it is essential that the process does not introduce an additional burden on nurse and midwife managers. The ONMSD has introduced guides, templates and videos to support managers, nurses, and midwives using the PDP. These can be found on the HSE ONMSD website.

Pride 2023

This year the INMO will be hosting, in collaboration with LGBT Ireland, a 'Pride at Work' event for nurses and midwives to celebrate and raise awareness about Pride and issues of importance to the LGBT+ community. The event will take place on Monday, June 26 at the Richmond Education Centre. Further information will be available in the June issue of *WIN* and on the INMO website. If you wish to get involved in the event, please contact steve.pitman@inmo.ie

On-site Education

INMO Professional offers extensive on-site programmes facilitated by expert practitioners. If you are interested in booking CPD courses for your organisation, please contact education@inmo.ie or 01 6640642.

Delivering courses for INMO Professional and writing for *WIN*

We are eager to offer members the opportunity to work with us in developing and delivering education courses. If you are an AN/MP, CN/MS, or a nurse/midwife with expertise in clinical or management practice, we would be interested in hearing from you. Please contact education@inmo.ie or 01 6640642. We are also interested in hearing from you if you would like to write professional and clinical articles for *WIN*. Please email steve.pitman@inmo.ie

INMO Professional

Education Programmes

Tel: 01 6640618/41
Email: education@inmo.ie

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

Book three education programmes and get the fourth free
www.inmoprofessional.ie

Keep your CPD up to date • Extensive range of programmes • NMBI category 1 approved • Digital certification provided

May 11 **Infection control risk register: regulation 27; development and review**

This session will outline the development of an infection control risk register for your facility. This is a requirement in meeting regulation 27 infection control in residential facilities in Ireland. The session will identify risk description, existing controls, additional controls required and complete a calculated risk rating score based a national framework. The sessions will assist the staff in achieving and maintaining governance compliance in this area for their facility and staff and resident/service user safety.

May 15 **Competency-based interview skills for nurses and midwives**

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

May 17 **Master your communication skills**

This online training will help you develop your interpersonal and communication skills at all levels in the organisation. It focuses on your key competencies for face-to-face and written communications to ensure you can understand what is being communicated to you; how to respond and how to communicate clearly and with purpose. Learn these practical skills to ensure more effective and impactful communications.

May 18 **Retirement planning seminar** *(in person)*

This short online course will enable nurses and midwives to understand the principles of effective leadership and management in front line healthcare delivery, identify key competencies required for effective management and understand how management competencies are applied to the healthcare setting to promote quality and safety in healthcare delivery. Fee: €10 INMO members; €65 non-members..

May 24 **Risk management and incident reporting**

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

May 31 **Subcutaneous administration of fluids** *(in person)*

This programme will educate participants in the administration of fluids by the subcutaneous route. It will cover topics such as accountability, indications for subcutaneous infusion, suitable sites and identification of fluids most commonly used. Calculation of the rate of infusion, the principles of an aseptic technique and complications which could occur before, during or after the procedure will be explored. Fee: €90 INMO members; €145 non members.

May 31 **Understanding epilepsy for nurses and midwives**

Epilepsy is a chronic disease that affects 1% of the population and can be associated with significant physical and psychosocial sequelae. A person with epilepsy often has comorbid conditions and must carefully manage their epilepsy and comorbid diseases, as well as navigate how their life is affected by their diseases. The management of patients with complex medical conditions, including epilepsy, is increasingly being overseen by nurses. Nurses who are not specialists in epilepsy can play a central role in providing optimal care, education, and support to their patients with epilepsy, given the proper tools. This course will provide a foundation on which to build increasing knowledge of epilepsy and care of the patient.

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

Jun 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.

Jun 7 **The importance of documentation for nurses and midwives – getting it right**

This short programme will assist nurses and midwives in understanding their duty of care and responsibility in the area of best practice in documentation, keeping good records and their ethical and legal responsibility of getting it right. Topics will include; introduction to legal and professional requirements, the NMBI code and guidance for recording clinical practice, the relevant HIQA regulations and standards, adhering to consent and data protection legislation in record keeping, the purpose of healthcare records.

Jun 7 **Peripheral intravenous cannulation** *(in person)*

This programme provides guidance on the skill of peripheral intravenous cannulation. Instruction will be provided on the sites used for peripheral intravenous cannulation, identifying criteria for evaluating a vein and the principles of an aseptic technique. The aim is for participants to be able to carry out the procedure in a competent and safe manner. While this course will provide the necessary knowledge and skills to undertake peripheral intravenous cannulation, it will be necessary for each nurse and midwife attending to ensure that they abide by their local policy on peripheral intravenous cannulation in their place of work. Participants are also required to hold the following: hand hygiene training certification (within the past two years); management and administration of intravenous drugs certification (within the past two years) and a management of anaphylaxis certification (within the past two years). €90 INMO members; €145 non members

Jun 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. On completion of the course, participants will understand the anatomy and physiology of wound management, understand and be able to identify the factors influencing wound healing, understand and be able to identify the differences between acute and chronic wounds, understand and be able to implement a holistic assessment of individuals with wounds and understand the current modalities of different types of dressing and their application.

Jun 15 **Introduction to management and leadership skills for nurses and midwives**

The aim of this short online programme is to identify key managerial and leadership competencies for front line 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.

Jun 19 **Tools for safe practice** *(Free for INMO members)*

This programme provides safe practice tools to protect the nurse and midwife and patient within current health care 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 patient 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. This programme is free for INMO members. Places must be booked on-line in advance of your attendance.

Jun 28 **Phlebotomy** *(in person)*

This programme provides participants with the skill and theory to perform phlebotomy in a competent and safe manner. It will cover topics such as sites used for phlebotomy, criteria for evaluating a vein, principles of an aseptic technique as well as complications that may arise during and after the procedure. Guidance will be given on how to reassure the individual in relation to the procedure and on gaining consent. Fee: €90 INMO members; €145 non-members

Jul 12 **Tools for safe practice** *(Free for INMO members)*

This programme provides safe practice tools to protect the nurse and midwife and patient within current health care 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 patient 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. This programme is free for INMO members. Places must be booked on-line in advance of your attendance.

INMO Professional Cornmarket

IN PERSON EVENT

Retirement Planning

Thursday, 18 May 2023

Time: 9.30am - 2.30pm

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

Fee: €10 INMO members; €65 non members

INMO Professional in partnership with Cornmarket Financial Services have developed an in person seminar to help support members planning for retirement. Topics covered on the day will be: Superannuation, calculation of the lump sum, options for increasing benefits, AVCs, planning your finances in retirement, investment goals, personal taxation and budgeting and money saving tips.

Book now: **education@inmo.ie** or **01 6640618/41**

More information www.inmoprofessional.ie/course

SCAN ME!

INMO Professional INMO Irish Nurses and Midwives Organisation Working Together

ONLINE COURSE

Understanding Epilepsy

for nurses and midwives

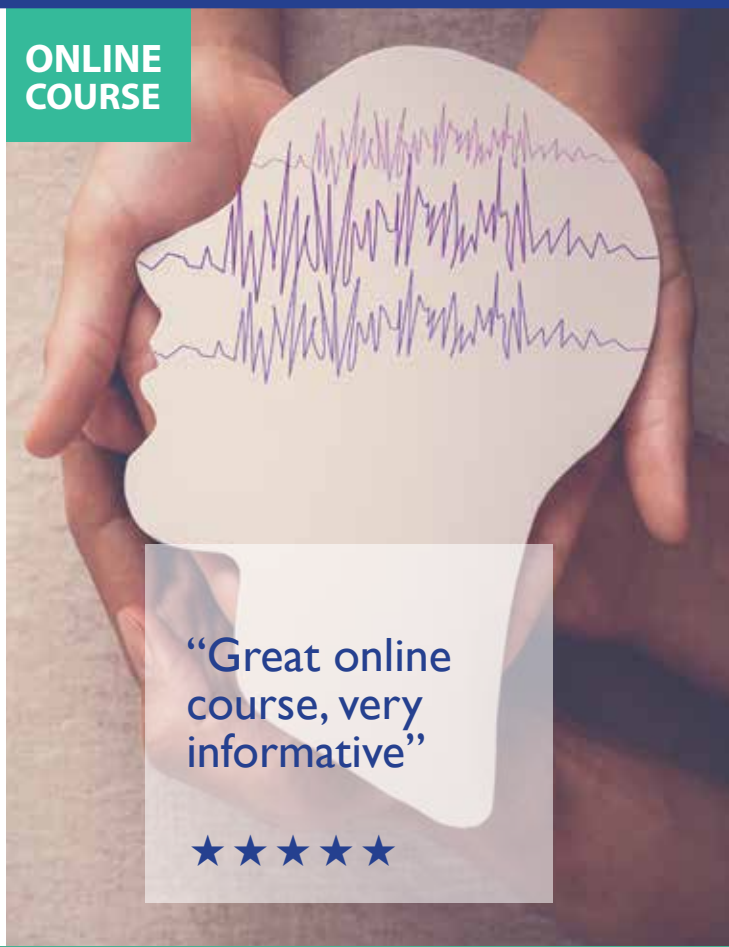
3 NMBI CEUS

Wednesday, 31 May 2023

Online from 10.00am - 1.00pm

Fee: €30 INMO members; €65 non members

Epilepsy is a chronic disease that affects 1% of the population and can be associated with significant physical and psychosocial sequelae. A person with epilepsy often has comorbid conditions and must carefully manage their epilepsy and comorbid diseases, as well as navigate how their life is affected by their diseases.



Book now: **education@inmo.ie** or **01 6640618/41**

Please include your INMO number, email and telephone number

SCAN ME!

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

Aug 21 **Mindfulness and meditation in holistic nursing and midwifery care**

Mindfulness is a buzz word. From Google to Apple to Nike, all are teaching this technique to their leaders and employees. We invite all nurses and midwives to learn this skill for their personal and professional use. Many scientific researches have proven across the globe that practice of mindfulness brings measurable physiological changes in the brain called neuroplasticity. Practitioners report improved general sense of wellbeing and less stress and pain. We will explore the process of psychosomatic illnesses and how we can help our patients during difficult times. Therapeutic use of mindfulness techniques such as turning towards the symptoms, pain, anger, fear, anxiety, depression, discomfort, instead of fighting the pain and wishing it goes away experiencing the pain as it is without adding or trying to subtract the pain. Mindfulness-based practices are part of national health care system in many countries. Let's reduce suffering and bring peace in our healthcare system.

Aug 23 **Tools for safe practice** *(Free for INMO members)*

This programme provides safe practice tools to protect the nurse and midwife and patient within current health care 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 patient 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. This programme is free for INMO members. Places must be booked on-line in advance of your attendance.

Aug 28 **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 (October 2021). This programme will provide information and outline the actions required by registered providers to ensure that procedures, consistent with the national standards for infection prevention and control in community services, published by HIQA, are implemented by staff.

Aug 29 **Delegation principles and practices**

This programme is aimed at all nurses, midwives and clinical nurse and midwife managers who work with health care assistants. It explores the issues surrounding delegation and decision making, including appropriate clinical supervision for delegated functions. Participants will learn the difference between clinical and managerial delegation and how delegation differs from assignment of a task. Guidance will be provided on the assessment of a delegate's experience and role, and how best to match appropriate clinical supervision to a specific delegated function. The professional, legal and quality of care issues involved when deciding to delegate a function will also be explored.

Aug 30 **Infection control risk register: regulation 27; development and review**

This session will outline the development of an infection control risk register for your facility. This is a requirement in meeting regulation 27 infection control in residential facilities in Ireland. The session will identify risk description, existing controls, additional controls required and complete a calculated risk rating score based a national framework. The sessions will assist the staff in achieving and maintaining governance compliance in this area for their facility and staff and resident/service user safety.

Sep 1 **Best practice for clinical audit for nurses and midwives**

This programme equips participants with the 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 5 **The importance of documentation for nurses and midwives – getting it right**

This short programme will assist nurses and midwives in understanding their duty of care and responsibility in the area of best practice in documentation, keeping good records and their ethical and legal responsibility of getting it right

Sep 12 **Understanding epilepsy for nurses and midwives**

Epilepsy is a chronic disease that affects 1% of the population and can be associated with significant physical and psychosocial sequelae. A person with epilepsy often has comorbid conditions and must carefully manage their epilepsy and comorbid diseases, as well as navigate how their life is affected by their diseases. The management of patients with complex medical conditions, including epilepsy, is increasingly been overseen by nurses. Nurses who are not specialists in epilepsy can play a central role in providing optimal care, education, and support to their patients with epilepsy, given the proper tools. This course will provide a foundation on which to build increasing knowledge epilepsy and care of the patient.

INMO Professional

INMO
Irish Nurses and Midwives Organisation
Working Together

IN PERSON EVENT

Subcutaneous administration of fluids

5 NMBI CEUS

Wednesday, 31 May 2023

Time: 9.30am - 2.30pm

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

Fee: €90 INMO members; €145 non members

This programme will educate participants in the administration of fluids by the subcutaneous route.

