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WIN

Journal of the Irish Nurses and Midwives Organisation

World of Irish Nursing & Midwifery

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94% of members reject government proposals

Cover image *pictured (l-r) on this month's WIN cover are: Karen Bugler, Ashling Smyth, Jade Gannon and Roisin Mallee*

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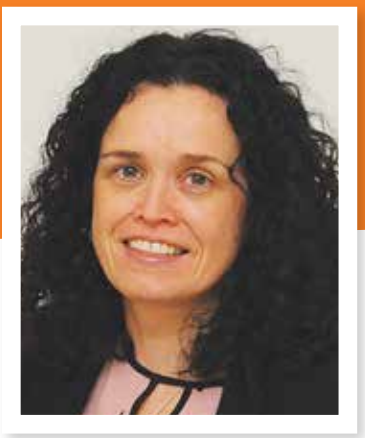
Minister – it's time to 'press ahead'



IN THIS issue of *WIN* you will see an overview of our journey to date to secure safe staffing and equal pay. Members overwhelmingly rejected the government and employer proposals. The task ahead is to address the outstanding issues.

To recap: in 2007, recruitment in nursing and midwifery was restricted by the government and the workforce has not recovered since. More than a decade on, we are providing care with 2,000 fewer whole-time equivalent nurses and midwives.

Demand for the public health service has increased significantly and activity exceeds the safety limits every day. Constant occupancy levels are well over the 83% safety threshold in acute hospitals, with 100% occupancy being normal in many of them. We've seen record levels in the INMO trolley count, meaning 2018 will see over 100,000 patients admitted to Irish hospitals for whom beds were not available. And in our community care settings, missed care and care left undone reports are routine.

The moratorium on recruitment has been lifted but its legacy remains. Despite recruiting efforts, staffing levels remain stubbornly low. The result is burnout among staff, chaotic work environments, lower job satisfaction, increased resignations and poorer care outcomes.

For decades, safe staffing levels have been determined by historical precedent, rather than by an evidence-based needs approach. The nurse and midwife staffing framework developed and published by the Department of Health in early 2018 changed all that. The framework determines correct staffing levels based on patient needs and the correct mix of nursing, midwifery and healthcare assistant staff to deliver that care. The ratio of nurses/midwives to care assistants is set at 80:20 and allows the ward CNM2 to manage the ward in a supervisory role.

This framework has been proven by research here in Ireland, taken from three pilot wards in busy acute hospitals. It showed a decrease in patient length of stay, mortality, post-op infections, hospital-acquired pneumonia, sepsis, pulmonary embolisms and DVT. Job satisfaction increased, meaning lower staff turnover, fewer injuries at work, less sick leave, and lower agency and recruitment costs.

In the foreword, the Minister for Health wrote: "Importantly the research clearly demonstrates the positive impact on both patients and nurse staffing. Given the outcomes from this research, it is now time to press ahead with the national implementation to ensure the future stabilisation of the nursing resource and continue to impact positively on patient outcomes."

Unreal, isn't it? So where is the rush to 'press ahead'? The Department of Health's own research shows that this framework will save lives, cut hospital occupancy levels, improve patient care and reduce costs, but, amazingly, funding to roll out this model in all Irish hospitals has not been provided. Instead we continue with the failed, costly and chaotic model of unplanned crisis staffing.

Nurses and midwives know the value of having enough appropriately trained staff to provide care. We know the positive outcomes that come from having the time to deliver proper care. We also know (and witness daily) the negative effects of understaffing.

The Department of Health's framework is independently evaluated and improves patient care, experience at work and value for money. We now must ensure that this framework becomes a reality and is fully funded. This must be a central point of HSE service planning for 2019. The INMO campaign for safe staffing will require a real commitment to improving nurses and midwives' pay: to populate rosters, keep our trained staff, and implement the framework.

That could be the light at the end of this dark tunnel we've had since the 2007 moratorium. It's now up to the Department of Health and HSE to 'press ahead': nurses and midwives are losing patience.

Phil Ní Sheaghdha
General Secretary, INMO

Your priorities with the president

Martina Harkin-Kelly, INMO president

Emma's courage

RETURNING from the Irish Hospital Consultants Association conference on October 7, I learned of the death of Emma Mhic Mhathúna. Emma was a courageous warrior who fought for her family in the aftermath of a catastrophic misreading of her tests. Whether it was on the *Late Late Show* or in her meeting with the Pope, Ireland was inspired by her bravery and the hope she held in her heart. I know all members join us in extending our heartfelt sympathy to her family.

Members on the move

I ATTENDED balloting meetings across the country recently, prior to our resounding 94% rejection of the government proposals. For me, going to these meetings reaffirmed two things. Firstly, we are all fed up with the recruitment and retention crisis which makes our work so much harder and secondly, that nurses and midwives are engaged, active and motivated. Together we are strong and I am proud to see us standing together.

Council of the Isles

FEMALE union reps from across the UK and Ireland met in Dublin on September 27 and 28 to discuss the issues we are collectively facing. Ann Noonan and I represented the INMO, joining 50 delegates from unions including the ASTI, CWU, Fórsa, NIPSA, Unite and the Wales TUC. We discussed Brexit, abortion, gender stereotypes and careers, pensions for women, gender pay gap legislation, and invisible disabilities. The next meeting will be held in London.

Telephone Triage Section conference

THE Telephone Triage Section met in the Richmond Centre on October 3, covering topics including emergency care, sepsis, ophthalmic conditions and Lyme disease (*see page 21*). The conference also heard from Steve Pitman on professional development and Dave Hughes on pay restoration in section 39sThese conferences are a vital part of the INMO's work and I'd like to thank Carmel Murphy, Hazel James, Geraldine Byrne and Edwina Commerford for a fantastic day.

'Raise the Roof' rally

THERE are approximately 10,000 people living homeless in Ireland, a figure that has rightly shamed the nation. The 'Raise the Roof' rally captured the angry sentiment across the country at this continuing crisis. At least 15,000 people packed the streets around Leinster House on October 3. The protest was addressed by ICTU president Sheila Noone and saw musicians such as Frances Black and Damien Dempsey express their solidarity. INMO members were out in force led by myself, Phil Ní Sheaghdha and Dave Hughes.

EFN general assembly

THE general assembly of the European Federation of Nurses was held in Bratislava, Slovakia between October 9-12. Phil Ní Sheaghdha and I attended, representing the INMO, along with EFN President Elizabeth Adams. Our 28-country talks in Bratislava focused on skill mix and workforce planning. We worked to establish a framework to highlight the best examples of national policies, aiming to learn lessons from across Europe in order to improve outcomes for nurses and patients alike. We also heard from Lord Crisp on increasing the visibility of nursing and voted in EFN elections, with Finland winning the vice presidency and the Czech Republic and Cyprus securing positions on the executive committee. The next general assembly will be held in Brussels in April 2019.

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

Quote of the month

"The most potent weapon in the hands of the oppressor is the mind of the oppressed" – Steven Biko

Report from the Executive Council

OCTOBER'S Executive meeting was focused and brisk. Despite the fact that thousands are forced to wait on trolleys, we were frustrated to note that the HSE still doesn't have a winter plan in place. This was especially galling,given that the Department of Health had just spent €16 million on rent for its new, unused offices.

The Executive Council meeting focused on the government's proposals to fix the recruitment and retention crisis. There was widespread agreement that the plan to tinker with allowances for a minority of nurses and midwives would not do the job. The plans simply do not go far enough. The Executive Council decided to ballot members, recommending a vote to reject.

And did they ever. A resounding 94% of members agreed with the Executive Council, rejecting the plans as insufficient in dealing with the crisis in our professions. I am deeply proud to see thousands of nurses and midwives standing up for our health service and speaking with one voice.

The next steps will be decided by the next Executive Council meeting on November 4 and 5. This allows the government time to enter into serious dialogue with us and avert the otherwise inevitable industrial action.

Get in touch

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An overwhelming 94% of members reject government proposals: *"These proposals would do nothing to address the short staffing and appalling working conditions they face every day"*

Nurses and midwives reject government recruitment and retention proposals

A BALLOT of INMO's membership resulted in 94% rejecting the proposals that emanated from the employers to address the recruitment and retention crisis in nursing and midwifery.

The proposals put to the Organisation in the context of Clause 3 of the Public Service Pay Stability Agreement involved an increase in some allowances and a reduction in the number of years required to become a senior staff nurse.

Government had hoped that separate proposals relating to new entrants, defined as those employed in the Public Services post 2011 when pay cuts had disadvantaged them, would have been persuasive to nurses and midwives in addition to the specific proposals on recruitment. However, in an overwhelming verdict, nurses and midwives, by a margin of 94%, rejected the proposals on the basis that they will not resolve the current and ongoing crisis that sees high reliance on agency and overseas recruitment in order to provide minimal staffing levels, which nurses and midwives say are compromising safe patient care.

Reacting to the outcome of the vote INMO general secretary Phil Ní Sheaghdha said: "It is not surprising that nurses and midwives have expressed their anger in such an overwhelming rejection of these proposals. These proposals would do nothing to address the short staffing and appalling working conditions they face every day. The clear message we have received from our members is that they feel abandoned and put upon by being forced to care for an increasing number of patients in poor and dangerous working conditions due to understaffing because of an inability to attract and retain nurses and midwives in our public health service.

Clear message: *"By a margin of 94%, members rejected the proposals on the basis that they will not resolve the current and ongoing crisis that sees high reliance on agency and overseas recruitment in order to provide minimal staffing levels, which nurses and midwives say are compromising safe patient care"* *Pictured right: Claire Kane, student nurse and Joan Salalima, staff nurse, cast their ballots*

"The HSE, this year, has failed to produce a funded workforce plan identifying the numbers of nurses/midwives it was prepared to recruit in the year 2018. There are over 1,100 vacant positions on a daily basis."

Ms Ní Sheaghdha went on to say: "Clause 3 of the Public Service Pay Agreement had provided an opportunity to fully address the clear anomaly which sees nurses and midwives as the lowest paid professional grade in the public service, without knock-on claims from others and as a response to the recruitment and retention issues manifest to all."

She pointed out that government has not spoken directly with the Organisation and said: "We now require direct dialogue with government if a dispute is to be avoided."

The INMO Executive Council is to consider the issue of industrial action when it meets on November 5.

INMO president Martina Harkin-Kelly said: "This overwhelming rejection of the proposals in respect of recruitment and retention sends a strong wake up call to government who are sleep walking into a serious industrial dispute if the recruitment and retention crisis is not taken seriously and addressed immediately."

"A once-in-a-generation chance for the future of the health service"

BY THE time she was on the road, it was already getting dark, but Marie McLaughlin *(pictured)* was on a mission. As she said: "This may be the most important decision to protect the future of the health service."

Marie is a nurse on the Inishowen peninsula. It's about two hours' drive from there to a meeting room in the Mill Park Hotel in Donegal town.

Marie, along with thousands of other nurses and midwives, had made her way to an INMO meeting to get informed and vote on the government's proposals to fix the recruitment and retention crisis.

There were well over 100 such meetings held across the country over a two-week period. Some, as in Donegal, were in packed hotel function rooms. Others were on lunch breaks between shifts in health facilities in Cavan and Cork. Or, as in a Dublin hospital, in the breakroom of the ICU, where nurses gathered at 2am on a Saturday to discuss how they'd vote.

As one member said: "I really think this is a once-in-a-generation chance for the future of the health service. We all want to work in a safe environment both for us and for patients."

Tony Fitzpatrick, INMO director of industrial relations, greets INMO member Marie McLaughlin after her two-hour drive from the Inishowen peninsula to the INMO briefing meeting and ballot in Donegal town

The INMO has campaigned for years to end the recruitment and retention crisis, which saw maternity wards understaffed, nursing posts left vacant, and a steady flow of highly trained graduates leave for fairer pay and safer conditions abroad.

This not only made the nurses and midwives' work harder but has real consequences for patient safety.

The proof is in the pudding. Hospitals across Ireland are desperate for new nurses and midwives. They pay recruiters €10,000 a head for new staff, plaster their walls in recruitment posters, yet still only have one applicant for every four positions.

The central problem in hiring and holding on to staff is pay. Nurses and midwives were getting better offers from overseas and their pay slips simply didn't match up to the commitment they put in.

Yet when asked to remedy the situation, the government proposals were piecemeal. Some staff – only a minority – would get an increase in their allowances, the equivalent of a scant few euro a week. Others would be brought into the allowances system, while staff nurses could progress three years sooner to the senior staff nurse grade than they can now.

This fell far short of what was needed to end the crisis. The INMO Executive Council and a special delegate conference asked members to vote on the government's proposals, recommending firmly that they vote against them. The question was simple: accept or reject. The answer was even simpler: a resounding 94% of members voted to reject.

The INMO's elected Executive Council will meet on November 5 to discuss what the next steps will be. If nothing has changed, the likely outcome of that meeting will be to ballot members to take industrial action.

But the ball is in the government's court. It can avoid industrial action by engaging with the union and working out a solution to the recruitment and retention crisis.

Whatever the government chooses, one thing is clear: despite their frustration, nurses and midwives are determined and united.

– Michael Pidgeon, media relations officer

INMO welcomes extra health spending

But budget fails to act on nursing/midwifery staffing crisis

THE extra investment in Ireland's public health service announced in the budget for 2019 was welcomed by the INMO. However, the Organisation questioned the inaction on the recruitment and retention crisis in nursing and midwifery.

The HSE has been unable to hire and retain sufficient nurses and midwives to run services, and have been forced to use expensive overseas recruiters and agency staff. Recruitment of overseas staff costs over €10,000 per person hired, and by July, agency nurses and midwives had already cost over €50 million in 2018.

The INMO argues that this could be avoided with an across-the-board pay rise for nurses and midwives, but no provision was made for this in this year's budget.

INMO general secretary Phil Ní Sheaghdha said: "With hundreds of admitted patients waiting on trolleys every day, the health service is unable to cope. Years of underinvestment have taken their toll, so the budget's extra funding is welcome and much needed. We will seek to meet with the HSE to ensure that its service plan provides for additional nurses and midwives.

INMO general secretary Phil Ní Sheaghdha: *"The budget's extra funding for health service is much needed… however, without a resolution to the recruitment and retention crisis, problems will continue"*

"However, without a resolution to the recruitment and retention crisis, problems in the health service will continue. The HSE simply cannot hire enough nursing and midwifery staff on the current pay levels and the exodus of Ireland's highly trained nurses and midwives will continue."

Key appointments will ensure nursing/midwifery voices are heard as Sláintecare is implemented

THE INMO welcomed the appointment of members to the new Sláintecare Implementation Advisory Council last month.

The 23-member advisory council includes people from a range of backgrounds, including two trained nurses:

- Annette Kennedy, WHO Commissioner and President of the International Council of Nurses
- Liam Doran, former general secretary of the INMO.

INMO general secretary Phil Ní Sheaghdha said: "Healthcare should be for all, based on need not on means. We have always been strong advocates for Sláintecare and welcome the appointment of this new council. Both Annette Kennedy and Liam Doran are strong advocates for patients and will bring vital nursing and midwifery perspectives to the council.

Annette Kennedy and Liam Doran appointed to Sláintecare Implementation Advisory Council

"Sláintecare is a major opportunity for patients and staff alike, which could open up nursing-led care in communities across the country.

"But for it to make a real difference, government need to dedicate serious additional investment in the health service. The budget has to reflect this. We're facing a real crisis in our health service and are struggling to provide safe levels of care. The difficulties in recruiting and retaining nurses and midwives remain. Without real reform and pay equality, the problems will only continue."

INMO president Martina Harkin-Kelly said: "Nurses and midwives are looking forward to working with the Sláintecare team to reform our health service and end the two-tier system. I wish the new council members well and encourage the government to ensure that Sláintecare gets the funding it needs to deliver a health service Ireland can be proud of."

INMO backs 'Still Waiting' health campaign

HUNDREDS of patients, health workers and people from across the country joined the 'Still Waiting' health campaign's national demonstration in Dublin on October 6, 2018. Marching from the Garden of Remembrance to the Custom House, the protesters called for implementation of Sláintecare, an increase in hospital capacity, and increased investment in health.

INMO members were one of the largest groups on the march, with nursing students speaking to RTÉ News, Virgin Media News and FM104.

INMO general secretary Phil Ní Sheaghdha addressed the crowd at the conclusion of the march. "Health is a very basic human right that every citizen of this republic should expect," she said. "We cannot achieve that while so many of our nurses and midwives are forced to leave these shores."

Separately, the Still Waiting campaign also hosted a public meeting in Kilkenny, calling for more local investment in health. Liz Curran, INMO IRO, spoke at the meeting saying that the Irish health service desperately needed additional capacity and the staffing to go with it.

Tony Fitzpatrick, INMO director of industrial relations, reports on current national IR issues

Members reminded of protocol for any transfer of tasks disputes

SINCE the implementation of the transfer and sharing of tasks between medical and nursing staff, a number of local disputes have arisen over who is the appropriate staff member (doctor or nurse) to carry out the task of first dose medication, phlebotomy or intravenous cannulation.

The final report of the National Implementation and Verification Group in relation to task transfer between medical and nursing staff in the acute hospital sector was issued in November 2017.

A key principle of the agreement is that the task is undertaken by the staff member who is most appropriate to do so at that time and in that location. The tasks (first dose medication, phlebotomy or intravenous cannulation and discharge of patients) remain the responsibility of each qualified and trained health professional and no individual or group is excluded from this responsibility.

There is an agreed protocol in place to deal with any disputes that arise over task sharing. Under this procedure:

- Where either a doctor or nurse has a concern regarding the implementation or application of any of the four tasks in an individual case or more generally, in the first instance they should raise the matter with the appropriate clinical or nursing lead on duty at the time of the event or incident
- This event or incident should be recorded by the clinical or nursing lead, who should seek to resolve the issue at that point, recording progress in relation to the matter. Every effort should be made to address the issues in a collaborative manner to provide solutions
- When efforts made locally to deal with and resolve the matter have been exhausted, and if the matter remains unresolved, it may be then referred to the director of nursing, the clinical director and the hospital manager
- In the event of ongoing issues or difficulties, the matter may be brought to the attention of the Local Implementation Group which should meet to agree a method of proceeding
- If this is not successful this matter should be referred to the hospital group director of nursing, hospital group clinical lead and hospital group CEO.
- Should difficulties continue to persist the parties to the agreement will meet at a national level to review the situation and to agree a method of dealing with the matters.

As part of the roll out of the process, local implementation groups (LIGs) were established in each site and these forums should be used to raise any concerns that arise for nurses and midwives or for any other group of staff.

In particular staffing deficits, skill mix dilution or unavailability of training would greatly inhibit any nurse or midwife's ability to carry out the task on a particular day.

If any difficulties arise over these matters, you should seek advice from your local representative or your local IRO.

INMO balloting on S39 pay restoration proposals

THE INMO attended a second day of conciliation at the WRC on October 2, 2018 with the HSE and the Department of Health regarding pay restoration in Section 39 funded organisations.

The union side was led by the Irish Congress of Trade Unions and the four unions involved were the INMO, SIPTU, Fórsa and Unite.

The proposal covers 50 pilot S39 organisations in the first instance with the aim of setting out the timeline and payment structure to provide for full pay restoration.

The process is subject to the verification and audit process outlined in the interim report in June 2018 and involves:

- Pilot organisations making a formal application with detailed payroll calculation per individual employee, supported by statutory declarations signed by their CEO and a board member
- A phase of validation together with HSE internal review on the submissions
- A review of the ability of organisations to pay within their existing resources.

It is important to note that this agreement does not change whether the organisation aligns itself, or not, to consolidated pay scales, how organisations keep pace with the pay scales or their progression once the original pay reduction has been restored. The restoration schedule is as follows:

- Management has agreed to the payment of the first phase of this restoration which is €1,000 annual increase in salary, effective from the April 30, 2019 (this is up to €1,000 provided the effect of this measure does not result in any individual attaining a salary increase that exceeds the earlier loss incurred)
- A further payment will apply from October 1, 2020 equating to 50% of outstanding restoration due
- A final payment will apply from October 1, 2021 equating to the remaining balance, which will provide for a 100% restoration from this date.