While this course will provide the necessary knowledge and skills to undertake phlebotomy, it will be necessary for each attendee to ensure that they abide by their local policy on phlebotomy in their place of work and hold an up to date Hand Hygiene Training certificate (within the last 2 years).

"It was excellent... fantastic presentation"

★★★★★

Book now: **education@inmo.ie** or **01 6640618/41**

More information www.inmoprofessional.ie/course

SCAN ME!

INMO Professional

INMO
Irish Nurses and Midwives Organisation
Working Together

ONLINE COURSE

Tools For Safe Practice

for nurses and midwives

3 NMBI CEUS

Monday, 19 June 2023

FREE

Online from 10.00am - 1.00pm

Practical advice on:

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

"Excellent presentation and presenter was so knowledgeable."

★★★★★

Book now: **deborah.winters@inmo.ie** or **01 6640618**

Please include your INMO number, email and telephone number

SCAN ME!

Searching databases

This month the library looks at Medline and PubMed, two important resources for research, policy development, CPD and general updates

Medline versus PubMed – What is the difference?

Medline is a bibliographic database of life sciences and biomedical information. It is maintained by the US National Library of Medicine (NLM) and provides access to more than 29 million references dating back to 1946.[1] This vast database provides access to citations from more than 5,600 biomedical journals, covering topics such as medicine, nursing, dentistry, veterinary medicine, health care systems and preclinical sciences from around the world.

Medline is behind a pay wall and is accessible through the library. Searching Medline can sometimes be a little simpler than searching via PubMed, particularly if you are already used to searching a specific platform for example OVID or EBSCO. The INMO Library also subscribes to different versions of the Medline database, which includes citations back to 1946 and e-pub ahead of print or in process citations.

PubMed is a free search engine that allows users to search the Medline database and other related biomedical literature. PubMed, launched in 1996, is also maintained by the NLM and provides access to over 34 million citations from various sources, including Medline and PubMed Central (PMC).

While Medline is a standalone database, PubMed allows users to search multiple databases at once, including Medline, PMC and other sources of biomedical literature. The amount of available full-text material will be limited using PubMed. In general, you can choose either one of these databases when undertaking a search. It is not necessary to search both as you will end up with similar results.

Why use Medline or PubMed?

When undertaking a comprehensive search, it is important to ensure that multidisciplinary resources such as these are included in the strategy. Medline/PubMed are considered one of the leading databases for health sciences research and are widely used by researchers, clinicians and students from all healthcare-related disciplines. They provide a comprehensive search tool for finding published research studies, including clinical trials, case studies and observational studies.

Medline is a widely used database for nursing literature, as it contains numerous nursing-related journals and publications. When searching for nursing literature via Medline, you can use specific keywords and medical subject headings (MeSH) related to nursing, such as "nursing care," "nurse-patient relations," "nursing assessment," "nursing diagnosis" and "nursing education". You can also filter your search to nursing literature by limiting a search by "nursing journals".

Tips for getting the most out of PubMed and Medline

Use filters: PubMed offers several filters that can help refine your search results. For example, you can filter by publication date, article type, language, and more. You can also use the "Related Citations" and "Similar Articles" links to find additional relevant articles.

Use MeSH terms: MeSH is a controlled vocabulary that is used to index articles in PubMed. Using MeSH terms in your search can help you find more relevant articles.

Use Boolean operators: Boolean operators (such as 'and,' 'or' or 'not') can be used to combine search terms and create more specific search strings.

Use the advanced search: The advanced search page allows you to use a combination of search fields, filters and Boolean operators to create more complex searches.

Search within articles: If you find an article that is particularly relevant to your search, you can use the "Related Information" and "Cited by" links to find additional articles that cite or are related to that article.

Stay up to date: Create an account in PubMed and save your searches to receive email alerts when new articles that meet your search criteria are added to the database.

By using these tips, you can ensure that your PubMed searches are more efficient and effective and that you are able to find the most relevant articles for your research.

Library news

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

Literature Searching Service

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

Other library services

For further information on this or any of the library services, please call: 01 6640614/25 or email: library@inmo.ie If you wish to visit the library, please make an appointment in advance so we can ensure that there will be a staff member available to assist you. The library opening hours are Monday to Thursday: 9am-5.00pm, Friday: 8.30am-4.30pm.

Online – Introduction to Effective Library Search Skills

Next course date: Tuesday, June 13, 2023

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.

INMO Professional

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INMO Professional Events 2023

ONLINE AND IN-PERSON EVENTS

All conferences and webinars are Category 1 approved by NMBI

SCAN ME!

JUNE 29
Emergency Department Nurses Section Webinar
Online from 11am

SEPTEMBER 5
Clinical Placement Co-ordinators Seminar
The Richmond Education and Event Centre, Dublin

SEPTEMBER 26
Telephone Triage Nurses Section
Midlands Park Hotel, Portlaoise, Co Laois

OCTOBER 14
Operating Department Nurses Section
Knightsbrook Hotel
Co Meath

NOVEMBER 16
All Ireland Midwifery Conference

NOVEMBER 23
Assistant Directors Section Webinar

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

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Royal College of Midwives

SAVE THE DATE

All Ireland Midwifery Conference 2023

Thursday, 16 November 2023

COMING SOON
CALL FOR POSTERS

For further details go to
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Operating Department Nurses Section Conference 2023

SAVE THE DATE

Saturday, 14 October 2023

The Knightsbrook Hotel,
Trim, Co Meath

Are you interested in presenting
on some recent initiatives in your department?
Contact: **jean.carroll@inmo.ie**

INMO Professional

i-learn Royal College of Midwives

Intervention with a smoking patient

The latest RCM i-Learn module we are highlighting brief advice and intervention that can be made with pregnant clients who smoke

SMOKING in pregnancy poses significant health risks to the mother and to the baby. The concept of offering 'very brief advice' is a proven intervention to trigger quit attempts that has the potential to improve the health and save the lives of both mother and baby. All staff coming into contact with pregnant women have a role to play, mainly through triggering quit attempts by delivering very brief advice on smoking.

This course aims to help midwives to deliver very brief advice on smoking to women and families. The module will take approximately one hour to complete.

Why this topic is important

Smoking is the greatest modifiable risk factor for poor outcomes in pregnancy and is the most important behaviour to change. Pregnant women who smoke should be supported with quitting as early as possible in pregnancy. The earlier in pregnancy a woman stops smoking the greater the reduction in the risk of adverse pregnancy outcomes; however, stopping smoking at any time during pregnancy will improve the blood flow and oxygen that the baby receives and therefore improve outcomes.

Pregnant women who are exposed to second-hand smoke are at increased risk of having low birth weight babies, babies small for gestational age and stillbirth.

Informing pregnant women that there is a local service, that is effective and that other pregnant women have found useful, can help motivate them to make an attempt at stopping smoking.

Role of the midwife

Midwives are especially well placed to deliver very brief advice to pregnant women. When taking the full medical history at the booking appointment, past and present smoking status should be included with smoking status being a mandatory field in electronic and/or written notes.

The very brief advice steps include three steps: Ask, Advise and Act. The module includes short videos with examples of ways that midwives can sensitively and supportively ask about smoking status, enquire about how a quit attempt is going, and how to respond appropriately.

Midwives are also well placed to discuss the myths around smoking during pregnancy. The module presents a number of videos that show midwives how to challenge these myths with accurate information and to encourage women to stop smoking.

Learning outcomes

Having completed this module you will be able to:

- Describe the main effects of smoking on the health of the mother and baby
- Understand the patterns and prevalence of smoking among pregnant women
- Understand how and where 'very brief advice' fits into the care pathway
- Establish smoking status, including carbon dioxide(CO_2) screening
- Advise women on the best way of stopping smoking or managing their exposure to smoke
- Support women to quit or manage their exposure to smoke
- Deal with issues as they arise.

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

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A column by Maureen Flynn

Quality & Safety

A practical guide to clinical audit

NURSES and midwives make a significant contribution to quality improvement by being members of clinical audits teams, leading audits, collecting and analysing data, eg. nursing and midwifery quality care metrics (QCMs), and working together with colleagues and patient partners on quality improvement action planning. A revised practice guide for clinical audit has just been published by the HSE's National Centre for Clinical Audit (NCCA). This guide will help to improve the consistency and quality of clinical audit, informing the planning and management of high-quality healthcare.

About the clinical audit guide

Clinical Audit: A Practical Guide (2023) provides updated guidance to healthcare professionals in relation to clinical audit design, governance, data protection and ethical issues. It provides a standardised framework for the seven stages of clinical audit *(see Figure)*.

The guide also includes resources such as checklists and templates, a clinical audit proposal form, a clinical audit report template and quality improvement/action plan templates to facilitate the implementation of the stages of clinical audit.

Opportunity to get involved

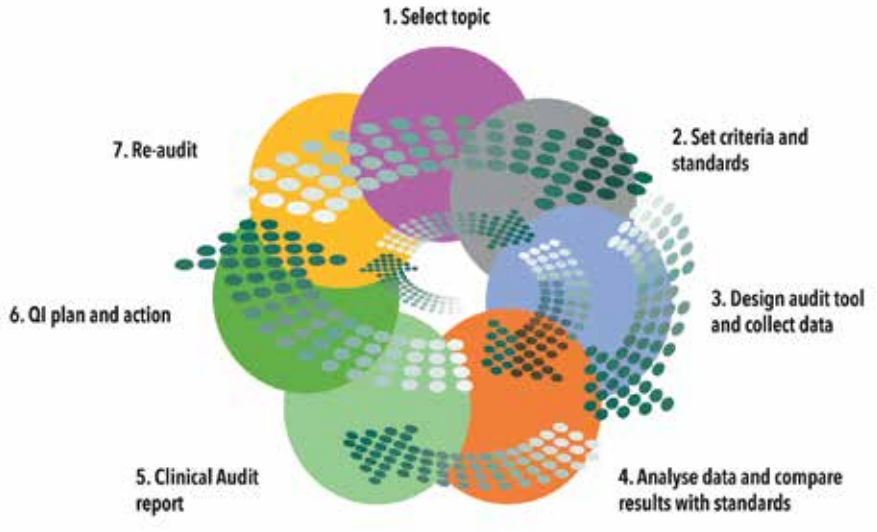
At your next ward, department or team meeting, you might like to talk about the plans for clinical audit in your area of nursing and midwifery practice. The guide can be used to prompt your conversation.

What is the NCCA?

The HSE National Centre for Clinical Audit was established in April 2022 following publication of the HSE *National Review of Clinical Audit Report 2019* and is primarily responsible for implementing the report's recommendations.

The NCCA is building the capacity and capability of HSE staff, services and stakeholders to standardise and promote the implementation of a programme of work for clinical audit under the five key pillars:

Figure: Clinical audit cycle



- National governance for clinical audit
- Local governance for clinical audit
- Education and training for clinical audit
- Education and training resources for clinical audit
- Legislative changes affecting clinical audit.

This is being delivered by working in collaboration with the National Quality and Patient Safety Directorate, HSE Services clinical audit services that are funded by the HSE, external stakeholders and patient partners and representative groups.

A wide range of national clinical audits are commissioned and managed on behalf of the HSE by clinical audit service providers, including the National Office of Clinical Audit, the Royal College of Physicians of Ireland, the National Perinatal Epidemiology Centre in UCC, the National Clinical Strategy and Programmes Division and the Out of Hospital Cardiac Arrest Register in NUI Galway.

Further information

The National Review of Clinical Audit found that there were a number of different definitions for clinical audit across the healthcare system, resulting in confusion around clinical audit design. Therefore, the guide should be read in conjunction with HSE NCCA Nomenclature – Glossary of Terms for Clinical Audit, available online at: **https://www.hse.ie/eng/about/who/nqpsd/ncca/nomenclature-a-glossary-of-terms-for-clinical-audit.pdf**

For further information, see **www2.healthservice.hse.ie/organisation/ncca** Follow us on Twitter (@hsencca) or contact us via email at ncca@hse.ie

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

Acknowledgements
Thank you to my colleagues Patricia Gibbons, Karen Reynolds and Maria Lordan Dunphy from the National Quality and Patient Safety Directorate for collaboration and assistance in writing this column

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Chronic disease nursing
The nephrology experience

Catherine Nunan and Deborah Macdonald discuss the promotion of partnership in care in a renal setting

MORE than 500 people develop kidney failure in Ireland annually.[1] End-stage renal failure is a multifactorial, irreversible chronic illness which necessitates indefinite renal replacement therapy or a successful renal transplant.[2] In Ireland, it is estimated that the incidence of end-stage renal failure is 80-90 per million population.[3] Haemodialysis is one of the primary methods of renal replacement therapy for almost 70% of patients with end-stage renal disease.[4] Over two million people currently receive dialysis treatment worldwide.[3]

Ireland has an aging population[5] and it is unsurprising that there has been an increase in the number of older patients commencing haemodialysis. The Irish Longitudinal Study on Ageing (TILDA) reports that 64.8% of our over 65 years of age cohort live with co-morbidity which, alongside other age-related factors, reduces the option of renal transplantation for this cohort of patients, requiring lifelong management with haemodialysis. This has challenged the healthcare system to develop and expand to support the healthcare needs of an ageing population.[6] Renal services have responded with the establishment of satellite dialysis units across Ireland, with clinical governance links to existing hospital units.

Nurses in dialysis services work to promote positive patient experiences, support patients to live well with chronic disease and to deliver healthcare which improves patient outcomes, quality of life and increases life expectancy.[7] Living with a chronic illness is a big adjustment, and as an irreversible pathological condition, end-stage renal disease can result in a permanent change in health status, with many patients experiencing emotional adaptation characterised by constant challenge and struggle. It is however important for us, as nurses, to remember that despite these challenges many patients can live well and can lead normal lives.

Figure 1: Sláintecare model of care

One of the key enablers to support patients to live well is the availability of healthcare within the community. The delivery of local haemodialysis services aligns with the *National Framework for the Integrated Prevention and Management of Chronic Disease in Ireland 2020-2025* and Sláintecare strategy *(see Figure 1)*. The model identifies five levels of services for the integrated prevention and management of chronic disease. Currently in our unit delivery of outpatient haemodialysis services to patients in the community is at level 0 of this model with the overall goal for improved care and outcomes for Irish patients undergoing haemodialysis treatment. This is now more important than ever, given that the prevalence of end-stage renal failure will continue to rise over the next decade.[1]

Given our commitment to patient-centred care and patient autonomy, we as a team at the Wexford dialysis unit explored the concept of shared haemodialysis care. The concept of shared care originated in the 1990s, characterising the partnership models that were used between primary and secondary care services around information sharing.[9] Over time, the concept evolved to shared haemodialysis care, underpinned by the promotion of patient choice and autonomy, and has been in use for over two decades in the UK.[8]

An innovative programme was developed for new and existing staff to support their understanding and use of a shared haemodialysis care approach. This article presents an overview of the process which was undertaken to develop an educational programme to underpin and further support the delivery of a shared haemodialysis care approach in our dialysis unit.

Shared haemodialysis care

Shared haemodialysis care means working in partnership with patients, in a systematic way, to engage them in their own treatment. It encourages patients to take an interest in helping themselves, promoting a more positive feeling towards their dialysis. Shared haemodialysis care

fosters mutual trust, sharing of responsibility and encourages active participation in care and decision making among staff and patients. It puts individuals back in control as it provides the opportunity, the information and the choice to participate in aspects of their treatment, and thereby improve their experience and their outcomes[8] while supporting quality improvement locally.[10]

Shared care focuses on encouraging, educating and supporting clinic-based dialysis patients and giving them the choice to learn about all the components of their own dialysis care. The haemodialysis process is broken down into small tasks such as: preparing equipment, measuring weight and blood pressure, and self-cannulation.

With support and supervision, and in partnership with the staff, patients are given the opportunity to take on as many of these tasks as they feel comfortable with and are able to do, at a pace that suits their individual needs. The emphasis is on taking part and engaging at a level that suits them and patients are always offered the opportunity to participate in various aspects of their care. The World Health Organization (WHO) highlights the benefit of enhanced patient engagement, and identified how better outcomes can be achieved across a range of medical conditions when patients are supported in managing their own health.[11] It is also important to dispel any myths that may exist on the shared-care approach. It is not about cutting or reducing staffing levels and patients will not be left on their own should individuals not feel ready to engage in this approach. Nurses are always available to patients and will support and promote patients in their individual engagement within a shared-care approach.

Embedding a shared-care approach

Education is essential to support staff development, lifelong learning and the introduction of new care delivery models.[13] Education is particularly important within a shared haemodialysis care approach, as nurses require theoretical knowledge, clinical experience and confidence in order to support and promote patient autonomy. Indeed, the promotion of autonomy is recognised as a key facilitator of empowerment.[12]

In a collaborative and iterative process, staff and management reviewed and considered the existing staff induction programme and educational resources. Building on these resources, additional topics, new content and resources were identified to further enhance nurses' knowledge and equip staff with skills specifically focused on empowering patients to participate in decisions concerning their treatment and care.

A revised 33-hour, blended learning, foundation programme was created with recorded online lectures supported by discussion on the material with an allocated preceptor. Given the importance of sustaining this cultural change, work was also completed in tandem, on the review and enhancement of clinical policies, ensuring that a partnership shared-care approach is embedded throughout the unit.

The key objectives of the programme are:

- To provide learners with an up-to-date, evidence-based knowledge on the management of haemodialysis in patients with renal failure
- To provide a platform to critically examine the factors contributing to safe haemodialysis, including clinical management of complications
- To critically discuss and understand patient education strategies to enhance the psychological and physical support structures for patients on haemodialysis living with end-stage renal disease.

The programme was submitted to the NMBI in November 2021 and was awarded 33 CEUs. The programme was formally introduced initially in January 2022 as part of our induction training for new staff, who are supported clinically with supernumerary status for six weeks. Existing staff were invited to undertake the programme with the support of an allocated mentor. It is envisaged that all staff will complete the programme by early 2023.

Challenges of implementing shared haemodialysis care

Unsurprisingly, we faced some challenges when initially implementing the education programme to support the introduction of the shared haemodialysis care approach. Concerns were expressed by nurses regarding the lack of time and available resources to undertake the programme. There was an initial lack of confidence and some reticence among both staff and patients around the shared haemodialysis care approach, with questions being asked in relation to what happened if shared care didn't work or it was too much for the individual patient. Indeed, others asked what would happen if they changed their mind and no longer wished to be involved and engage with their care.

As with the introduction of many new initiatives, we understood that some resistance was normal[15] and we took a proactive approach to understand and manage it. We conducted a staff questionnaire to identify what additional information and learning tools would assist and used this information to guide us during the implementation phase of the project.

As patients are key partners in this new initiative, the first step was to introduce the idea in our unit's monthly newsletter. This stimulated curiosity and questions. Everyone was provided with an information leaflet outlining the steps involved and how they could become involved in this approach. We also provided a range of opportunities for patients to familiarise themselves with how the shared-care approach would work. We did this in numerous ways, including:

- Offered and provided training to patients, who came in on their 'day off' dialysis to train in our training room so they were not taking up a dialysis slot; training away from the clinical area gave them the privacy to 'make mistakes' and learn from them
- Facilitated patients to come into the unit early to practise setting up their dressing packs, machines etc before the rest of the shift was brought in
- Provided aids as required such as mirrors and printed instructions, pictures, modified protocols and photographs.

Interestingly, word spread across the unit organically and other patients then began to ask questions about how they could get involved in their dialysis when they saw their 'colleagues' setting up their packs or lining their machines.

A shared haemodialysis care ethos is ongoing in our clinic but needs continual encouragement. Staff, patients and the environment are all subject to change and motivation, and enthusiasm can wane. Sharing and collaborating with other clinics, health professionals and patients discussing shared-haemodialysis care with each other gives rise to new ideas and inspirations and re-energises and motivates everyone.

The key to our success is that shared-haemodialysis care is the normal thing to do and is not seen as an additional burden for staff or patients.

We have noticed that our shared-care patients have been more involved in decisions about their own healthcare and that their understanding of their renal disease and treatment modality has increased. We see patients are more active in decision making particularly around monitoring

their diet, fluids and medication. They have a better understanding of how to reduce the risk of complications and importantly, when to seek help.[14]

Staff reported increased team motivation, and greater enthusiasm between patients and staff. The shared haemodialysis care approach was also viewed by staff as a continuous professional development tool as it promoted staff and patients to discuss how they might collaborate and work together to improve care.

Conclusion

The HSE has established an Integrated Care Programme for the Prevention and Management of Chronic Disease (ICPCD). This programme aims to provide better care to people with chronic diseases by providing a continuum of preventative, management and support services to patients with these conditions. This model of care is also supported by the WHO, which reported that empowering patients to become active participants in their care has been recognised as a key component of all healthcare reform models.[12]

The dialysis unit team has found that empowering staff with additional educational and continuing professional development initiatives, and the shared haemodialysis care approach, have complemented each other and created a culture of patients and staff collaborating together to set goals, rather than setting goals for patients.

Given the benefits for both the individual – patient and nurse – and the organisation, a shared haemodialysis care approach has been firmly embedded as a cornerstone of patient-centred care in connected dialysis centres nationally.

Catherine Nunan is a clinical nurse specialist and Deborah Macdonald is a clinic manager at the Renal Unit, B. Braun Wellstone Renal Dialysis Unit in Wexford

Acknowledgements

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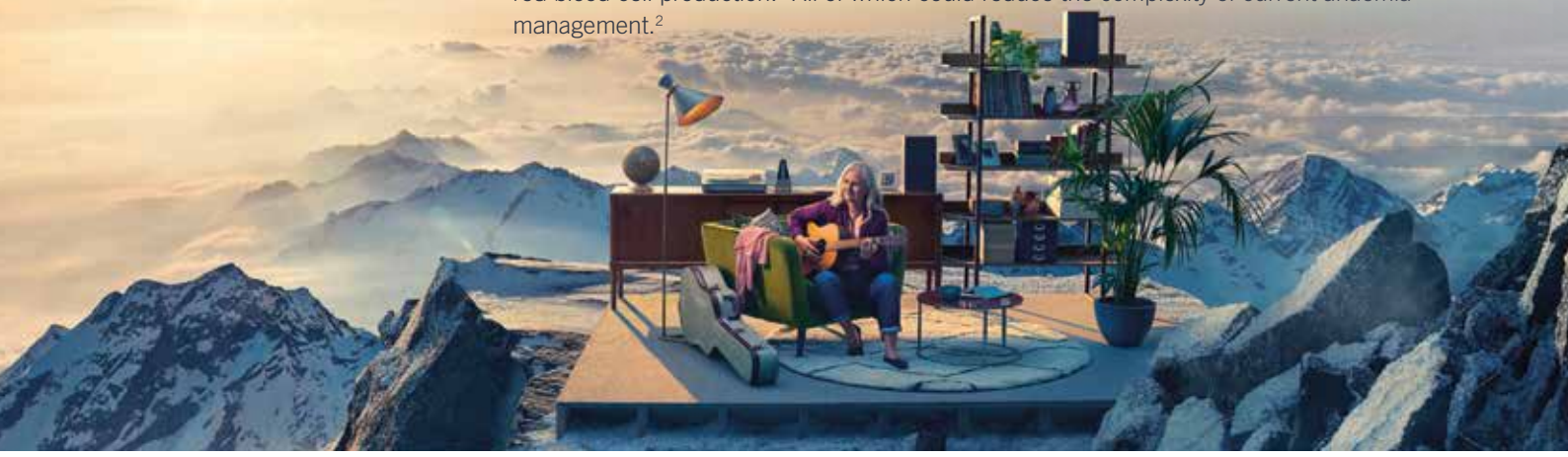