The WRC proposals also recognise that some remaining S39 organisations are likely to have pay restoration issues and the parties will commence engagement on this issue in 2019.

The INMO will now convene information sessions and balloting of the various Section 39 organisations to which these proposals apply. Local IROs will be in contact with regards to these arrangements.

Staffing crisis increasing overcrowding

'Unless pay increases, vacancies will remain' – INMO general secretary

ALMOST 8,000 admitted patients were forced to wait on trolleys and chairs in emergency departments, corridors and on wards in September 2018, according to INMO trolley/ward watch.

The analysis for September showed that 7,765 patients were treated without hospital beds, including 68 children under the age of 16. Connolly Hospital, Blanchardstown, Midlands Regional Hospital, Tullamore, and Letterkenny University Hospital all hit record highs for the month of September. The hospitals with the highest trolley figures in the country were:

- University Hospital Limerick, with 894 trolleys
- Cork University Hospital, 781
- University Hospital Galway, 609
- Letterkenny University Hospital, 502
- Midland Regional Hospital, Tullamore, 461

Speaking at the recent INMO special delegate conference, one nurse said: "I love nursing patients, I don't love nursing numbers. Every single day I'm forced to apologise for this health service. We cannot continue like this."

INMO general secretary Phil Ni Sheaghdha said: "Nearly 8,000 people on trolleys should be regarded as a national crisis but it's become business as usual in the Irish health service. Our members are telling us that they can't go on with this number of unfilled vacancies. It's not safe for patients and it's not safe for staff. The HSE simply cannot hire enough nurses and midwives on these wages. Unless pay increases, vacancies will remain open, wards will remain understaffed and things will only get worse."

INMO members have voted to reject the government's proposals aimed at addressing the recruitment and retention crisis in nursing and midwifery, viewing them as far from sufficient to address the number of vacancies across the country *(see pages 8-9)*.

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

Hospital	Sept. 2006	Sept. 2007	Sept. 2008	Sept. 2009	Sept. 2010	Sept. 2011	Sept. 2012	Sept. 2013	Sept. 2014	Sept. 2015	Sept. 2016	Sept. 2017	Sept. 2018
Beaumont Hospital	310	409	608	830	680	730	280	620	644	732	383	254	268
Connolly Hospital, Blanchardstown	211	229	226	176	297	387	317	540	485	327	172	205	294
Mater Hospital	262	366	519	443	446	368	334	187	311	371	350	373	392
Naas General Hospital	85	17	243	157	370	230	151	118	249	180	156	212	340
St Colmcille's Hospital	32	29	152	200	89	240	119	45	n/a	n/a	n/a	n/a	n/a
St James's Hospital	22	39	178	169	150	114	84	117	329	159	219	108	102
St Vincent's University Hospital	459	536	500	389	584	638	405	163	200	419	415	257	210
Tallaght Hospital	166	329	383	354	661	175	63	337	312	450	450	448	365
Eastern total	**1,547**	**1,954**	**2,809**	**2,718**	**3,277**	**2,882**	**1,753**	**2,127**	**2,530**	**2,638**	**2,145**	**1,857**	**1,971**
Bantry General Hospital	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	6	3	25	36	32
Cavan General Hospital	74	267	91	262	433	341	142	206	15	180	39	78	33
Cork University Hospital	229	235	275	437	567	529	146	304	326	477	441	628	781
Letterkenny General Hospital	281	34	16	33	49	25	28	176	130	158	263	459	502
Louth County Hospital	19	n/a	n/a	24	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Mayo University Hospital	202	72	28	114	147	45	145	57	64	118	206	132	114
Mercy University Hospital, Cork	107	71	113	90	195	185	149	134	240	142	220	215	137
Mid Western Regional Hospital, Ennis	22	4	18	31	116	275	186	146	255	453	380	383	353
Midland Regional Hospital, Mullingar	38	24	6	n/a	24	254	25	79	44	147	216	222	178
Midland Regional Hospital, Portlaoise	n/a	2	8	4	56	113	96	13	508	302	411	445	461
Midland Regional Hospital, Tullamore	43	9	17	23	10	3	12	n/a	n/a	14	16	8	24
Monaghan General Hospital	6	2	22	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Nenagh General Hospital	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	2	4	2
Our Lady of Lourdes Hospital, Drogheda	349	116	302	323	331	842	626	214	593	606	507	134	134
Our Lady's Hospital, Navan	40	47	72	169	7	75	8	57	26	33	49	243	57
Portiuncula Hospital	21	9	n/a	105	33	149	26	36	49	36	98	94	114
Roscommon County Hospital	50	60	80	50	113	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Sligo University Hospital	79	56	8	55	168	153	102	45	200	210	51	323	247
South Tipperary General Hospital	34	92	10	64	13	125	123	224	97	107	350	396	365
St Luke's Hospital, Kilkenny	n/a	n/a	n/a	n/a	34	47	35	209	128	278	188	229	78
University Hospital Galway	126	209	380	321	356	642	271	282	446	514	499	598	609
University Hospital Kerry	129	46	11	16	73	68	59	51	91	138	133	114	282
University Hospital Limerick	139	166	72	201	502	384	279	345	551	784	825	902	894
University Hospital Waterford	n/a	n/a	63	46	164	59	136	152	68	257	333	505	259
Wexford General Hospital	189	19	42	178	336	490	53	73	144	35	154	96	138
Country total	**2,177**	**1,540**	**1,634**	**2,546**	**3,727**	**4,804**	**2,647**	**2,803**	**3,981**	**4,992**	**5,406**	**6,244**	**5,794**
NATIONAL TOTAL	**3,724**	**3,494**	**4,443**	**5,264**	**7,004**	**7,686**	**4,400**	**4,930**	**6,511**	**7,630**	**7,551**	**8,101**	**7,765**

Comparison with total figure only: Decrease between 2017 and 2018: - 4%
Increase between 2016 and 2018: 3%
Increase between 2015 and 2018: 2%
Increase between 2014 and 2018: 19%
Increase between 2013 and 2018: 58%
Increase between 2012 and 2018: 76%
Increase between 2011 and 2018: 1%
Increase between 2010 and 2018: 11%
Increase between 2009 and 2018: 48%
Increase between 2008 and 2018: 75%
Increase between 2007 and 2018: 122%
Increase between 2006 and 2018: 109%

World news

Nurses and midwives in action around the world

Australia
- South Australia nurses defend industrial action
- Nurses mark 100 days of industrial action
- Lobbying for legislation change to help 'exhausted' nurses

Brazil
- Brazilian Nursing Association manifests itself in electoral politics

Canada
- Staff, not studies, needed to fix gaps in long-term care, says nurses union
- Thunder Bay health unit, nurses, to go to mediation as threat of work stoppage looms

New Zealand
- Migrant nurses shouldn't be channelled only into aged care

Paraguay
- Nurses announce national mobilisation

Philippines
- Health union denounces harassment of members

Spain
- Flexible work day allows an end to the 'overlap' in nursing

UK
- NHS hospitals warn of lack of preparation for winter as figures reveal next year will be 'tougher than ever'
- Charge for migrants to use NHS to double to £400, government announces

United States
- Hospitals in path of Hurricane Michael forced to evacuate
- UC nurses to finalise contract with 15% pay raise
- Nurses hold town hall meetings to address alleged staff shortage

Cashel nurses step up their 'work to rule' protest

NURSES in the rehabilitation unit in St Patrick's Hospital, Cashel, stepped up their industrial action last month in protest against chronic understaffing.

INMO members began a more extensive 'work to rule' protest early last month and have been focusing solely on patient care since and refuse to perform 12 other tasks, including:
- Clerical duties
- Attend staff meetings
- Answer phones
- Attend non-mandatory training
- Admit patients in the morning without safe staffing levels.

INMO IRO Liz Curran: *"There are simply too few staff to care for our patients in the way we were trained to do so"*

This followed the more limited 'work to rule' protest the previous month which saw nurses refuse to do four tasks. The earlier protest was suspended to allow for talks with the HSE and management at the Workplace Relations Commission, but the engagement did not lead to agreement to fix the understaffing problem.

INMO IRO Liz Curran, said: "We just want to care for our patients in the way we were trained to do. There are simply too few staff to do that and patients are suffering as a result. The Cashel nurses have been enormously patient but are totally frustrated. They have made very modest requests on behalf of patients and the HSE has not made sufficient progress."

INMO joins housing protest

MORE than 12,000 people thronged the streets around Leinster House, Dublin at the Raise the Roof Rally in protest at the ongoing and escalating housing crisis on October 3, 2018.

The national protest had been called by the National Homeless and Housing Coalition to coincide with debates in the Dáil on legislation to end evictions and enshrine a right to housing.

The INMO was well represented, with nurses, midwives, students, Executive Council members and union staff joining fellow citizens from all sectors of society in protest.

Those gathered heard from several speakers including: housing campaigner Fr Peter McVerry; construction worker Keith Troy; Irish Congress of Trade Unions president Sheila Nunan; director of the Irish Traveller Movement Bernard Joyce; and renowned Irish singer Damien Dempsey.

INMO representatives at the protest included (l-r): Michael Pidgeon, media relations officer; Freda Hughes, media department; Damien O'Connor, accounts; Martina Dunne, PA; Angela Clarke, head of accounts; Neal Donohue, student and new graduate officer; Martina Harkin-Kelly, INMO president; Steve Pitman, head of education and professional development; Beibhinn Dunne, media department; and Phil Ní Sheaghdha, general secretary

The cervical cancer debacle has demonstrated yet again the high price paid in this country for suppressing information that should rightly be public knowledge, writes **Dave Hughes**

When words are not enough

THE news of the passing of Emma Mhic Mhathúna sent shock waves across the country and, although she had disclosed her terminal illness in one of the most compelling and grief filled *Morning Ireland* interviews ever only months previously, the speed at which the cervical cancer took her surprised most.