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Patients not currently/previously treated with an erythropoiesis-stimulating agent (ESA): Recommended starting dose: Patients <100kg: 70 mg three times weekly. Patients ≥100kg: 100mg three times weekly. Patients converting from an ESA: : Patients on ESA treatment can be converted to roxadustat. *Dialysis patients stable on ESA:* only consider conversion if clinically valid reasons exist. *Non-dialysis patients stable on ESA:* conversion not studied, only consider on benefit-risk to patient. The recommended starting dose is based on the average prescribed ESA dose in the 4 weeks before conversion. The first roxadustat dose should replace the next scheduled ESA dose. See Table 1. in the SPC. Maximum recommended dose: Patients not on dialysis do not exceed a roxadustat dose of 3 mg/kg body weight or 300 mg three times weekly, whichever is lower. Patients on dialysis do not exceed a roxadustat dose of 3 mg/kg body weight or 400 mg three times weekly, whichever is lower. Dose adjustments and Hb monitoring: The individualised maintenance dose ranges from 20 mg to 400 mg three times per week (400 mg only for CKD patients on dialysis). Monitor Hb every 2 weeks until a level of 10-12 g/dL is reached and stabilised, then every 4 weeks or as clinically indicated. The dose of roxadustat can be adjusted stepwise up or down from the starting dose 4 weeks after treatment start, then every 4 weeks except if the Hb increases by >2 g/dL, in which case the dose should be reduced by one step immediately. When adjusting the dose, consider the current Hb level and the recent rate of change in Hb level over the past 4 weeks, and follow the dose adjustment steps in Table 2 in SPC section 4.2. If dose reduction is required for a patient on the lowest dose, reduce the dose frequency to twice a week. If further dose reduction is needed, the frequency may be reduced to once weekly. Maintenance dose: After stabilisation of target Hb levels, monitor Hb levels regularly and follow dose adjustment rules. Consider alternative explanations in patients with inadequate Hb response (see SPC section 4.2). Patients starting dialysis while on roxadustat treatment: No specific dose adjustments required. Follow normal dose adjustment rules. Concomitant roxadustat treatment with inducers or inhibitors: When initiating/discontinuing concomitant treatment with strong inhibitors or inducers of CYP2C8, or inhibitors of UGT1A9, monitor Hb levels routinely and follow dose adjustment rules. Missed dose: If there is >1 day until the next dose, the missed dose must be taken as soon as possible. If ≤ one day remains before the next dose, skip the missed dose. Then resume the regular dosing schedule. Elderly: No adjustment of starting dose (see SPC section 5.2). Patients with hepatic impairment: Mild hepatic impairment: No adjustment of starting dose. Moderate hepatic impairment: Caution is recommended. Reduce starting dose by half or to the level closest to half the starting dose. Severe hepatic impairment: Not recommended (see SPC sections 4.4 & 5.2). Paediatric population: No data are available in patients < 18 years of age. **Contraindications:** EVRENZO is contraindicated in the following conditions: Hypersensitivity to the active substance, peanut, soya, or to any of the excipients listed in section 6.1 of the SPC; Third trimester of pregnancy (see sections 4.4 & 4.6 of the SPC); Breastfeeding (see section 4.6 of the SPC). **Warnings and precautions:** Cardiovascular and mortality risk: Overall, the cardiovascular and mortality risk for treatment with roxadustat has been estimated to be comparable to the cardiovascular and mortality risk for ESA therapy based on data from direct comparison of both therapies (see SPC section 5.1). Since, for patients with anaemia associated with CKD and not on dialysis, this risk could not be estimated with sufficient confidence versus placebo, a decision to treat these patients with roxadustat should be based on similar considerations that would be applied before treating with an ESA. Further, several contributing factors have been identified that may impose this risk, including treatment non responsiveness, and converting stable ESA treated dialysis patients (see SPC sections 4.2 and 5.1). In the case of non-responsiveness, treatment with roxadustat should not be continued beyond 24 weeks after the start of treatment (see SPC section 4.2). Conversion of dialysis patients otherwise stable on ESA treatment is only to be considered when there is a valid clinical reason (see SPC section 4.2). For stable ESA treated patients with anaemia associated with CKD and not on dialysis, this risk could not be estimated as these patients have not been studied. A decision to treat these patients with roxadustat should be based on a benefit risk consideration for the individual patient. Thrombotic vascular events: The reported risk of thrombotic vascular events (TVEs) should be carefully weighed against the benefits to be derived from treatment with roxadustat particularly in patients with pre existing risk factors for TVE, including obesity and prior history of TVEs (e.g., deep vein thrombosis [DVT] and pulmonary embolism [PE]). Deep vein thrombosis was reported as common and pulmonary embolism as uncommon amongst the patients in clinical studies. The majority of DVT and PE events were serious. Vascular access thrombosis (VAT) was reported as very common amongst the CKD patients on dialysis in clinical studies (see SPC section 4.8). In CKD patients on dialysis, rates of VAT in roxadustat treated patients were highest in the first 12 weeks following initiation of treatment, at Hb values more than 12 g/dL and in the setting of Hb rise of more than 2 g/dL over 4 weeks. It is recommended to monitor Hb levels and adjust the dose using the dose adjustment rules (see Table 2) to avoid Hb levels of more than 12 g/dL and Hb rise of more than 2 g/dL over 4 weeks. Patients with signs and symptoms of TVEs should be promptly evaluated and treated according to standard of care. The decision to interrupt or discontinue treatment should be based on a benefit risk consideration for the individual patient. Seizures: Seizures were reported as common amongst the patients in clinical studies receiving roxadustat (see SPC section 4.8). Roxadustat should be used with caution in patients with a history of seizures (convulsions or fits), epilepsy or medical conditions associated with a predisposition to seizure activity such as central nervous system (CNS) infections. The decision to interrupt or discontinue treatment should be based on a benefit risk consideration of the individual patient. Serious infections: The most commonly reported serious infections were pneumonia and urinary tract infections. Patients with signs and symptoms of an infection should be promptly evaluated and treated according to standard of care. Sepsis: Sepsis was one of the most commonly reported serious infections and included fatal events. Patients with signs and symptoms of sepsis (e.g., an infection that spreads throughout the body with low blood pressure and the potential for organ failure) should be promptly evaluated and treated according to standard of care. Secondary hypothyroidism: Cases of secondary hypothyroidism have been reported with the use of roxadustat (see SPC section 4.8). These reactions were reversible upon roxadustat withdrawal. Monitoring of thyroid function is recommended as clinically indicated. Inadequate response to therapy: Inadequate response to therapy with roxadustat should prompt a search for causative factors. Nutrient deficiencies should be corrected. Intercurrent infections, occult blood loss, haemolysis, severe aluminium toxicity, underlying haematologic diseases or bone marrow fibrosis may also compromise the erythropoietic response. A reticulocyte count should be considered as part of the evaluation. If typical causes of non-response are excluded, and the patient has reticulocytopenia, an examination of the bone marrow should be considered. In the absence of an addressable cause for an inadequate response to therapy, Evrenzo should not be continued beyond 24 weeks of therapy. Hepatic impairment: Caution is warranted when roxadustat is administered to patients with moderate hepatic impairment (Child Pugh class B). Evrenzo is not recommended for use in patients with severe hepatic impairment (Child Pugh class C) (see SPC section 5.2). Pregnancy and contraception: Roxadustat should not be initiated in women planning on becoming pregnant, during pregnancy or when anaemia associated with CKD is diagnosed during pregnancy. In such cases, alternative therapy should be started, if appropriate. If pregnancy occurs while roxadustat is being administered, treatment should be discontinued and alternative treatment started, if appropriate. Women of childbearing potential must use highly effective contraception during treatment and for at least one week after the last dose of EVRENZO (see SPC sections 4.3 and 4.6). Misuse: Misuse may lead to an excessive increase in packed cell volume. This may be associated with life threatening complications of the cardiovascular system. Excipients: EVRENZO contains lactose. Patients with rare hereditary problems of galactose intolerance, total lactase deficiency or glucose galactose malabsorption should not take this medicinal product. EVRENZO contains Allura Red AC aluminium lake (see SPC section 6.1) which may cause allergic reactions. EVRENZO contains traces of soya lecithin. Patients who are allergic to peanut or soya, should not use this medicinal product. Effects on ability to drive and use machines: Roxadustat has minor influence on the ability to drive and use machines. Caution should be exercised when driving or using machines. **Interactions:** Effect of other medicinal products on roxadustat: *Phosphate binders and other products containing multivalent cations:* Roxadustat should be taken >1 hour after administration of phosphate binders or other medicinal products or supplements containing multivalent cations (not lanthanum carbonate) (see SPC section 4.2). *Modifiers of CYP2C8 or UGT1A9 activity:* Monitor Hb levels when initiating/ discontinuing concomitant treatment with gemfibrozil, probenecid, other strong inhibitors/inducers of CYP2C8 or other strong inhibitors of UGT1A9. Adjust the dose of roxadustat following dose adjustment rules based on Hb monitoring. (see SPC section 4.2). Effect of roxadustat on other medicinal products *OATP1B1 or BCRP Substrates:* Co administration of roxadustat with simvastatin in healthy subjects increased the AUC and C_{max} of simvastatin and simvastatin acid. The concentrations of simvastatin and simvastatin acid also increased when simvastatin was administered 2 hours before or 4 or 10 hours after roxadustat. Co administration of roxadustat with rosuvastatin increased the AUC and C_{max} of rosuvastatin. Co administration of 200 mg of roxadustat with atorvastatin increased the AUC and C_{max} of atorvastatin. Interactions are also expected with other statins. Monitor for adverse reactions associated with statins and for the need of statin dose reduction. Roxadustat may increase the plasma exposure of other medicinal products that are substrates of BCRP or OATP1B1. Monitor for possible adverse reactions of co administered medicinal products and adjust dose accordingly. See SPC. Roxadustat and ESAs: It is not recommended to combine administration. **Pregnancy and lactation:** There are no data on the use of roxadustat in pregnant women. Roxadustat is contraindicated in the third trimester of pregnancy and is not recommended during the first and second trimester. If pregnancy occurs during EVRENZO treatment, discontinue EVRENZO and switch to an alternative if appropriate. EVRENZO is contraindicated during breast-feeding. Fertility: The potential effects of roxadustat on male fertility in humans are unknown. At a maternally toxic dose, increased embryonic loss was observed. Women of childbearing potential must use highly effective contraception during treatment and for at least one week after the last dose. **Undesirable effects:** Summary of the safety profile: The safety of EVRENZO was evaluated in 3542 non dialysis dependent (NDD) and 3353 dialysis dependent (DD) patients with anaemia and CKD who have received at least one dose of roxadustat. The most frequent (≥10%) adverse reactions associated with roxadustat are hypertension (13.9%), vascular access thrombosis (12.8%), diarrhoea (11.8%), peripheral oedema (11.7%), hyperkalaemia (10.9%) and nausea (10.2%). The most frequent (≥1%) serious adverse reactions associated with roxadustat were sepsis (3.4%), hyperkalaemia (2.5%), hypertension (1.4%) and deep vein thrombosis (1.2%). List of adverse reactions: Adverse reactions observed during clinical studies and/or in post-marketing experience are listed in this section by frequency category and MedDRA system organ class. Frequency categories are defined as follows: very common (≥1/10); common (≥1/100 to <1/10); uncommon (≥1/1,000 to <1/100); rare (≥1/10,000 to <1/1,000); very rare (<1/10,000); not known (cannot be estimated from the available data). *Infections and infestations:* : Common: Sepsis. *Endocrine disorders:* Not known: Secondary hypothyroidism. *Metabolism and nutrition disorders:* Very common: Hyperkalaemia. *Psychiatric disorders:* Common: Insomnia. *Nervous system disorders:* Common: Seizures, headache. *Vascular disorders:* Very common: Hypertension, vascular access thrombosis (VAT)[1], Common: Deep vein thrombosis (DVT). *Gastrointestinal disorders:* Very common: Nausea, diarrhoea, Common: Constipation, vomiting. *Skin and subcutaneous tissue disorders:* Not known: Dermatitis Exfoliative Generalised (DEG). *Hepatobiliary disorders:* Uncommon: Hyperbilirubinaemia. *Respiratory, thoracic, mediastinal disorders:* Uncommon: Pulmonary embolism. *General disorders and administration site conditions:* Very common: Peripheral oedema. *Investigations:* Not known: Blood thyroid stimulating hormone (TSH) decreased.[1]This adverse reaction is associated with CKD patients who were on dialysis while receiving roxadustat. Description of selected adverse reactions. *Thrombotic vascular events:* In CKD patients not on dialysis, DVT events were uncommon, occurring in 1.0% (0.6 patients with events per 100 patient years of exposure) in the roxadustat group, and 0.2% (0.2 patients with events per 100 patient years of exposure) in the placebo group. In CKD patients on dialysis, DVT events occurred in 1.3% (0.8 patients with events per 100 patient years of exposure) in the roxadustat group and 0.3% (0.1 patients with events per 100 patient years of exposure) in the ESA group (see SPC section 4.4). In CKD patients not on dialysis, pulmonary embolism was observed in 0.4% (0.2 patients with events per 100 patient years of exposure) in the roxadustat group, compared to 0.2% (0.1 patients with events per 100 patient years of exposure) in the placebo group. In CKD patients on dialysis, pulmonary embolism was observed in 0.6% (0.3 patients with events per 100 patient years of exposure) in the roxadustat group, compared to 0.5% (0.3 patients with events per 100 patient years of exposure) in the ESA group (see SPC section 4.4). In CKD patients on dialysis, vascular access thrombosis was observed in 12.8% (7.6 patients with events per 100 patient years of exposure) in the roxadustat group, compared to 10.2% (5.4 patients with events per 100 patient years of exposure) in the ESA group (see SPC section 4.4). *Seizures:* : In CKD patients not on dialysis, seizures occurred in 1.1% (0.6 patients with events per 100 patient years of exposure) in the roxadustat group, and 0.2% (0.2 patients with events per 100 patient years of exposure) in the placebo group (see SPC section 4.4). In CKD patients on dialysis, seizures occurred in 2.0% (1.2 patients with events per 100 patient years of exposure) in the roxadustat group, and 1.6% (0.8 patients with events per 100 patient years of exposure) in the ESA group (see SPC section 4.4). *Sepsis:* In CKD patients not on dialysis, sepsis was observed in 2.1% (1.3 patients with events per 100 patient years of exposure) in the roxadustat group, compared to 0.4% (0.3 patients with events per 100 patient years of exposure) in the placebo group. In patients on dialysis, sepsis was observed in 3.4% (2.0 patients with events per 100 patient years of exposure) in the roxadustat group, compared to 3.4% (1.8 patients with events per 100 patient years of exposure) in the ESA group (see SPC section 4.4). *Skin reactions:* : Dermatitis exfoliative generalised, part of severe cutaneous adverse reactions (SCARs), has been reported during postmarketing surveillance and has shown an association with roxadustat treatment (frequency not known). Prescribers should consult the full summary of product characteristics in relation to other adverse reactions. **Overdose:** Single supratherapeutic doses of roxadustat 5 mg/kg (up to 510 mg) in healthy subjects were associated with a transient increase in heart rate, an increased frequency of mild to moderate musculoskeletal pain, headaches, sinus tachycardia, and less commonly, low blood pressure (all non serious). Roxadustat overdose can elevate Hb levels above the desired level; manage with discontinuation or reduction of roxadustat dosage and careful monitoring and treatment as clinically indicated. Roxadustat and its metabolites are not significantly removed by haemodialysis. **Package Quantities, Basic NHS cost:** EVRENZO (12 pack tablets): United Kingdom (UK): 20 mg = £59.24, 50 mg = £148.11, 70 mg = £207.35, 100 mg = £296.21, 150 mg = £444.32. Ireland (IE): POA. **Legal Classification:** UK: POM. Ireland POM/S1A **Product licence numbers:** Great Britain (GB): PLGB 00166/0427-0431. Northern Ireland (NI)/ IE: EU/1/21/1574/001-005. **Marketing Authorisation Holder:** GB: Astellas Pharma Ltd., 300 Dashwood Lang Road, Bourne Business Park, Addlestone, United Kingdom, KT15 2NX. NI/IE: Astellas Pharma Europe B.V. Sylviusweg 62, 2333 BE Leiden, The Netherlands. **Date of Preparation of Prescribing Information:** February 2023. **Document number:** MAT-IE-EVZ-2023-00002 **Further information available from:** UK: Astellas Pharma Ltd., Medical Information: 0800 783 5018. IE: Astellas Pharma Co. Ltd., Tel.: +353 1 467 1555. For full prescribing information, please see the SPCs which may be found at: GB: www.medicines.org.uk; NI: https://www.emcmedicines.com/en-gb/northernireland/; IE: www.medicines.ie.