Emma leaves behind her five broken-hearted children for whom she did her very best in the time she had left by securing funding for their future, which inevitably will be difficult and for which the resources will be needed. The sympathy of Irish nurses and midwives throughout the land goes to her family and friends. There are simply no words that can offer adequate consolation for the loss of such a young and vibrant life and a woman who we all came to know in the final months of her life.

Emma came to prominence following revelations from Vicky Phelan, the woman who exposed the fact that errors made in the cervical screening programme had led to late diagnosis and potentially fatal consequences for herself and many other women. As the story unfolded the numbers impacted have grown and the issues of who knew what and when became controversial and intensely political.

While the errors made were the root of the issue, the failure to notify the women impacted by those errors and the delays in follow up treatment, as a consequence, led to calls for a public inquiry about the role played by different state agencies and private laboratories in the issue. The Scally Report into the controversy was overtly critical of the HSE and some senior consultants for the manner in which they ultimately advised the affected women.

The key issue emerging from these tragic events is the individual's right to know, at the earliest possible time, of any diagnosis relating to their health. Where information is withheld or delayed there is devastating impact on lives and families. For victims, the fear is that all that could have been done in their interests was not.

For nurses and midwives, these very sad stories reaffirm the essential advocacy role held in respect of their patient or client group. Nurses and midwives using their expertise must always have the confidence and freedom to speak on behalf of patients where they consider a wrong has occurred or through error or omission, care has been missed. When systems evolve which suppress such free advocacy, the ultimate consequences reflect on all.

Unfortunately, large organisations both public and private often develop a clandestine culture cloaked with secrecy. When it occurs in a public service its impact is often on the most vulnerable who need state support whether in healthcare, justice, education or other areas, and its consequences are severe and even possibly a matter of life or death.

Questioning the system can be met with a defensiveness and a complete lack of candour, if not denial or cover-up. Yet no written policy can be found in any organisation to openly promote such lack of candour, denial or cover-up. It is, therefore, a matter of culture and learned behaviour. The words spoken at the very top of an organisation can subconsciously promote such unnecessary secrecy and defensiveness.

Comparing the health service and its employees with employees of commercial companies and suggesting that health service employees who speak out about failures in their service lack the loyalty shown by employees in companies sends a covert signal to all employees that confuses concepts of confidentiality with secrecy and promotes protectionism for the organisation over the interests of the client.

For example, criticising the INMO's vigilance in counting admitted patients waiting on trolleys and chairs, or senior figures in the health service saying that employees of Coca-Cola don't run down their employer publicly, sends a not too subtle message to the workforce about what is acceptable.

In the same way as 'insurance' is used as the great blocker when you cannot find any other reason to say no, policies on confidentiality become the catch-all for unnecessary secrecy and the withholding of legitimate information from people about their own affairs.

We are learning a painful lesson in this country of the high price paid by suppressing information that should rightly be public knowledge. From Church scandals to the multiple tribunals on planning, banking and the Gardaí, we see the havoc wreaked on society by acceptance of cultures of secrecy, lack of candour and openness.

The clock can never be turned back in life and often the only remedy for the injured party is compensation. For the unfortunate victims of the cervical smear test controversy, no compensation will ever restore their health or their life, and they are permanently left wondering how it might have been had they been informed earlier.

28 nations represented at EFN GA

106th EFN general assembly examines social rights and skill mix

REPRESENTATIVES of the EU's three million nurses met in Bratislava, Slovakia in October, as part of the European Federation of Nurses Associations' (EFN) 108th general assembly.

Some 28 countries were represented at the talks, which examined workforce planning and skill mix and how the European Pillar of Social Rights could be applied to healthcare.

The event also heard from Lord Nigel Crisp, co-chair of Nursing Now, the campaign group which is working to raise the global profile of nursing.

INMO president Martina Harkin-Kelly and INMO general secretary Phil Ní Sheaghdha represented Ireland at the assembly.

EFN general assembly , Slovakia, 2018
Nurses from 28 European countries gathered in Slovakia to discuss workforce planning and skill mix as well as examining how the European Pillar Social Rights could be applied to healthcare

Colourful night at the International Section's biannual Culturefest event

Region Two Igorot dancers (l-r): Margie Ringor, Lynne Roma, Charmaine Espino, Coralee Espino and Jovie Calucag

Left: The Sanlahi dance crew (l-r): Ruby Jane Andrade, Allan De Fiesta, Maria Jebulan and Jirah Busal Gallener
Right (l-r): Marie Santiago, Nada de la Rosa, Allan De Fiesta, Coralee Espino, Philma Tobin, Willyboy De Fiesta, Lynne Roma, Lily De Fiesta and MJ Murphy

THE International Nurses and Midwives Section held its biannual Culturefest at the Richmond Education and Event Centre last month.

More than 60 people, some as young as five years old, were in attendance for an enjoyable evening.

A special thank you goes to the Section's chairperson Elizabeth Allauigan for organising this event.

The Section would also like to thank the sponsors for the night: Dr Danny Collins, consultant anaesthetist at St James's Hospital ICU, Angie Norton, owner of Makati Restaurant, Olivia Geordie and Amy Cubos.

It was a colourful event that featured the Region Two group performing the traditional dance of the Igorot, the collective name for several Australasian ethnic groups which live in the mountains of Luzon, northern Philippines.

The Sanlahi dance crew, led by Allan de Fiesta, performed a contemporary dance routine that filled the room with a unique atmosphere.

One of the highlights of the evening was the parade of ethnic costumes which were elegantly modelled by nurses and visitors from other Filipino communities.

The evening concluded with delicious food and networking in the elegant surroundings of the Richmond's tea room.

Richmond plays host to successful conference for Telephone Triage Section

THE first of the National Section's network conferences took place in early October at the Richmond Education and Event Centre when telephone triage nurses gathered for their national conference. Almost 50 members were in attendance at the conference. The topics were excellent, and everyone reported that they thoroughly enjoyed the surroundings.

Those in attendance heard updates on sepsis, air ambulance service, ophthalmics, systems review, Lyme disease, pay restoration and section 39 organisations. The committee was delighted to be in a position to deliver on all the topics requested by members ahead of the conference.

Evaluations of the day will, as always, be reviewed and feedback will be given at the next meeting, which will be the Section's AGM, taking place on Wednesday, January 23, 2019 at the Midland Park Hotel, Portlaoise. We hope to see you all there.

Busy agenda set for Retired Section's September meeting

MORE than 50 members of the Retired Nurses Section met at the Richmond Education and Event Centre for its September meeting.

A number of topics were discussed, including the nomination of delegates to attend the special delegate conference in relation to the Public Sector Pay Commission proposals, and an update on the social committee's diary, which included a three-night autumn break in Mayo.

The highlight of the meeting was guest speaker Sinead Ryan, who spoke on 'financial fitness after 50.' Sinead is an independent financial consultant who writes regularly for the *Irish Independent,* and also appears frequently on a number of TV shows. Members who attended benefited greatly from her advice.

The Section will meet next for the AGM on Thursday, January 24, 2019 at INMO HQ.

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

Nursing/midwifery salary scales as at October 1, 2018

Student nurse/midwife/intellectual disability	14,243 (degree students 36 weeks rostered placement)											
Staff nurse/midwife (Post qualification, Pre-Registration)	24,850											
Staff nurse/midwife	29,056	31,110	32,171	33,367	34,876	36,383	37,883	39,180	40,480	41,775	43,070	44,343
LSI after three years on max												45,701
Senior staff nurse/midwife	47,898								*Applies to nurses in possession of two of the five nursing qualifications where you must have held the qualification or are in training for the second qualification on October 1 1996.			
Dual qualified nurse* (registered in any two of the 5 disciplines)	35,806	38,062	39,265	40,191	41,212	42,570	43,893	45,841				
LSI after three years on max								47,201				
Senior dual qualified nurse	49,471											
Clinical nurse/midwife manager 1	45,179	46,006	47,174	48,361	49,530	50,707	52,018	53,240				
Clinical nurse/midwife manager 2/ specialist	49,056	49,868	50,555	51,677	52,917	54,134	55,351	56,721	57,995			
(plus allowance of €801 pa payable on a red-circle basis to theatre/night sisters who were in posts on 5/11/'99)												
Clinical instructor	51,185	52,013	52,626	53,764	54,911	56,148	57,393	58,636	59,876			
Clinical nurse/midwife manager 3	56,448	57,565	60,389	61,499	62,616	63,747						
Nurse tutor	57,736	58,521	59,302	60,087	60,870	61,656	62,436	63,223	64,007	64,790		
Principal nurse tutor	60,552	61,694	62,737	65,997	67,136	67,179	68,484	70,233				
Student public health nurse	33,157											
Public health nurse	47,799	48,591	49,268	50,334	51,560	52,748	53,944	55,288	56,540			
(plus allowance of €1601 pa payable on a red-circle basis to staff who were in posts on 5/11/'99)												
Asst dir of public health nursing	56,452	59,553	60,828	62,002	63,188	64,812						
Director of public health nursing	74,111	76,358	78,611	80,959	83,115	85,368						
Advanced nurse practitioner	56,993	58,097	59,162	62,431	63,460	64,656	65,773	66,884	70,237			
Asst dir of nursing band 1	56,993	58,097	59,162	62,431	63,460	64,656	65,773	66,884	70,237			
Asst dir of nursing non band 1 hospitals	54,125	55,279	56,452	59,553	60,828	62,002	63,188	64,811				
Director of nursing band 1	75,597	77,698	79,803	81,901	84,001	86,109	88,208					
Director of nursing band 2	70,326	72,234	74,147	76,053	77,970	79,880	81,792					
Director of nursing band 2a	69,784	70,983	72,187	73,385	74,588	75,786	76,987					
Director of nursing band 3	65,952	66,369	67,783	69,185	70,581	71,988	73,385					
Director of nursing band 4	61,624	63,489	65,347	67,214	68,029	69,838	71,644					
Director of nursing band 5	57,649	58,897	60,144	61,388	62,633	63,885	65,132					
Area director – nursing and midwifery planning dev unit	**79,520**	**81,897**	**84,250**	**86,267**	**88,516**	**90,812**	**93074**					
Director – nursing and midwifery planning dev unit	72,448	74,404	76,560	78,929	81,525	84,191						
Director centre of nurse education	66,286	67,318	69,327	71,337	73,346	75,356	77,364	79,459				
Hospital group director of nursing and midwifery	98,145	102,507	106,869	111,229	115,592	117,485						

Up for the challenge

David Miskell, newly appointed IRO for the northeast, is no stranger to the issue of short staffing. Interview by **Tara Horan**

DEALING with short staffing is far from a new experience for David Miskell, the INMO's newly appointed industrial relations officer for the northeast region. Indeed, the issue of short staffing and overcrowding is David's abiding memory of his three years RGN training in Tallaght Hospital, which he began in the wake of the nurses' dispute of 1999.