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

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

▼ 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.

CKD, chronic kidney disease. 1.EVRENZO SMPC. 2. Sanghani NS, Haase VH. Adv Chronic Kidney Dis 2019; 26:253–266.
MAT-IE-EVZ-2023-00007 I March 2023

astellas

KISQALI®
ribociclib

KISQALI—the only CDK4/6 inhibitor with statistically significant overall survival across all 3 phase III trials[1–3]

NCCN RECOMMENDED | National Comprehensive Cancer Network® (NCCN®) now recognizes ribociclib (KISQALI®) + ET, a Category 1 preferred treatment option, for showing an **OS BENEFIT IN 1L PATIENTS** with HR+/HER2- mBC[4]

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

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

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

REFERENCES:

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2. Im S-A, Lu Y-S, Bardia A, et al. Overall survival with ribociclib plus endocrine therapy in breast cancer. *N Engl J Med*. 2019;381(4):307-316.
3. Slamon DJ, Neven P, Chia S, et al. Overall survival with ribociclib plus fulvestrant in advanced breast cancer. *N Engl J Med*. 2020;382(6):514-524.
4. Referenced with permission from the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) for Breast Cancer V.4.2022. © National Comprehensive Cancer Network, Inc. 2021. All rights reserved. Published June 21, 2022. Accessed July 29, 2022. To view the most recent and complete version of the guideline, go online to NCCN.org. NCCN makes no warranties of any kind whatsoever regarding their content, use, or application and disclaims any responsibility for their application or use in any way.

ABBREVIATED PRESCRIBING INFORMATION

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

Kisqali (ribociclib) 200 mg film-coated tablets

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

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

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

Dosage and administration:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Pregnancy, Fertility and Lacation

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

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

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

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

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

Legal Category: POM

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

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

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

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

Prescribing information last revised: April 2022

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

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November 2022 | IE253121

New roadmap for breast cancer

The WHO is calling on all countries to join a UN-led global initiative to tackle breast cancer that could save 2.5 million lives by 2040, writes **Seamus O'Reilly**

THE World Health Organization (WHO) has unveiled new framework guidelines with the goal of reducing global breast cancer mortality by 2.5% per year until 2040, thereby averting an estimated 2.5 million deaths.[1] The Global Breast Cancer Initiative (GBCI) Framework provides national programme managers, policy makers and multisectoral actors in all countries with the guidance needed to assess, strengthen and scale-up services for the early detection and management of breast cancer.

This evidence-based Framework lays out a roadmap for immediately implementable strategies for countries with diverse health systems using a stepwise, resource-appropriate approach, presented under three pillars (*see Figure 1)*:

- Health promotion for early detection (prevention and pre-diagnostic interval)
- Timely breast diagnostics (diagnostic interval)
- Comprehensive breast-cancer management (treatment interval).

The GBCI was launched by the WHO in March 2021 following a steady escalation in the recognition of breast cancer as a public health priority during recent decades. Breast cancer has now overtaken lung cancer as the world's mostly commonly-diagnosed cancer, and is responsible for one in six of all cancer deaths among women, according to statistics released by the International Agency for Research on Cancer (IARC) in December 2020.[2]

Indeed, projected increases in breast cancer incidence and mortality will impact all WHO regions (*see Table 1*) with a greater relative impact on countries with the most limited resources, as measured by the United Nations Human Development Index (HDI)[3] *(see Table 2)*.

While there has been substantive progress in reducing breast cancer mortality in many high-income countries (HIC) during the past two decades, little progress has been made in low-and middle-income countries (LMIC). The five-year breast-cancer survival rates exceed 90% in HICs, compared to 66% in India and 40% in South Africa.[1] The higher mortality in these lower-income countries is a result of late-stage diagnosis and inadequate access to quality care. The premature

Figure 1: The Global Breast Cancer Initiative: operational approach based on three pillars of action

Table 1: Estimated increases (%) in new cases of and deaths from breast cancer across WHO regions, 2020–2040[3]

Projected increases in 2020-2040 (both sexes, all ages)	WHO regions					
	African Region	Region of the Americas	South-East Asia Region	European Region	Eastern Mediterranean Region	Western Pacific Region
New breast cancer cases	91.2	39.1	50.7	12.8	80.5	21.0
Breast cancer deaths (both sexes, all ages)	93.0	52.3	62.3	25.5	94.2	45.2

deaths and high out-of-pocket expenditure that arise when breast cancer services are unavailable or unaffordable result in social disruption, impoverishment, family instability and orphaned children, and also threaten economic growth.

Accelerating the implementation of WHO's Global Breast Cancer Initiative has the potential to avert not only millions of avoidable female cancer deaths but also the associated, intergenerational consequences of these deaths. Working in unison with other UN agencies and partner organisations, the GBCI will provide guidance to governments on how to strengthen systems for diagnosing and treating breast cancer, which in turn is expected to lead to improved capacities to manage other types of cancer.

"Global partners, experts and other organisations will be convened through the Initiative to map existing activities, develop roadmaps, and establish multisectoral working groups to address health promotion and early detection, timely breast cancer diagnosis, and comprehensive breast cancer treatment and supportive care," explained Dr Ben Anderson, professor of surgery and global health medicine at the University of Washington, US, who is leading the work on the new Initiative at WHO. "The demand for a global approach, that brings together the best expertise on breast cancer control from around the world, is high, as is the excitement about what can be achieved."

Table 2: Estimated increases (%) in new cases of and deaths from breast cancer based on country classification, 2020-2040[3]

Projected increases in 2020-2040 (both sexes, all ages)	Low HDI	Medium HDI	High HDI	Very high HDI
New breast cancer cases	97.2	59.6	30.8	15.8
Breast cancer deaths (both sexes, all ages)	98.9	69.2	53.6	30.0

Three pillars

Within a health-system framework, the breast cancer patient-care pathway is defined by three sequential intervals – the pre-diagnostic interval, the diagnostic interval and the treatment interval. Each of the three GBCI pillars defines specific clinical processes to be followed and outcomes to be achieved during a patient-care interval in order to improve existing healthcare delivery systems. Key performance indicators (KPIs) have also been identified for each pillar in order to monitor programmatic inputs, outputs and outcomes to determine possible gaps in care delivery. The three pillars are:

- Health promotion, which will include public education about the signs and symptoms of breast cancer, risk reduction strategies (such as avoiding obesity, limiting alcohol intake and encouraging breastfeeding), and reducing the stigma associated with breast health that exists in some parts of the world. The GBCI has set a goal of a stage I or II diagnosis for more than 60% of patients with invasive cancers
- Timely breast cancer diagnosis, which should reduce delays between the time a patient first interacts with the health system and the initiation of breast cancer treatment. Although breast tumours do not change in days or weeks, cancer survival rates begin to erode when delays to initiate treatment are greater than three months. Current delays in some settings and among certain vulnerable populations can be more than a year. Basic diagnostic services are feasible in all settings, so long as they are well organised and lead to timely referral for specialist care. The GBCI wants to see patients undergoing diagnostic evaluation, imaging, tissue sampling and pathology within 60 days of diagnosis
- Comprehensive breast cancer management should include access to surgery, chemotherapy and/or radiotherapy as well as rehabilitation support for women following treatment and palliative services to reduce pain and discomfort. More than 80% of patients need to undergo multimodality treatment without abandonment, according to the GBCI.

Pillar 1: early detection

The Framework outlines that early-detection programmatic strategies will vary based on health-system readiness at national and/or subnational levels. In settings where late-stage breast-cancer presentation is common, stage shifting is required to catch patients with early-stage disease. Early detection begins with breast-health awareness through the establishment of early-diagnosis programmes. These programmes focus on identifying people with signs and symptoms suggesting malignancy and linking them with cancer diagnostic services.

Organised, population-based screening is not an appropriate or practical initial step in any setting until the required infrastructure and quality control measures are in place and fully functional. Thus, all healthcare systems require the capacity to diagnose symptomatic breast complaints, such as lumps, thickenings or other clinical detectable abnormalities, regardless of whether they can afford and effectively organise mammographic screening programmes.

Pillar 2: timely diagnostics

The KPI benchmark of pillar 2 (breast cancers diagnosed within 60 days, or two months, of initial presentation) is based on the concept that the clinical detection of breast cancers early in their course will improve breast-cancer outcomes only if the pathologic diagnosis and initiation of

high-quality treatment are timely.

The Framework states that treatment should start within three months of initial presentation as studies have identified that delay beyond this period leads to lower rates of breast-cancer survival. By securing a definitive diagnosis within two months, the stage is set for initiating treatment within three months.

Prompt breast diagnosis relies on a number of key factors including:

- A balance between the centralisation and decentralisation of diagnostic services
- The co-ordinated effort of radiologists, pathologists and surgeons
- An organised patient navigation system from the primary-care level facility where the patient first presents to the higher-level facility where diagnostic evaluation takes place.

A diagnostic centre needs to be available and accessible to conduct a work-up of breast abnormalities. By centralising diagnostic services, quality is better maintained; however, centralised services are less convenient for patients who need to travel to access them, and this can be a source of diagnostic delay. The Framework recommends that all diagnostic services should not be located at a tertiary-care facility, since the number of patients requiring services would be many times larger than the number of those who are ultimately found to have cancer. Secondary-level hospitals may be the best location for breast diagnostic services as they are more likely to be geographically accessible, if they can secure the specialised expertise required to maintain quality.

Pillar 3: cancer management

The KPI benchmark of pillar 3 (> 80% of breast-cancer patients complete their recommended treatment) is based on the notion that access to, including the affordability of, standard breast-cancer treatment is a major barrier in most LMICs. A large problem in LMICs is the failure to complete treatment, or to its being delayed to such a degree that its therapeutic benefits are limited.

The Framework states that treatment should begin with multidisciplinary planning whereby a patient-specific management plan is formulated around evidence-based, resource-adapted guideline compliant treatment. The term 'abandonment' refers to failure to complete the planned treatment in its designated time course for reasons other than medical indications for treatment disruption. Abandonment is often the result of health-system failures that are beyond the patient's control. The Framework calls for all rates of, and reasons for, abandonment to be tracked with the aim of addressing system failures that may have contributed to it.

The health system is responsible for assessing itself to determine whether the delivery of cancer treatment for individual patients is in fact realistic and feasible. The standardisation of patient-centred metrics regarding access to treatments – including patient-reported outcome measures (PROMs) and patient-reported experience measures (PREMs) – is necessary, the document stresses.

In addition to the cancer-directed treatments (surgery, radiotherapy, systemic anti-cancer medications), supportive services are essential to patient compliance and effective care delivery during treatment, as well as to recovery following therapy.

Implementation strategies

The Framework document provides guidance on resource-appropriate strategies for improving the prompt diagnosis of breast cancer at an early stage and the timely completion of multimodality treatment to improve breast cancer mortality rates. It is anticipated that these measures will stimulate the following:

Establishment of national priorities and countrywide engagement to:

- Raise political will for improving outcomes in cancer and other noncommunicable diseases
- Integrate national strategies in a common stepwise approach to health-system strengthening
- Align multiple UN and international partners through stakeholder mapping and engagement
- Assess current country capacity and workforce utilisation and identify opportunities for improvement
- Establish coherency within national cancer-control planning (including the development of national action plans)
- Generating investment cases for mobilising domestic and external resources for breast-cancer programmes
- Help in prioritising technology and infrastructure investments for cancer management not limited to breast cancer.