An activist from his early days, David was the INMO rep for his class for the three years of training. "While we were very focused on the student matters at that time – placements, allowances and so on – the other issues that stand out from then are unfortunately very similar to today – short staffing and the lack of pay parity," he said.

"I'm finding a lot of the issues today are mainly down to staffing and the implications of working in an environment that is constantly short staffed and overcrowded," David said. "The fall-out from this is pressure and stress – trying to work in such an environment can be particularly challenging."

The recent lunchtime protest held by INMO members outside Cavan General Hospital served to highlight the ongoing unsafe staffing levels and overcrowding there. "The national position on staffing is widely known, but it is important that messages go out locally as well. What is actually going on in their local hospital is very important to people," he said.

"There's no better place to see or feel it than in any of the locations – be it acute services, public and community health, care of the elderly, ID. While there are many challenges, most of them emanate from the lack of staffing, lack of resources and difficult working environments.

"There is a strong sense that the way in which nurses and midwives' pay is positioned is unfair. People understand the logic that you will not be able to recruit nurses and midwives unless the remuneration package is adjusted accordingly. We are only looking for parity and I got a strong feeling from our recent meetings that members are very much prepared to pursue the issue."

The fight for parity is also very familiar to David from his training days. "As the last cohort of diploma in nursing students, it was a bone of contention with us coming into contact with students from the other therapeutic grades – obviously we knew that we were paid less at the end game and we worked longer hours as well."

It was perhaps such inequalities that piqued David's interest in industrial relations to such an extent that, when he finished his nurse training, he decided to study law in Galway. Throughout his three years there, David kept up his registration, working as an agency nurse while studying.

Having gained his law degree from NUIG, David took up a temporary position in the INMO Information Office in 2007. He found this invaluable in becoming familiar with day to day entitlements of nurses and midwives and in advising people on various issues and procedures.

He then worked with the Mandate union, supporting retail and admin workers for nine years, before moving to the Irish Medical Organisation, where he worked as a senior industrial relations officer dealing with general practice and public and community health doctors. He received an MA in industrial relations from UCD's Smurfit Business School during this time.

However, he was always interested in coming back to the INMO and seized the opportunity when the IRO position came up in the northeast. He has been appointed to provide workplace support and advice to members throughout Cavan, Louth, Meath and Monaghan, including Our Lady of Lourdes Hospital, Drogheda and Cavan General Hospital. This area was previously covered by Tony Fitzpatrick, before he was appointed director of industrial relations, and by Noel Treanor in the interim.

As well as the issues of overcrowding and short staffing that are unfortunately common features to all regions, David is finding incorrect grading of posts a particular area of concern in the northeast.

"I don't know how extensive this is across the country but it certainly seems to be a feature in the northeast region. People are working at a particular level but are being paid below that level and at the moment there is a lack of a process to deal with that from the HSE. The HSE's approach to this can be challenging. For example, management might apply particular guidelines around regularisation and regrading on one level but then fail to follow that."

David paid tribute to the INMO reps in the area who have been invaluable in helping him get to grips with the issues in the region, giving him pointers and filling him in on the background of their own particular environments. He hopes to run a rep training course in the region in the near future and would like to encourage more people to get involved in the Organisation.

"This is a really important time for nursing and midwifery. I'm looking forward to supporting members in winning the respect and pay our professions deserve," said David.

Data doesn't lie

CNM2 Mary Heffernan believes that the Framework for Safe Nurse Staffing and Skill Mix is an unqualified success. **Alison Moore** reports

"I KNOW when the ward is busy. I don't need data to tell me this."

This was the initial reaction of Mary Heffernan, a CNM2 from Beaumont Hospital, on hearing her ward was going to be a pilot site for the Framework for Safe Nurse Staffing and Skill Mix. It was news she did not welcome at first, but she very soon changed her position when she experienced it in action.

Ms Heffernan was speaking at the INMO's recent symposium on safe nurse staffing.

Richmond Ward, where Ms Heffernan works, was selected as a pilot site for the Framework in 2016. She explained that it is an "extremely busy" 24-bed neurosurgical ward with 97% bed occupancy; with 60% of admissions to the ward being emergency and 40% elective. Being such a busy environment, Ms Heffernan told the symposium that she was not overly enthusiastic about implementing the framework at first.

"When I was told that we would be one of the pilot wards it wasn't news I welcomed. My initial concerns were: Where would we get the time to input the data? Would the data input be a complicated process? And how could this project be sold to nurses who were already stretched? It was a frequent occurrence for us to be short staffed."

Her concerns were allayed when she subsequently met with Karen Green, Beaumont's director of nursing, Dr Philipa Ryan Withero, the deputy chief nursing officer at the Department of Health, and Sinead Lardner, the project officer from the Department of Health.

"When I was informed of the type of data we would be collecting the project was music to my ears," she said.

To illustrate, Ms Heffernan offered four examples of the data to be collected.

- The nursing hours per patient day, patient acuity and dependency
- The time spent by nursing staff attending education
- The time spent by staff bringing patients to MRI/x-ray, etc, giving the ability to capture the length of time the nurse is off the ward and the hours that the nurse is not available to attend to her allocated patients ("a too familiar occurrence leading to many hours not accounted for prior to this project")
- The time spent by staff attending to the patients who have returned to the ward for wound dressings or time answering questions on the phone from discharged patients.

Getting staff on board

Ms Heffernan told the symposium that education was pivotal in getting the staff on board.

"As for me, it was the same for the staff – education, education, education. All of the staff were fully educated prior to the project commencement on Richmond Ward as it is very important that the data is input correctly."

She explained that this involved staff coming in on their days off (time was given back at a later stage). In order to achieve maximum accuracy, the staff were assessed inputting the data by Aisling McCall, the safe nurse staffing co-ordinator, or by Ms Heffernan herself.

She told the symposium that from the outset the staff were aware of the importance of correct data collection to determine the correct staffing and skill mix for Richmond Ward, and within a short time of collecting the data they received a dividend.

"We were informed by the Task Force that we would be receiving a staff uplift, an increase in our staff nurse to HCA complement. This was a direct result and a clear example of how this project has been an advantage to the patients and staff on Richmond Ward."

Ms Heffernan explained how the data collection worked in practice on a daily basis.

"Once the data collection commenced, it was either my responsibility or that of the nurse in charge to remind the staff each day to do their predictions or actualisation for their patients.

"It was apparent to me, as the owner of the project for the Richmond Ward, that there was a necessity to check the previous day's data each morning to ensure 100% completion. If this is not done the safe nurse staffing co-ordinator will contact the ward to inform us of incomplete data. Having the co-ordinator is vital for the success of the project," she said.

In the early stages of the project implementation, Ms Heffernan explained that when any teething problems arose, they had to ring TrendCare (the company behind the workforce planning and workload management system) in the UK for technical support, but now Ms McCall corrects any problems that occur.

Ms Heffernan highlighted the degree to which all staff had embraced the project; when she was on holidays earlier in the year she came back to find that 100% of data had been input.

Benefits to the ward

Outlining the benefits to Richmond Ward, Ms Heffernan said that first and foremost, the CNM2 role was "100% supervisory". Further to this, the ward received a staff uplift of 4.5 staff nurses and 4.5 HCAs.

"We now have two HCAs on duty each day. Prior to the project we had one, and we now have one HCA on night duty when prior to the project we didn't have any.

"So if a patient requires one to one specialising, we have the staff to accommodate this. We now have the ability to have a nurse in charge in the evenings who does not have allocated patients. This was not the situation before," she said.

Significantly, according to Ms Heffernan, there has been no agency spend since the project commencement.

"Of course, we have had unexpected

staff absence, but our staff are more flexible now and will change shifts to accommodate needs," she added.

Since the increase in staff numbers, the ward's bi-monthly nurse metric results have been consistently above 95%.

There has also been more time for staff education and professional development.

"I am able to allocate time to staff to do their online mandatory training to attend study days, etc. Before the project was introduced to the ward, staff would do this on their time off and get the hours back at a later time."

The research findings by Prof Jonathan Drennan, from the School of Nursing and Midwifery at UCC, shows better patient outcomes as outlined in *Evaluation of the Pilot Implementation of the Framework for Safe Nurse Staffing and Skill Mix* report, which was published in April 2018.

"I think this is due to the increase in our staff numbers. With more nurses at the bedside, patient deterioration is picked up quicker," said Ms Heffernan.

Furthermore, the report found that staff job satisfaction had increased from 71.4% to 84.6%.

Evidence base

Having an evidence base that reflects your needs has made a significant difference, Ms Heffernan added.

"We are all using the same language now. In times gone by you rang your nurse manager for help in times of increased activity or increased a patient dependency only to be told that you have to correct your staff complement.

"Now we ring with the data, which reflects our request. The system is so finely tuned that once the data has been input, you ring management stating the nursing hours you are short and it cannot be ignored. The data has been imported and facts are facts.

"At the press of a button you can see if you are over or under nursing hours on the shift," she said.

Challenges

Ms Heffernan stressed that even though Richmond Ward has had a staff uplift as a result of the project, many senior nurses have left for promotional posts or retirement.

"We are left with a very junior workforce. Staff in the past year have been recruited to the Richmond from Italy, Spain, Portugal, Croatia, Philippines and India. So we have a very diverse nursing team, with different training and experience," she said.

As a result of this, focus has been put on building up the nursing team and educating staff to take on their nursing roles and give safe quality care.