Implementation of shared work plans on:

- Developing national standards for the diagnosis and treatment of cancer and the supportive care of people with the disease
- Providing education and training opportunities to balance workforce delegation and ensure task-specific competency
- Improving access to essential medicines and health products
- Promoting community participation.

Measurement of the impact and quality of steps taken to:

- Strengthen registries and information systems
- Develop quality improvement processes and procedures
- Develop a monitoring and evaluation framework for breast health as an essential component of women's healthcare, aimed at supporting stakeholders in monitoring and evaluating implemented strategies for addressing deficits in breast healthcare.

Investing in data systems and embedding monitoring and evaluation into programme implementation will allow stakeholders to determine the extent to which a programme or project is on track towards meeting its goals. Performing a root cause analysis (RCA) to investigate underlying aetiologies relating to the KPI and three-pillar approach can enable stakeholders to tailor effective implementation strategies. RCAs can reveal relationships among different variables and underlying causes, leading to process deficits.

Conclusion

The GBCI Framework document will facilitate major improvements in breast cancer outcomes through directed interventions based on health system performance, as measured by the GBCI KPIs for each pillar. A health system that can manage breast cancer will find itself better able to address all cancers that depend on early detection, prompt diagnosis and effective multimodality therapy.

As so much is known about the proper management of breast cancer, and because the pathways to tackling it are so well worked out, this provides an opportunity to improve health systems in a resource-appropriate way. Such an approach can be embraced as a tool for improving global health at a level higher than ever before.

Seamus O'Reilly is a consultant medical oncologist at Cork University Hospital and associate professor at University College Cork

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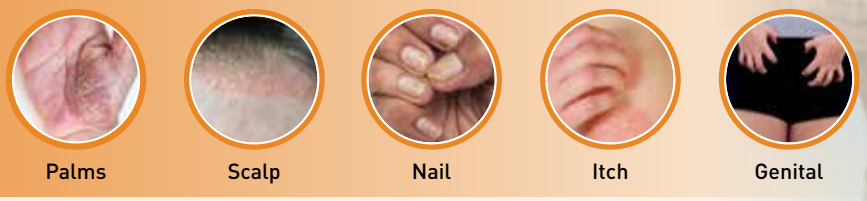

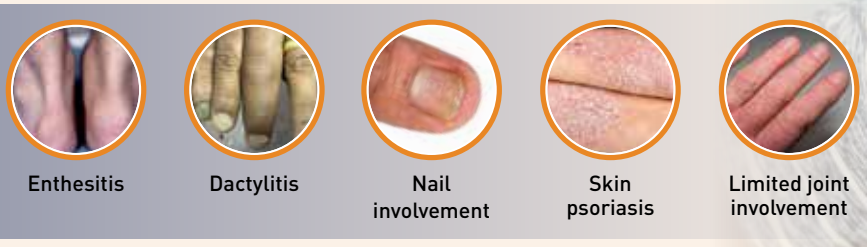

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Interactions: Co-administration of strong cytochrome P450 3A4 (CYP3A4) enzyme inducer, rifampicin, resulted in a reduction of systemic exposure of OTEZLA, which may result in a loss of efficacy of OTEZLA. Therefore, the use of strong CYP3A4 enzyme inducers (e.g. rifampicin, phenobarbital, carbamazepine, phenytoin and St. John's Wort) with OTEZLA is not recommended. In clinical studies, OTEZLA has been administered concomitantly with topical therapy (including corticosteroids, coal tar shampoo and salicylic acid scalp preparations) and UVB phototherapy. OTEZLA can be co-administered with a potent CYP3A4 inhibitor such as ketoconazole, as well as with methotrexate in psoriatic arthritis patients and with oral contraceptives.
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Abbreviations: PDE4, phosphodiesterase-4; PsA, psoriatic arthritis; PsO, psoriasis.

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IE-OTZ-0622-00004

Date of preparation: August 2022

AMGEN®

Focus on: Psoriatic arthritis

WIN presents a case of psoriatic arthritis in a 41-year-old woman

A 41-YEAR-OLD woman with psoriasis attended rheumatology clinic with a painful right big toe, associated with swelling and erythema. She described a three-month history of intermittent swelling and pain of her metacarpophalangeal and distal interphalangeal (DIP) joints, with early morning stiffness lasting two hours.

She had already been started on methotrexate 25mg subcutaneously and folic acid by the dermatology team for her psoriasis. She explained that she had tried several nonsteroidal anti-inflammatory drugs (NSAIDs) in the past few months and, while they had helped her pain, they had not settled her joint swelling.

After a lengthy discussion, a decision was made to start adalimumab 40mg every two-weeks subcutaneously. A biologic work-up was started including routine bloods, QuantiFERON test, HIV, hepatitis B and C serology, varicella titre, fasting lipids and chest x-ray. At her six-monthly follow up, she had achieved remission.

Psoriatic arthritis

Psoriatic arthritis (PsA) is an immune-mediated disease that can affect synovial joints and the insertion of tendons into bones (enthesis). It can affect the sacroiliac joints (frequently unilateral) with non-articular features, including nail changes and iritis.

Treatment

The treatment for PsA includes both non-pharmacological and pharmacological therapies (*see Table 1*).

Typically, the treatment for mild disease includes non-pharmacological therapies such as physical therapy, weight reduction, smoking cessation and exercise. Initial treatment also frequently includes NSAIDs to reduce pain and stiffness. Intra-articular corticosteroid is an option for limited PsA.

To reduce inflammation, prevent joint damage and maintain quality of life treatment is usually escalated to include conventional disease modifying anti-rheumatic drugs (csDMARDs), such as methotrexate or sulfasalazine. Failure to respond adequately to csDMARD therapy results in escalation to a biologic agent or a Janus kinase (JAK) inhibitor, as either adjunctive or alternative modes of treatment. See *Table 1* for pharmacological, non-pharmacological and symptomatic therapies for psoriatic arthritis.

Table 1: Pharmacological, non-pharmacological and symptomatic therapies for psoriatic arthritis[3]

Non-pharmacologic therapies	Physical therapy, occupational therapy, smoking cessation, weight loss, massage therapy, exercise
Symptomatic treatments	Nonsteroidal ant-inflammatory drugs (NSAIDs), glucocorticoids, local injections
Pharmacologic therapies	
• Oral small molecules (OSM)	Methotrexate, sulfasalazine, cyclosporine, leflunomide, apremilast
• Tumour necrosis factor inhibitor (TNFi) biologics	Etanercept, infliximab, adalimumab, golimumab, certolizumab pegol
• Interleukin-12/23 inhibitor (IL-12/23i)biologic	Ustekinumab
• Interleukin-17 inhibitor (IL-17i) biologics	Secukinumab, ixekizumab, brodalumab
• CTLA4-immunoglobulin (CTLA4-ig)	Abatacept
• JAK inhibitor	Tofacitinib

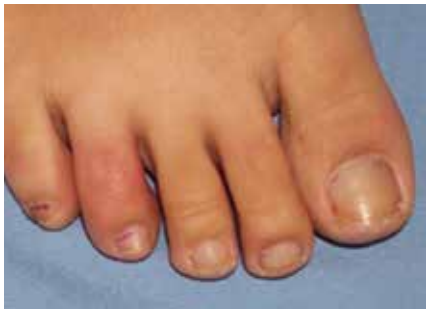

Figure 1. Dactylitis of the fourth toe of the left foot – the fourth toe is diffusely swollen and is described as a 'sausage toe' (Image: Uptodate)

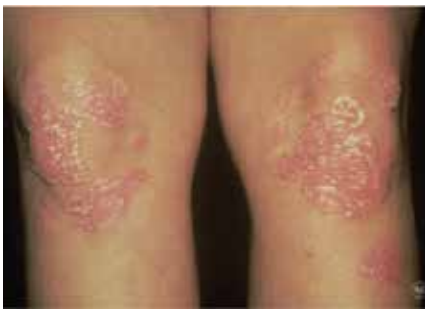

Figure 2. Plaque psoriasis on knees (Image: American Academy of Dermatology)

Bernadine Louis is a dermatology specialist registrar at St Vincent's University Hospital and Gerry Wilson is professor of rheumatology at UCD and a consultant rheumatologist at the Mater University Hospital and St Vincent's University Hospital

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Pelvic floor problems:

Incontinence, bladder pain and dyspareunia

Susmita Sarma discusses the treatment options available for incontinence, prolapse, dyspareunia and bladder pain syndrome

IN THE second part of our short series on pelvic floor problems, we focus on treatment for incontinence and prolapse, as well as discussing faecal incontinence and dyspareunia and their associated treatments.

Surgery for stress incontinence

The past three years has seen a seismic shift in the surgical treatment for stress urinary incontinence (SUI). The mid-urethral sling or tension-free vaginal tape (TVT) – once the gold standard procedure for SUI – was suspended by the chief medical officer in June 2018. The most recent NICE guidance recommends that women should be offered the choice of open/laparoscopic colposuspension or autologous rectus fascial sling surgery.[1] Retropubic mid-urethral mesh sling should also be included as an option.

The pause here in Ireland was expected to last a few months but has continued pending several issues raised including the creation and maintenance of a national database for mesh registration, a national consent form, the assurance that only appropriately trained surgeons should carry out such surgery and the creation of mesh removal centres. The HSE Mesh Complications Service now has two sites open – at the National Maternity Hospital (Holles St) and Cork University Maternity Hospital. It is not known when the pause will be lifted.

Pelvic organ prolapse

Women can present at any age with signs and symptoms of pelvic floor dysfunction. While the most common risk factors for pelvic organ prolapse tend to be parity and ageing, women can also present with pressure symptoms and a sensation of something coming down from chronic coughing, constipation and obesity. Whether a patient presents with symptoms of prolapse or prolapse is found incidentally, it is important to take a thorough history, including asking for details of prolapse, urinary, bowel and sexual function.

It is important to perform an examination to rule out a pelvic mass and to discuss with the patient their desire for and expectations of treatment. For many women with asymptomatic prolapse, there may be no requirement for treatment. Lifestyle modifications should be encouraged including weight loss where indicated, management of constipation and heavy lifting. For postmenopausal women with vaginal atrophy, local vaginal oestrogen should be considered and is safe. When possible, a 16-week course of pelvic floor muscle training is recommended.[1] For women who cannot contract their pelvic floor, referral to a pelvic floor physiotherapist is indicated.

Vaginal pessary

Vaginal pessaries should be considered next for symptomatic prolapse. It is important to treat atrophy when present prior to insertion of a pessary. It may take a few appointments to find the right size pessary and patients should be aware of the common complications of a pessary, including bleeding, discharge, expulsion of the pessary and the necessity of having it changed regularly.

There is a wide range of vaginal pessaries available depending on whether a women is sexually active or not and many women can be taught to successfully self-change their pessary. These are broadly divided into support pessaries and space-occupying pessaries. If a sexually active women can self-change her pessary, either type is suitable as long as it gives the desired effect. A six-monthly change of pessary is necessary if a woman is unable to self-change. In studies of long-term use of pessaries, in women who were successful in finding a comfortable, effective pessary, use at five years has been shown to be high at over 75%.

Surgical management of prolapse

For women who have found limited or no benefit with conservative management or vaginal pessaries and are symptomatic, the next option is surgical treatment. Discussions around deciding whether surgical management is suitable should include the benefits and risks of the different types of surgical procedures, including changes in urinary, bowel and sexual function. Recurrence after prolapse surgery is common and can range from 10-30%. Recurrences are more common in women with a high BMI, greater severity of prolapse at first presentation and smokers. Younger women who have not completed their family should be encouraged to do so prior to having surgery.

Surgery for uterine prolapse

For women with a uterine prolapse causing symptoms, a vaginal hysterectomy is the surgical management of choice. This can be combined with a sacrospinous fixation for support of the vault of the vagina. For women who have an elongated cervix but the body of the uterus is well supported, a Manchester repair is an option where the cervix is amputated only. This is not suitable for women who wish to have a further pregnancy. For women who wish to preserve their fertility, a sacrospinous hysteropexy will allow for this but again where possible, delay surgery until after her family is complete.

Mesh

Where a significant uterine prolapse exists or following a vaginal hysterectomy, a significant vault prolapse occurs, an abdominal sacrocolpopexy using mesh is another option although not currently available in Ireland due to the current pause in place. A vaginal sacrospinous fixation is also suitable for vault prolapse.

For women who are not sexually active and have significant medical comorbidities which make them more at risk of post-operative complications, a colpocleisis is a good surgical procedure which results in vaginal closure and has low morbidity and

high success rates. It is suitable for both significant uterine and vault prolapses.

Anterior and posterior wall prolapse

Vaginal mesh procedures are no longer recommended for vaginal prolapse. This is due to the known existence of serious and well recognised complications and the lack of long-term efficacy. The surgical management of an anterior wall prolapse is the standard fascial repair and the same for the posterior wall. Again, it is important when discussing the option of surgery that the complications are highlighted and the failure rates (30% for the anterior and 10% for the posterior) are understood. A good source of information for patients are the patient information leaflets from the International Urogynaecological Association (IUGA): **www.yourpelvicfloor.org**

Faecal incontinence

Some 28% of women attending gynaecology clinics report anal incontinence.[2] Anal incontinence describes involuntary loss of faeces or flatus. Faecal incontinence is the involuntary passing of liquid or solid stool. Flatal incontinence describes the involuntary passing of flatus. Faecal continence requires intact anal sphincter function, rectal sensation, adequate rectal capacity and compliance, colonic transit time, stool consistency and cognitive and neurologic factors.