"We realised that the junior staff needed to enhance their knowledge. A decision was taken by Sharon Tracy, the neurocentre directorate nurse manager, to put one of our senior nurses in the role of practice support on the ward for six months. We hope to see the positive benefits to the staff of this change in due course."

Success

Challenges aside, there was no escaping Ms Heffernan's enthusiasm for the safe staffing framework.

"I have been involved in this project since June 2016. And I am delighted to be able to say that is an extremely beneficial project for nursing. Personally, I think it is a project to be embraced. I hope that all the data received will be acted upon and that and that the future for our patients is that they will receive safe, good quality care, and that all staff will work in an environment with the correct number of staff and the correct skill mix, receiving the necessary education and training to deliver save care.

"The IT system we are using to input the data is so user friendly. I am a dinosaur when it comes to it, and I can manage it no problem."

Using the metrics and feedback loops in the system, Ms Heffernan underlined the gains that had been achieved under the framework.

- There has been an increase in nurse metric results >95%
- There was an increase in staff numbers (4.5 staff nurses and 4.5 HCAs)
- There has been an increase in staff satisfaction (71.4% to 84.6%)
- Improved overseas staff integration
- No agency spend.

"The overall conclusion is that this project has been an unqualified success for the Richmond Ward.

"So let's all together embrace this project. This change is to ensure positive patient experience and outcomes and to have the correct number of staff and correct skill mix to achieve this, today and into the future," she concluded.

Mary Heffernan

Mary Heffernan is a registered nurse and clinical nurse manager 2 on Richmond Ward at Beaumont Hospital in Dublin. Recently, as part of Beaumont Hospital Foundation's 'Honour your hero' initiative the RTE broadcaster Ronan Collins thanked Mary for her care following a recent illness. He said, "Mary was a rock throughout my time on the ward and I remember the kind way in which she dealt with me and her staff on the ward. It was a frustrating time trying to get my mobility back to normal and Mary was an enormous help and offered great encouragement to me". Mary has also appeared on TV3's *The Morning Show*

Q and A Bulletin Board

With INMO director of industrial relations Tony Fitzpatrick

Query from member

I have been placed on the critical illness protocol by my employer and have been out of work for five months with my illness. I am now back at work. If I have used up five months of paid sick leave under the critical illness protocol, what happens if I am absent from work again with a non-critical illness? Will I be paid sick pay under the normal sick leave scheme or under the critical illness protocol?

Reply

The critical illness protocol was revised and within the 12-month period from the date of return to work after you suffered with a critical illness/injury you can continue to access the extended sick pay limits normally given for critical illness/injury only. This applies even where you are not critically ill provided that you have previously been absent because of a critical illness/injury and you suffer from a non-critical illness/injury during the 12-months following the first day of the return to work following a critical illness/injury.

Query from member

As a newly qualified nurse working in the public health service, I have been offered a permanent post and would like to know what point of the staff nurse scale I will be placed on?

Reply

You will be placed on the first point of the staff nurse scale for 16 weeks and then in recognition of your 36-week clinical placement you will move to the second point.

Applying for a private hearing

Edward Mathews discusses the process and precedents involved when applying for a fitness to practise hearing to be held in private

IN THIS article in our ongoing series considering the fitness to practise (FTP) process, we will examine how the FTP Committee approaches applications for hearings, or a part of a hearing, to be in private or to have a name anonymised.

A fitness to practise complaint is a source of great worry. When it moves to a full hearing, naturally there is attendant fear and anxiety about the process and the future. With the advent of public hearings the stress experienced by nurses and midwives has escalated. I say this not to frighten, but in reality the nurses and midwives we are helping every day are extremely concerned about the ventilation of allegations in a public forum, and the reporting of the proceedings in the media.

Notwithstanding our concerns regarding whether or not it is advisable for hearings to take place in public, the legislature through the Nurses and Midwives Act 2011, has made it clear that hearings should presumptively take place in public, and indeed this is now the position with nearly all regulated professions.

Applying for a hearing in private

The Act provides that a hearing before the Committee will be in public unless the registrant or a witness makes an application for the entire hearing, or part of the hearing, to be held in private. For the purposes of clarity, a hearing held in private also includes anonymisation of a person's name. A witness may make such an application if they are required to give evidence, or alternatively where sensitive information regarding them will be dealt with during the hearing, even if they will not give evidence personally.

Simply making an application is not a sufficient basis for a hearing to be held in private. The Committee must be satisfied that the person applying for the hearing, or part thereof, to be heard in private, has shown reasonable and sufficient cause, and that the committee believes that a hearing in public would not be appropriate in the circumstances.

When to apply

The opportunity to make such an applications arises at what are called 'call over hearings'. These are regular procedural hearings of the FTP Committee, where the committee sits and hear preliminary applications on a wide range of matters such as compelling witnesses to attend, seeking production of documentation and applications relating to privacy or anonymisation.

Shortly after the complaint is referred for a full hearing, bearing in mind it can take a considerable amount to time to prepare a case, the registrant and their representative will be invited to attend a call over hearing and make any applications they wish.

It is important that applications for privacy or anonymisation are not made too early as the registrant will not have the notice of inquiry, which will specify the nature of the allegations and the witnesses to be called, nor will they be in possession of the documents the CEO intends to rely on in presenting the case against the registrant. These materials are essential as the witnesses to be called, the material they will give evidence on and the documents to be considered can have a significant impact on whether an application for privacy or anonymisation will be granted.

Precedent

There have been no cases in the superior courts dealing specifically with this issue, so there is a limited amount of guidance from available case law. The FTP Committee has only been dealing with such matters since 2014, which is a relatively short period of time, only allowing limited predictions of how a given Committee will approach a case.

In these circumstances, one would normally have regard to the law governing, or procedures of, other statutory regulators, both domestically and internationally, but the legal advice the FTP Committee has received is that the 2011 Act is a unique regime and therefore the practices or procedures of other regulators are not relevant.

It is not my intention to adopt a pejorative stance in relation to this advice, however, in the absence of any NMBI guidelines as to what the committee should consider, then the practice of other regulators should be useful in these uncharted waters, recognising that this must be understood in the context of the particular language of the statute governing a particular regulator's activities.

I am heartened by a conclusion drawn by Justice Hardiman in the recent Supreme Court decision in Corbally, concerning the FTP Committee of the Medical Council, to guidelines issued by the Medical Council in the UK. It is my view that a similar approach should be taken by the NMBI FTP Committee. Indeed, I think registrants and others should also be in possession of a policy document setting out the principles in operation when the Committee is considering applications for privacy or anonymisation. Furthermore, we have formally requested that the Board adopt guiding principles in this area – as they have done in relation to sanctions – however, this has not been forthcoming.

Demonstrating cause

Returning to the substantive issue, a registrant must show the Committee reasonable and sufficient cause that the

hearing should be heard in private. Key here is the requirement to show reasonable and sufficient cause. These are the terms used in the statute, and they are not defined, nor as mentioned is there any guidance for the NMBI as to what may be considered as reasonable or sufficient, or not as the case may be.

It is clear by the wording of the statute, that embarrassment or reputational damage arising from the holding of a public hearing into allegations of misconduct, without anything further, will not amount to reasonable and sufficient cause. This is indeed the position adopted by the Committee. This is a harsh and unwelcome reality; the embarrassment associated with that is to be regarded as inherent to the process.

That is not to say that such factors cannot, or should not, have a role in the overall FTP regime. Referring again to the recent Corbally decision, the Supreme Court has cautioned that taking into consideration the nature of public hearings, and the associated personal and professional trauma, the PPC and Board must exercise their functions in a serious and deliberative manner and ensure that only serious matters are the subject of a public inquiry.

Relevant disability

Our experience to date suggests, that if a registrant is alleged to be suffering from a relevant medical disability and it is proposed to call detailed evidence in relation to their medical condition, records, treatment, and perhaps extensive detail on their family and life history, on a number of occasions the Committee has granted an application for the hearing to be heard in private.

This of course is not to be taken as a given as each application is dealt with on its own facts. However, in such circumstances, it would seem the public interest is not served by dragging that person through the additional stress and trauma of a public hearing. In fact, other regulators have established health committees that deal with such allegations, and their deliberations are in private. The NMBI does have the facility to follow suit under the 2011 Act, however, they have not done so yet.

Additionally, where there is medical evidence, generally from a consultant, that the holding of a hearing in public would represent a serious threat to the registrant's health, then the Committee has granted applications for a private hearing.

Applications by others

Managers and colleagues

In terms of applications made by others, it is relatively common for managers or colleagues to make applications for either a private hearing, or that their evidence be heard in private, or that their name be anonymised. While again it is impossible to give any indication as to how such an application may be approached, it would seem that in the absence of very special circumstances they will be unlikely to be granted. If the registrant is to run the gauntlet of public scrutiny, so too are other professionals who reported or witnessed the conduct of the registrant in question.

Treating physicians

The treating physician can also make an application for a private hearing, particularly in circumstances where a they are treating a registrant who has disclosed something that may amount to misconduct, leading the physician to report the matter to the NMBI. Physicians in such cases might be concerned regarding a breakdown in trust between them and patients if the report they made becomes public knowledge.

Physicians may also apply for a private hearing because they are concerned regarding the impact of evidence relating to a registrant's condition being heard in public. Such applications will be considered in light of the merits of the case before the Committee. One might note that cases where physicians are making such applications are often cases where the registrant is making a similar application.

Patients and family members

Finally, family members of a patient or service user, or indeed the patient or service user, may make an application. The patient or service user may have more success in such an application, with family members being treated much the same as any other applicants.

Where the registrant is making an application, their representative will inform the CEO's legal representative, and in turn any applications from the CEO or other parties will be notified to the registrant and their representative. When the Committee sits to hear such applications it does so in private and in general the registrant is not required to attend.

The registrant

Concerning an application on behalf of a registrant, the INMO will make the application. This will be based on a mix between the facts of the case and the applicable law. It has been the position of the CEO of the NMBI, in some cases not to take a position on any application which a registrant makes, except to remind the Committee that the default position is that the hearing should take place in public unless the Committee is satisfied that there is reasonable and sufficient cause shown.