Faecal incontinence affects 10% of adults and increases with age, with up to 50% of patients in nursing homes reporting symptoms. High-risk groups include women post-childbirth, women with urinary incontinence and pelvic organ prolapse, post-anal surgery or radiotherapy. It is under-reported, similarly to urinary incontinence. Up to 25% of women who have had vaginal deliveries have anal incontinence.

All patients who experience faecal incontinence should be offered conservative management through lifestyle changes or pharmacological agents.[3] Initial management involves dietary changes and for women with hard stools a minimum of 1.5 litres of fluid a day. Food diaries are useful and common dietary triggers include caffeine and lactose. Eating small rather than large meals can decrease the sense of urgency.

For women who have loose stools contributing to faecal incontinence and where altering their diet has not had the desired effect, loperamide is the first-line treatment. Like other pelvic floor disorders, pelvic floor muscle training should be offered to women with faecal incontinence. After this, biofeedback, electrical stimulation and rectal irrigation can all be effective. When these fail, then further investigation with endoanal ultrasound and anorectal manometry or pudendal nerve conduction studies can be useful.

Endoanal ultrasound is the best way to assess sphincter pathology. Information on sphincter length and damage to the structure of the external and internal anal sphincters can be gained. Anorectal manometry assesses the resting and squeeze pressures of the sphincter complex and both are usually reduced in faecal incontinence. Pudendal neuropathy occurs during pregnancy and childbirth with a significant amount of repair occurring within a year of childbirth. In women with sphincter injuries, an increase in the pudendal nerve terminal motor latency value is seen.

Percutaneous tibial nerve stimulation has been studied in small numbers so there is not much data on its use, although some of these studies have shown an improvement in symptoms. Sacral nerve stimulation on the other hand, has a good deal of evidence showing its benefit for patients with faecal incontinence. The low dose continuous stimulation of the sacral nerves has been shown to have up to a 75% cure rate for faecal incontinence and 75-100% reporting a 50% improvement.

Surgery for faecal incontinence

Where a full-length external sphincter defect is found, the option of an anal sphincter repair is considered. However, the improvement in symptoms declines over time with 70% at five years having good control and dropping to 10% at 10 years. Patients with internal anal sphincter defects, pudendal neuropathy and organic bowel disorders will generally not find an improvement with secondary repairs. Bulking agents and other injectables which are placed above the dentate line do not yet have good medium- to long-term data on their efficacy. Finally, for women where faecal incontinence has proved refractory to other treatments, a colostomy can be considered.

Dyspareunia

Dyspareunia and vulvodynia are known as genital pain disorders and can have a significant negative impact on quality of life for women. Dyspareunia is a complex disorder characterised by painful intercourse, which can be superficial where pain is localised to the vulva or vagina, or deep where pain is felt deep in the vagina or lower pelvis. Vulvodynia is chronic pain that has been present for more than three months without a causative factor. The two conditions can occur simultaneously, but vulvodynia usually occurs without a provocation whereas intercourse causes dyspareunia. The prevalence of these condition varies widely, with the WHO reporting a global incidence of painful intercourse between 8-21%, which varied by country.[4]

Vulvodynia and superficial dyspareunia can be caused by conditions such as vulvovaginitis, vulval dermatosis such as lichen sclerosis, vaginal atrophy and childbirth. Up to 30% of women report pain at six months postnatal but many do not discuss it. Inflammation, tumours, neuropathic pain from pudendal neuropathy or structural defects post-surgery can all cause superficial pain. Deep dyspareunia can be caused by endometriosis, adhesions, pelvic inflammatory disease, irritable bowel syndrome and fibromyalgia.

Assessment

The assessment of dyspareunia involves a thorough history looking for pain characteristics and associated symptoms such as bladder or bowels, obstetric, gynaecological and sexual, including physical or sexual abuse. Physical exam includes excluding pelvic masses as well as an assessment of the pelvic floor muscles. If a single digit exam is tolerated vaginally, a small speculum may also be tolerated to allow visualisation of the cervix.

Treatment

Pelvic floor physiotherapy is an important part of treatment for all types of pelvic pain as pelvic floor muscle tension is increased in chronic pain conditions and can lead to a vicious cycle of causing more pain. This physiotherapy works by concentrating on relaxing and stretching the overtight muscles and retraining pain receptors. Biofeedback, vaginal dilators and, importantly, education are all effective in reducing pain. Cognitive behavioural therapy also has an important role to play, as it does in any pain condition.

Treatment will depend on the underlying condition. Vulvodynia without an identifying trigger will often respond to the tricyclic antidepressant amitriptyline at a low dose of 10mg at night. Topical lidocaine 5% used twice daily can also be effective.

For postmenopausal women with vulval atrophy, local vaginal oestrogen in a tablet or a cream has been shown to be very effective and safe even with long-term use. There are also a large number of commercially available water-based lubricants for women who may not want to use local oestrogen. For women with pain secondary

to pelvic floor muscle contractures, Botox has been shown to be useful but long-term data is still awaited.

Surgery

Where a secondary source for pain is identified, ie. endometriosis or adhesions or a local source such as a tumour, surgery may be indicated. Surgery for primary vulvodynia can involve the partial or complete excision of the vestibule, and should only be undertaken when pain can be localised to this area and provoked by examination. Symptoms can be significantly improved in 60-90% of patients.

Bladder pain syndrome

Bladder pain syndrome is a chronic pain syndrome and is a diagnosis of exclusion. It is defined as pelvic pain, pressure or discomfort perceived to be related to the bladder, lasting at least six months and accompanied by at least one other urinary symptom; for example, persistent urge to void or frequency in the absence of other identifiable causes. Because it is a diagnosis of exclusion, prevalence rates are difficult but are estimated to be around 2.3-6.5% and between two to five times more common in women than men.[5] A thorough history and exam should be carried out to rule out other disorders that may cause similar symptoms. A necessity for assessment is a bladder diary, ideally kept over three days, a food diary looking for links to flare-ups and urinalysis to rule out infection.

Not many investigations are required when dealing with bladder pain syndrome. Cystoscopy and biopsy are only carried out to exclude other conditions. Urodynamics are useful if there is coexisting overactive bladder/stress incontinence or voiding dysfunction symptoms that have not responded to conservative treatment.

Treatment starts with dietary modification including avoidance of caffeine, alcohol and acidic foods and drinks. Stress management and regular exercise have been shown to be beneficial for pain management in many chronic pain conditions. As with many other pelvic pain conditions, pelvic floor physiotherapy may help symptoms. Simple analgesia and then amitriptyline are next line therapies. If these fail to control symptoms, then referral to a specialist is recommended.

The options then mainly include the intravesical instillation of hyaluronic acid, lidocaine, heparin, cyclosporin A or intravesical injection of Botox. Patients who have Hunner lesions identified at cystoscopy may benefit from excision of these. Cystoscopy and cystodistension can be considered but do not have robust evidence for use. Neuromodulation, in the form of posterior tibial nerve or sacral nerve stimulation, has also a role if other treatment has failed. As a last resort, cystectomy with urinary diversion may be carried out.

Women with bladder pain syndrome who become pregnant can have improvement or worsening of symptoms, but the condition has no other adverse effect on their pregnancy or delivery. Bladder pain syndrome can have a significant adverse effect on quality of life and it is important to acknowledge this and to refer women for counselling if needed.

Susmita Sarma is a consultant obstetrician/gynaecologist at Galway University Hospital

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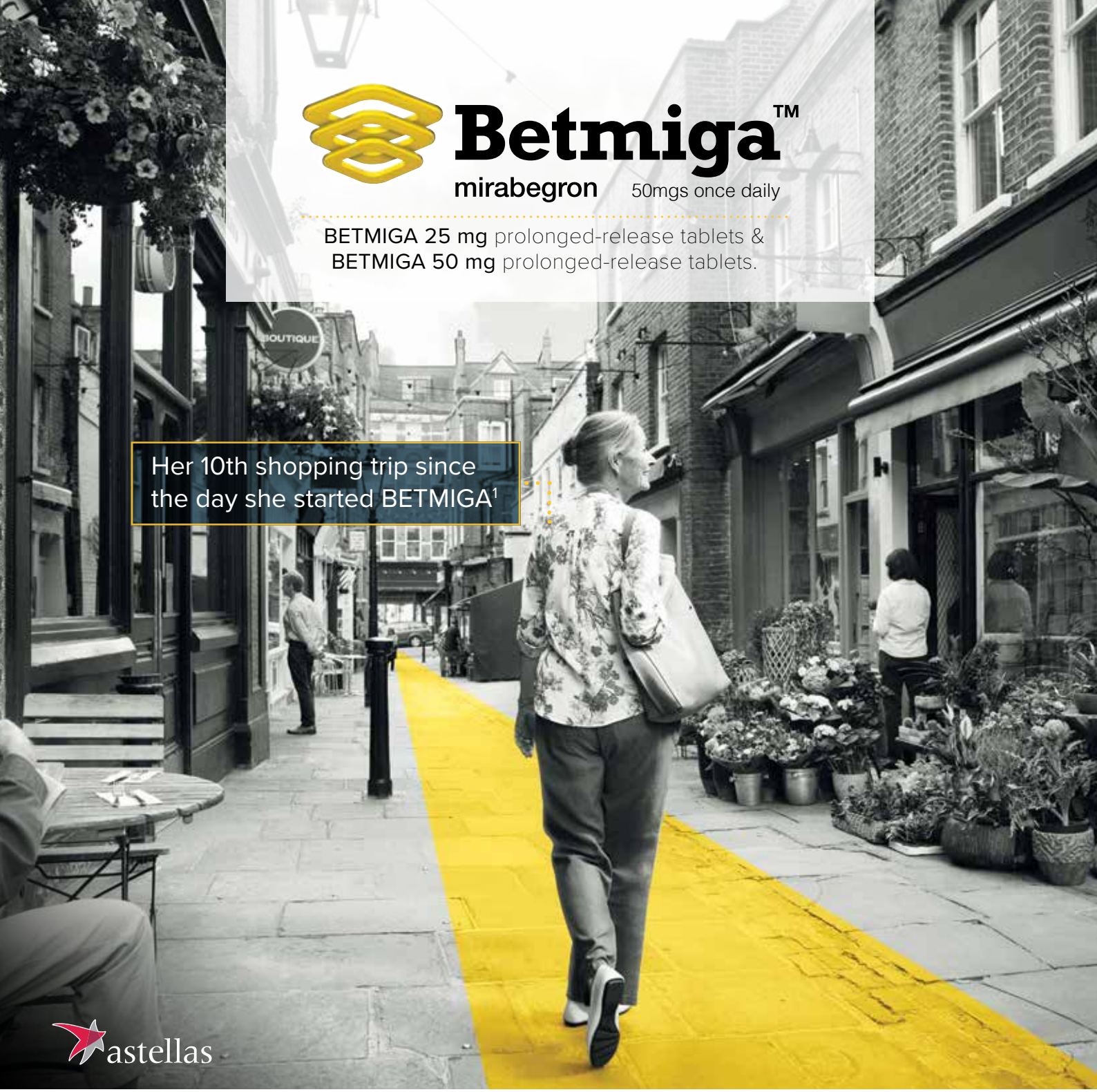


Prescribing Information: BETMIGA™ (mirabegron)
For full prescribing information, refer to the Summary of Product Characteristics (SPC). **Name:** BETMIGA 25 mg prolonged-release tablets & BETMIGA 50 mg prolonged-release tablets. **Presentation:** Prolonged-release tablets containing 25 mg or 50 mg mirabegron.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

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

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

Date of preparation: January 2023

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

MAT-IE-BET-2023-00002

New book offers support on breastfeeding multiples

BREASTFEEDING Twins and Triplets: A Guide for Professionals and Parents by Kathryn Stagg is a timely resource for both parents and all healthcare professionals who care for individuals breastfeeding multiple infants. Rates of multiple births are increasing related to increasing age of parenthood and fertility treatments.

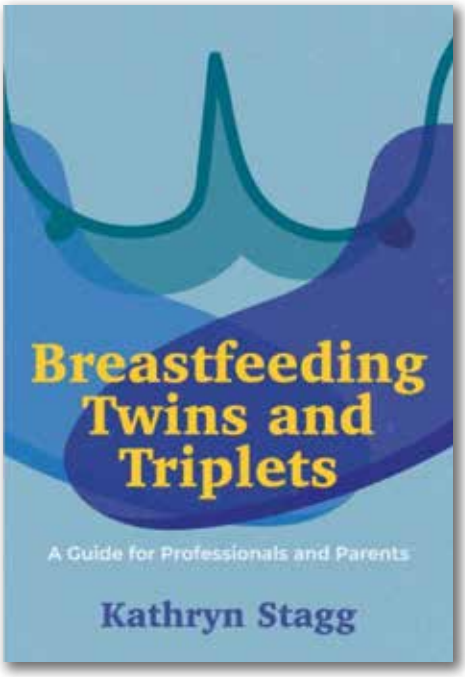
In this book, lactation expert Kathryn Stagg draws on her own experience of breastfeeding twins, as well as her extensive experience as a lactation consultant. The book is clear in its presentation, with simple language used throughout to outline tips for parents in various scenarios, while referring to up-to-date reliable evidence sources.

Each chapter also outlines personal stories and vignettes in which specific challenges are set out and what strategies are recommended to deal with them in each case. The personal stories are relatable, brief and share encouragement and positivity. Therefore parents will find this a particularly easy and useful guide to breastfeeding multiples.

This evidence-based book starts from the very beginning of the pregnancy journey, from the discovery of the multiple pregnancy, through to the various experiences of preterm and term multiples, and then moves to longer term breastfeeding journeys into toddlerhood. Attractive illustrations accompany each section to help explain concepts to parents.

Breastfeeding Twins and Triplets: A Guide for Professionals and Parents by Kathryn Stagg is published By Jessica Kingsley Publishers. ISBN 9781839970498

Review by Maeve Anne O'Connell PhD, assistant professor of midwifery at the Fatima College of Health Sciences in Abu Dhabi, UAE and associate editor of Women & Birth Journal (Journal of the Australian College of Midwives)

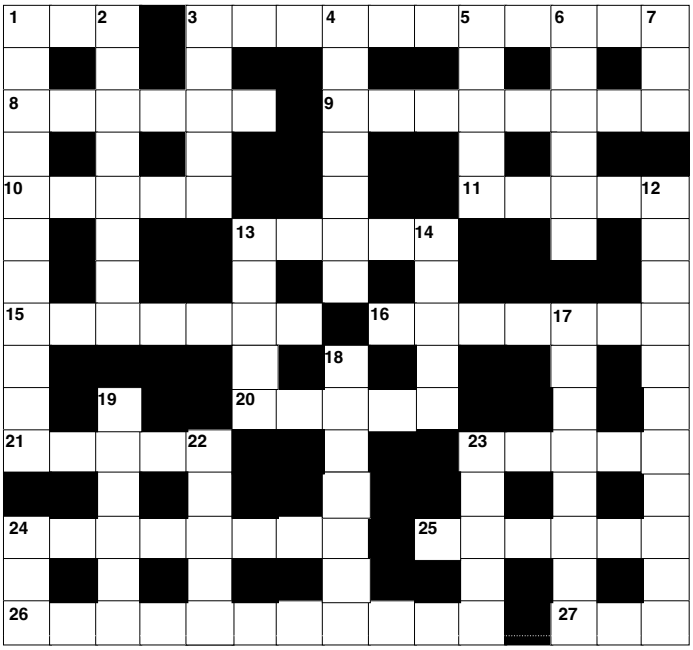


Take a break with WIN CROSSWORD Competition

WIN a €50 gift voucher

Across

1 Mongrel (3)
3 Cousins' coup broken up? That's very obvious (11)
8 Americans call it the Fall (6)
9 Dangerous hidden current in the sea (8)
10 You'll find them at the entrances to fields (5)
11 Pried, stuck one's hooter in (5)
13 Cooked in an oven (5)
15 Road travelled only by drug addicts? (7)
16 Santiago de Compostela is in this region in Northwestern Spain (7)
20 Post a message on one form of social media (5)
21 Express gratitude (5)
23 Fiery distress signal (5)
24 Spotted insect (8)
25 Streak around with one on the rink (6)
26 Organ that releases bile (4,7)
27 Assistance (3)



Down

1 Send an invoice to some bedlinen for a police document (6,5)
2 Turning a giant tor around (8)
3 Arrives (5)
4 & 5 So hygienic – like mice after a bath? (7,5)
6 Angle between 90 and 180 degrees in size (6)
7 Stitch together (3)
12 Vanished (11)
13 Explosion (5)
14 Unedited copy, or in America, conscription (5)
17 Might Ma create this delicious treat? (5,3)
18 Dwelt (7)
19 Composer of 'Messiah' (6)
22 East Mediterranean lamb dish (5)
23 The Eastern mystic sounds like an untrustworthy type (5)
24 Prisoner (3)

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 and putting *'Crossword Competition'* in the subject line. Closing date: **June 12, 2023.** If preferred you can post your entry to: WIN Crossword, MedMedia Publications, 17 Adelaide Street, Dun Laoghaire, Dublin A96E096

April crossword solution

Across: 1 Mow 3 Blaze a trail 8 Openly 9 Goodness 10 Ankle 11 Rucks 15 Iceberg lettuce 20 Owlet 21 Soave 23 Curie 24 Hairiest 25 Paella 26 Park and ride 27 Ask

Down: 1 Myocarditis 2 Wreckage 3 Bulge 4 Zigzags 5 Tudor 6 Agency 7 Las Vegas 12 Steeplejack 13 Virgo 14 Sheet 17 Umbrella 18 Clutter 19 Rapier 22 Eliza 23 Crate 24 Hip

The winner of the April crossword sponsored by MedMedia is Colette Gibbons, Westport, Co Mayo

QIDN

GRANTS FOR NURSE / CARE ASSISTANT EDUCATION

The Queen's Institute for District Nursing in Ireland (QIDN) is a registered charity (Charity Number 20003265). It aims to provide financial assistance for in-home palliative care, respite care for primary caregivers, and for medical equipment where this is not provided by our health services or where there is undue delay in accessing equipment. It also provides funding for education for nurses / care assistants who provide nursing care to children and adults with life limiting conditions.

- Nurses / Care Assistants can apply online for education grants at www.qidn.ie
- A referee will be required – usually a manager / employer – who can verify that the course in question would be beneficial in the workplace and that it is not being fully funded by the employer
- Any grant approved will only be paid on a fees refund basis – ie after the applicant has paid the fees
- Some brief information on the course content and course provider along with a copy of a receipt for fees must be uploaded with an application
- The Council of QIDN meets 4 times a year and will consider applications at these meetings. Grants are approved, or otherwise, based on the merits of each application and the funding available at the time. Council decisions are final.
- See www.qidn.ie for further information and to make an online application.

INMO Professional

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Irish Nurses and Midwives Organisation
Working Together

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For Equality
For Everyone

INMO PRIDE EVENT

Celebrating Pride in Work

Nursing, Midwifery and Healthcare

Monday, 26 June

The Richmond Education and Event Centre, Dublin

SAVE THE DATE

More information coming soon

Charity calls for increased mental health support for older people

'Older people's mental health is not talked about,' says ALONE chief

ALONE, the charity that helps people to age at home, has called for additional focus to be placed on mental health difficulties being experienced by older people. The call has come in response to a 300% increase in the past year in the number of mental health interventions carried out by the charity.

Speaking at the Joint Oireachtas Sub-Committee on Mental Health, ALONE chief executive Seán Moynihan said that in the fourth quarter of 2022, 29% of the 1,926 older people the charity assessed for their services identified issues relating to mental health, but more than half of whom had not attended a GP for support.

ALONE also cited research from The Irish Longitudinal Study on Ageing (TILDA) which found that 78% of older adults who have evidence of depression, and 85% who have evidence of anxiety, do not have a doctor's diagnosis.

"We do not give older age due consideration as a time where mental health difficulties may emerge for the first time. We don't discuss how ageing is associated with age-specific psychosocial risk factors for mental health difficulties, such as living alone, bereavement, physical illness, disability and cognitive decline," Mr Moynihan told the subcommittee.

"While many older people enjoy positive mental health, there is evidence to suggest that there is a significant mental health crisis among older people that is not being talked about," he continued.

"This has become all the more evident in the aftermath of Covid-19 restrictions. Increasingly, we are working with older people who have completely cut themselves off from their family, friends, community and life in general due to fears around Covid-19 that have not subsided."

The charity has said that specific mental health policy, evidence-based programmes and research for older people must be committed to, funded and implemented as part of 'Sharing the Vision', Ireland's national mental health policy. ALONE has also said that the action plan to combat loneliness and social isolation must be completed, funded and committed to, including funding for Irish research, and that older people must be provided with additional supports to re-engage with their communities.

Mr Moynihan said: "A Dáil debate took place in April two years ago on Covid-19, mental health and older people. Many positive ideas were discussed but not progressed. We believe that significant action on mental health difficulties being experienced by older people is overdue.

"As a country we put significant effort into telling older people to cocoon and stay inside and offering them support to do so. We have not done the same to support older people to re-engage with their communities. We need to identify and implement precision, research-backed interventions for the loneliness and social isolation that is impacting this group and all other groups affected by loneliness.

"We have quoted repeatedly the research which shows loneliness has as severe an impact on health as smoking. Why has it not received the same public health response?" Mr Moynihan asked.

UCD launches new graduate diploma programme in primary care nursing

University College Dublin (UCD), with support from the Department of Health, recently launched the Graduate Diploma in Primary Care Nursing Practice at the Kevin Barry Gallery, Charles Institute in UCD. Funded by the Sláintecare Integration Innovation Fund under Theme 4, the programme will be led by a cross-disciplinary team from the UCD School of Nursing, Midwifery and Health Systems and the UCD School of Medicine. Pictured above at the launch were (left, l-r): Rita Smith, associate dean, taught-graduate studies, School of Nursing, Midwifery and Health Systems; Prof Walter Cullen, head of general practice, UCD School of Medicine; and Kelly Moffin, deputy chief nursing officer, Department of Health; (right, l-r): Prof Cecily Kelleher, college principal, College of Health and Agricultural Sciences, UCD ; Muriel Farrell, Sláintecare Programme Management; and Georgina Bassett, deputy chief nursing officer, Department of Health

New 'symbol of support' for HSE dementia campaign

THE HSE-led 'Dementia: Understand Together' campaign launched its new community symbol recently to support people living with dementia and their families. Displaying the symbol, which is already in use by many organisations, sends an important message of support for people with dementia, according to Mary Butler, Minister for Older People and Mental Health. "This community symbol was developed with people living with dementia at its heart and it's great to see the integral work of the campaign coming to fruition."

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

May

Wednesday 3 - Friday 5
INMO Annual Delegate Conference
The Gleneagle Hotel, Killarney, Co Kerry. *Safe Staffing – Making it Happen*

Saturday 13
School Nurses Section talk on concussion. Richmond Education and Event Centre

Thursday 18
SALO meeting. Richmond Education and Event Centre and online from 12pm

Saturday 20
Midwives Section meeting. 9.30am via Zoom

Monday 22
Information clinic South/South West/South East region, 1pm-4.30pm, Education Room 2, Tipperary University Hospital

Wednesday 31
CPC Section meeting. 11am online

June

Monday 12
ANP/AMP Section meeting. Richmond Education and Event Centre and online from 11am

Tuesday 13
Third Level Student Health Nurses Section The Richmond from 10am

Saturday 17
PHN Section meeting. 10.30am via Zoom

Thursday 22
Assistant Directors Section meeting. 2pm via Zoom

Thursday 29
ED Section webinar 11am online

Condolence

- We extend our deepest sympathies to the family and friends of Meghan Mallee from Meath and formerly Australia who died in April. Meghan had previously worked in Our Lady's Hospital Navan and had recently taken up agency work ahead of her planned return to Australia. May her family find solace during this tragic time.

Clarification

- In the April issue it was stated that Cappagh Kids is part of the CHI group. This is incorrect. Cappagh Kids is supporting the CHI group.

INMO Membership Fees 2023

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

Breastfeeding: The best start

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

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

The Irish Nurses and Midwives Organisation supports breastfeeding
For more information log onto **www.breastfeeding.ie**

Nurse On Call

Nursing services and recruitment

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

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

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

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

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

CAYA Cancer Nurse Co-ordinator required – Irish Cancer Society

The Irish Cancer Society invites compassionate, person-centric nurses with experience in oncology haematology to apply for the role of Children, Adolescents and Young Adults (CAYA) Cancer Nurse Coordinator.
Send CV and cover letter to **recruitment@irishcancer.ie**
The closing date for applications is 10th May 2023
• Contract type: Permanent
• Hours: Full-time (35 hours per week)
• Location: Hybrid (Dublin office)
• Salary: €58,300
See **www.cancer.ie** for more details

Irish Cancer Society

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

Unite for safety – clean your hands!

Everyone has a role to play when it comes to boosting hand hygiene compliance. Refresh your skills with the Tork Clean Hands Training and establish a lasting culture of institutional safety within your healthcare facility.

Join Tork in celebrating World Hand Hygiene Day

Studies show that hand hygiene prevents up to 50% of infections acquired during healthcare delivery.* Fortunately, 8 out of 10 healthcare professionals would like to improve their hand hygiene compliance.** The Tork Clean Hands Training, available for free in desktop and VR, moulds professionals into hand hygiene role models to increase compliance and create safer patient environments.

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

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