In other cases, particularly where there is an allegation relating to medical disability on the part of the registrant or where the registrant is quite unwell, the CEO will also on occasion indicate a view that they feel the case in question is an appropriate case to grant the application. Notwithstanding whether the CEO takes a position the final determination is made by the Committee.

The decision

Having heard the factors which the registrant, or others, believes amount to reasonable and sufficient cause the Committee hears legal advice and then retires to consider the matter.

In essence they then have two things to decide, first has the registrant displayed reasonable and sufficient cause for a private or part private hearing or for their name to be anonymised. If they have not done so then the application will fall at this stage. If they have, the Committee must then additionally assess whether in light of the reasonable and sufficient cause shown, and the nature of the case overall, that it is appropriate in the circumstances for the hearing to proceed in private. They will then notify the parties of their decision.

It is difficult to offer predictions, but more worryingly we are not able to advise registrants in relation to any of the factors, goals or principles that are in play when the Committee is considering such applications, except the brief terms provided in the statute.

In some cases it is clear that no application can or will be made, but in others there is a considerable imperative to make an application and in this context registrants and witnesses would be well served by the production of a guiding document by the NMBI. This would assist all parties to better understand how the Committee will approach this delicate and important subject and also provide the Committee with clear guidance as to how such applications should be dealt with.

The INMO advocates frequently on this issue for its members and, where appropriate, we strongly advocate for private hearings to protect the health of our members and their privacy in relation to the intimate details of their health and welfare.

Edward Mathews is INMO director of regulation and social policy

Introducing Executive Council members

Martina Harkin-Kelly

President

MARTINA Harkin-Kelly comes from an extensive family background in nursing. All her siblings, including her twin sister, also went into nursing or midwifery. From a young age Martina would visit St Conal's Hospital, Letterkenny with her Irish dancing troupe to entertain the patients. She later got involved in mental health initiatives in secondary school and naturally progressed into nursing after her Leaving Certificate in 1983. Early in 1984 her nursing school was visited by Liam Doran, the then INMO student officer, at which point she became a member. She was, and still is, very impressed by the variety of services offered by the union – CPD, regulation/protection in the event of FTP, industrial relations support – but she was also acutely aware of the benefit of being part of a group and the power and solidarity that brings when trying to fight for your rights or fight for change.

"The union is like a family you can trust in tough times. We've got your back and we understand the journey our members have taken as many IROs and management also came this route. We are tuned into the profession, its ethos, values and competencies."

Indeed, for work rights to be upheld, Martina feels that all workers should be in a union. This gives them a voice within the working environment.

For Martina the magnitude of the recruitment and retention crisis has eclipsed all else. She feels that there is a real pull at the autonomy of nurses with many reports issued in recent years, but little learning gathered along the way.

"Policy makers still travel the same road without listening to nurses and midwives. Until this changes, we will continue to have a dysfunctional health service."

Catherine Sheridan

First-vice president

CATHERINE Sheridan was always interested in caring for people, so it was no surprise that she went into nursing. She is the paediatric early warning system co-ordinator for Galway University Hospitals and also works part-time as training site co-ordinator for Croí.

She became involved with the INMO when her and her colleagues had a workplace issue. It became apparent to her that it was important to have a voice and be part of a group that could represent nurses and midwives. She took a leadership role in this dispute and went on to become an INMO rep. She feels that all workers should be unionised as having back-up and somewhere to go for advice is important for morale.

"Nursing and midwifery are very challenging roles and our conditions have been deteriorating for years, which has been detrimental to an already weakened morale. Nurses and midwives often find that they've hit a wall and don't know where to turn. It is important that they know they have support and back-up. The INMO is so much more than just an industrial relations union, but an organisation that offers guidance, a huge variety of educational programmes as well as legal representation and advice."

In her role on National Executive, Catherine feels a huge sense of responsibility to speak, not for herself, but for her profession and all members of INMO. Her passion is to be a voice for those working in children's nursing nationally, but she is proud of providing a voice for all disciplines within nursing and midwifery.

"We have never had stronger need to speak out against the very poor conditions our colleagues are working in. Pay is a huge priority. We are an educated and motivated workforce, but this is not reflected in our pay."

Eilish Fitzgerald

Second-vice president

EILISH Fitzgerald always wanted to be a nurse from childhood. Prior to her becoming a nurse there had been no family tradition in nursing, but since then two of her nieces have gone in to the profession.

In the late 1990s, having just finished higher diploma in public health nursing, she had an issue with secondment which was successfully secured with the help of the INMO. Eilish became an active member during this time and was elected chairperson of her local branch during the 1999 strikes. She has also been active with the PHN Section for many years but promised that she would become more active nationally when her children had grown up.

Her main priority on National Executive is sustainability of the nursing and midwifery workforce. In order for this to happen she feels that we must have nurses who are going to be properly paid for the work they do, for the education/qualifications they achieve and for their continued professional development.

"At the end of the day, nursing and midwifery are the professions that are there at the beginning and end of life. It is important that we are correctly enumerated."

Eilish sees the need for all workers to be unionised given how often employers can take advantage.

"It is important to be protected and know your rights. The INMO is an all-encompassing union run by nurses and midwives for nurses and midwives. We provide indemnity, legal advice and representation, industrial relations support and professional development opportunities. We are the people who are there to help you in a crisis and that is what being in a union is all about."

The challenge of clinical placement

INMO student and new graduate officer, **Neal Donohue** advises students on what they need to know ahead of starting a clinical placement

ONE of the effects of understaffing in the health services is that clinical placement experiences have the potential to quell the enthusiasm of another generation of dedicated and passionate student nurses and midwives, driving them towards better pay and conditions overseas at the end of their training. Equally concerning is the fact that many students cite inadequate support and supervision as reasons for failing placement. Sometimes, the failure of a student can be directly associated with the failure of the health service.

Some 76% of respondents to the INMO's Nursing and Midwifery Internship Survey 2018 said that they did not find adequate staffing levels in the workplace to support their learning. According to the Nursing and Midwifery Registration Programmes Standards and Requirements, as set out by the Nursing and Midwifery Board of Ireland (NMBI), there should be a minimum of one clinical placement co-ordinator (CPC) to 30 student nurses and one CPC to 15 midwifery students. National figures show the ratio of CPCs to students is 1:52, falling desperately short of minimum NMBI standards, which is concerning for students.

Standards

From the moment you commence your training you must comply with the NMBI standards or you risk failing. Familiarise yourself with these standards, requirements and guidelines. These can be found at: **www.nmbi.ie/Home**

Every moment you are on placement you are being assessed. Your behaviour and attitude are as important as your capacity to learn and your ability to develop new skills. It is important to act in a professional manner. Read the NMBI Code of Professional Conduct and Ethics at **www.nmbi.ie/Standards-Guidance/Code**

Inadequate staffing levels limit staff nurses/midwives time to teach you. If you do not have a preceptor and you believe there are not enough CPCs while on placement you should email the CNM/CMM firstly and ask for this to be addressed. If your learning is not adequately supported in the workplace you must notify the Higher Education Institution (HEI) and keep a diary of days when you do not have a preceptor.

The NMBI Nurse Registration Programmes Standards and Requirements 2.5.2 clearly states that "Practice experience must be gained under the supervision of appropriately prepared preceptors and with levels of nursing staff and resources for the safe delivery of nursing care to those using the service." (Adapted from Article 23, Council Directive 2013/55/EU) If appropriate preceptors and appropriate levels of nursing/midwifery staff are not in place then this is not an appropriate placement for students. You should bring this to the attention of the HEI immediately.

Redeployment of students/interns is not acceptable. Your learning must be supported and supervised by a preceptor in accordance with NMBI standards and requirements. Your allocations officer has tailored your placements to accommodate your learning needs, therefore you may not be redeployed elsewhere. Although interns are employees, the same principle applies.

Scope of practice

It is important to work within your scope of practice. What you did not know yesterday you will be expected to know tomorrow. On speciality placements you will have limited ability to engage in clinical skills, but you must show evidence that you are learning.

All students, including interns are entitled to four hours protected reflective time. Use the protected reflective time wisely. It offers opportunity to reflect on clinical experience and study further to enhance your experiential learning.

Action plan

If you are not achieving the required standards on clinical placement you will be given an action plan. If you do not agree with your preceptor's assessment, then you should clearly state this in writing and ask for support from your CPC. If you are given an action plan, then it is important to understand the steps you must take to pass the placement.

Each HEI will have a policy relating to the progression of student nurses and midwives. This policy outlines the procedure following a failed placement. There are many reasons students may fail a placement, however, you may have grounds to appeal. Common reasons cited by students for poor performance are ill health, or tiredness due to working part-time jobs.

These may seem like reasonable arguments but the protection of the patient or service user is considered paramount by the NMBI. As regulated professionals nurses and midwives must make judgements regarding their ability to practice. If you, as a student feel that you are not able to practice safely then it is better to communicate this to your CPC and take some time off rather than fail in your professional responsibility.

Evaluations

Students must complete evaluation forms after every placement accurately and honestly. Many students report feeling uncomfortable documenting negative experiences for fear of reprisal. Anonymity must be maintained if these documents are to be completed truthfully, in the interest of providing better supports in the future. Evaluation forms provide an evidence base for the HEI and associate healthcare provider to examine the effectiveness of the structures that are in place.

Neal Donohue is the INMO's student and new graduate officer. If you have a question about the above article, or need support or information, you can contact him at email: neal.donohue@inmo.ie or Tel: 01-6640628

Standards in midwifery

The Midwifery Unit Network and the European Midwives Association have collaborated to produce a list of standards to guide midwifery units. This month **Deirdre Munro** examines standard 1

THE creation of the Midwifery Unit Standards is the first joint output collaboration between Midwifery Unit Net and the European Midwives Association. They were developed to guide midwives, managers and commissioners across Europe in creating and developing midwifery units.

Focusing on philosophy of care and the organisation of services, the aim of the Standards is to improve the quality of maternity care, reduce variability of practices and facilitate a biopsychosocial model of care. Addressing the gap in implementation of midwifery units, in hospitals and primary care settings, the Standards focus on philosophy of care, organisation of services and are intended to be used alongside clinical guidelines.

What is a midwifery unit?

A midwifery unit (MU) is a location offering maternity care to healthy women with straightforward pregnancies in which midwives take primary professional responsibility for care. MUs may be located away from (freestanding) or adjacent to (alongside) an obstetric service.

Theme 1 biopsychosocial model of care

The MU provides care based on the biopsychosocial model of care.[1-6] This model recognises childbirth as a physiological process which has inherent socio-cultural and psychological dimensions.[7] It reflects evidence that these dimensions cannot easily be separated, and that high-quality maternity care should take account of all of them.

MUs aim to encourage a sense of autonomy in women, active promotion of health and wellbeing, as well as protection from harm. These aims are encompassed by the two key concepts of salutogenesis and safety.[8,9,10]

Standard 1

The MU has a written philosophy of care document that needs to be mutually agreed among stakeholders. This document needs to be in line with the philosophy of care and values of the wider maternity services and includes a commitment towards:

Midwifery Unit Standards	Theme 1:	Biopsychosocial model of care
Standard 1: The midwifery unit has a written and public philosophy of care setting out shared values and beliefs		

1.1 Facilitating a physiological pregnancy, labour, birth and care of the baby

a) Supports staff skills and practices that facilitate physiological pregnancy, labour, birth, bonding, neonatal care and transition to parenthood

b) States that interventions should be considered and justified in relation to best clinical evidence, on the basis that the potential benefits outweigh the potential harms

1.2 Offering personalised and supportive care that promotes physical and psychological wellbeing

a) Recognises childbirth as a key life event and transition for mothers, babies, families and birth companions

b) Promotes emotional wellbeing in pregnancy, labour and birth and in the early days of motherhood

c) Respects women's human and reproductive rights to dignity, privacy and autonomy

d) Welcomes the woman's chosen companions

e) Commits to providing a positive start to caring for the baby, including working with Baby Friendly accreditation (UNICEF, 2017)

f) Endorses effective and prompt escalation and transfer to obstetric care, while still focusing on positive experiences and personalised supportive care

g) Acknowledges a clear understanding that caring for staff wellbeing helps to promote caring behaviours.

1.3 Promoting a social model of care

a) Providing holistic, woman-centred and family-focused care that is responsive to the reality of people's lives and supportive of equal access, equality and cultural diversity

b) Having a written philosophy of care including statements on autonomy, diversity and equality and how this will be achieved, including women's reproductive rights and choices on maternity care

c) Offering a wide range of integrated services and activities including, but not limited to, active birth workshops, baby massage groups, breastfeeding groups and new parent support groups. In deciding on such provision, consideration will be given to effective ways in which the MU can promote women's sense of wellbeing and agency in preparing for birth. Additionally, freestanding midwifery units may function as a Community Hub and offer an even wider range of services not limited to the provision of maternity and healthcare

d) Welcoming any potential service users, by offering information and support relating to pregnancy, birth and the postnatal period, as well as the opportunity to have a tour of the MU

e) Reinforcing an understanding that all care providers in the broader maternity care system would benefit from awareness of and training in a social model of care, recognising their impact on the experiences of women and families and overall quality of care.

Promoting and supporting the implementation, development and growth of midwifery units which provide holistic care to women and their family throughout Europe is one of the aims of the MUN.

Deirdre Munro is a midwife at Portiuncula Hospital and international officer of the Midwives Section

References on request by email to nursing@medmedia.ie (Quote Monro D. WIN 2018 ; 26 (9): 45)

In the next issue we will explore Theme 2: Equality Diversity and Social Inclusion

Quality & Safety

A column by Maureen Flynn

Public and patient involvement in NOCA – a meaningful partnership

THIS month's column continues our series with the National Office of Clinical Audit (NOCA). Since its inception in 2012, public and patient interest (PPI) representatives have been included in the membership of the NOCA governance board and each audit committee. Learning from this very valuable experience NOCA published a framework of PPI involvement.

This framework describes the approach to PPI involvement. It signals commitment to involve patients at the core of NOCA. Today, blind trust in healthcare is no longer acceptable. NOCA believes PPI representation and involvement in all they do strengthens and enhances national clinical audits and their impact on clinical care.

Approach to PPI representation

NOCA's approach is based on two key principles:

- Involvement: PPI involvement enhances planning, design and implementation of NOCA audits
- Relevance: Because of this, NOCA audits have a greater relevance for the people most directly affected by recommendations.

Each NOCA audit is overseen by a governance committee, made up of key healthcare stakeholders, including people who have a PPI role. For example, the governance committee for Major Trauma Audit (MTA) includes representation from pre-hospital care, emergency medicine, radiology, haematology, surgical and medical specialties, healthcare managers as well as nursing and health and social care professionals (*see Quality and Safety column July 2018, Vol 26, Iss 6*).

Importantly, two PPI representatives sit on this governance committee, and with the other committee members, oversee its strategic development and outputs. MTA, like other audits provides information to hospitals and nationally to the HSE and the Department of Health and the public. NOCA PPI representatives are influencing improvements at a hospital level and service delivery nationally.

Additionally, PPI representatives are involved in activities such as development of summary national reports written specifically to inform the public and NOCA website development.

What motivates PPI involvement?

The idea of community participation in health emerged in the early 1970s and has continued to evolve. It takes many forms such as health-service consumer councils, deep involvement of patient experience advisors in healthcare committees and improvement teams, PPI representation in research and clinical effectiveness activities and advocacy. PPI representatives currently on NOCA governance committees come from advocacy groups – such as Cairde, Sage and ICU Steps. Recent feedback from members provides insight into what motivates PPI representatives to become involved with NOCA - *see box above*.

Get involved

Are you involved in a quality improvement initiative in your area? At your next meeting you might consider how you involve patients and the public in your work. NOCA's framework provides information on the role and characteristics of a successful PPI representative, along with suggestions for recruitment, training, orientation and support for PI representatives. You can download copies of NOCA's PPI Framework at: **www.bit.ly/nocaPPIframework**

Insights: public/patient involvement

The creation of a truly patient led service, centred around the needs of both individuals and communities cannot be achieved without a constant commitment to ensuring that the public have opportunities to influence in ways that are relevant and meaningful to them and in ways which will make a difference to services.

– Brigid Doherty, PPI representative NOCA Governance Board

For me, I trust my participation in NOCA will be of benefit to current and future patients. I am just one patient's voice but I hope I represent many. Acknowledgement of patients' views and acting upon them can improve the patient experience.

– Barbara Egan, PPI representative, NOCA ICU Governance Committee

People usually get involved because they want to improve health care or because they had a negative experience themselves and want to ensure that no one else experiences the same difficulties' when they are the most vulnerable.

Iryna Pokhilo, PPI Representative NOCA Governance Board

I believe it's very important that we are learning, [….] sharing and publishing this learning openly with all to help reduce the same re-occurrences […] to expectant mums and babies and also trauma to staff.

– Siobhan Whelan, PPI representative, National Perinatal Epidemiology Centre Governance Committee

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

Acknowledgements
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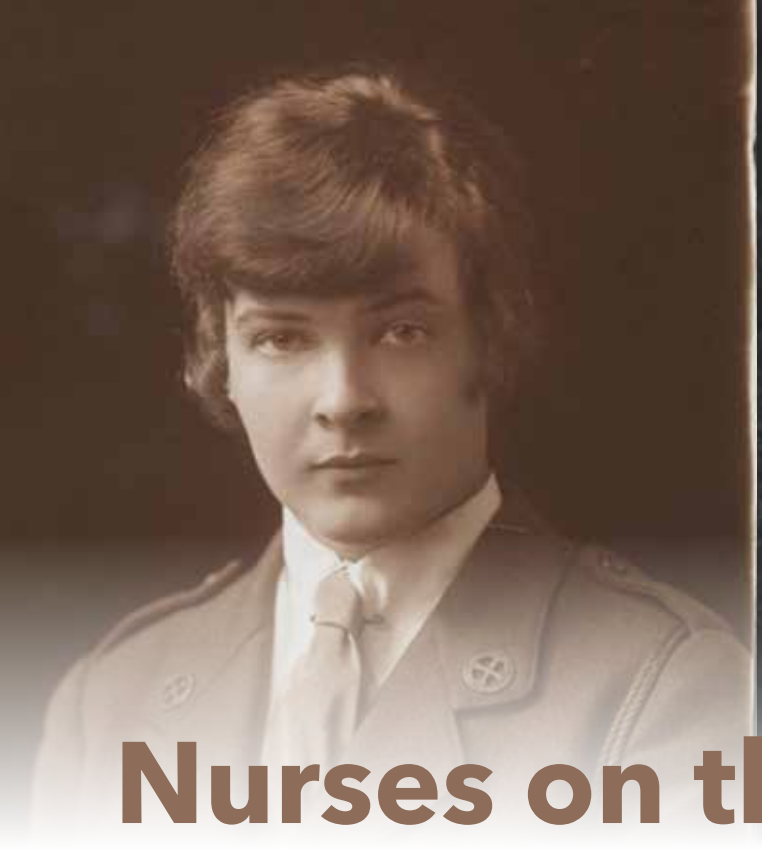

Nurses on the frontlines

As this month marks the centenary commemoration of the end of the First World War, **Steve Pitman** reflects on the role of Irish nurses

NOVEMBER 11, 2018 will mark the 100th anniversary of the end of the First World War, a conflict that brought devastation, death and suffering to millions of people around the globe.

Nurses were on the frontlines caring for troops and civilians from all sides, often displaying characteristic heroism and bravery. The work of the nurse was exhausting and dangerous, and offered a first-hand experience of the horrors of war.

Elizabeth O'Malley, a nurse from Westport, trained in Jervis Street Hospital and joined the Queen Alexandra Imperial Military Nursing Service in 1916. Her grandniece, Sabina Purcell, recalled in an interview with *The Irish Times* what Elizabeth had shared with her family after the war, "She nursed soldiers with horrific injuries, many with limbs blown off and suffering from the effects of gas." Elizabeth also spoke of the trauma and the constant screaming of the soldiers.

The nursing building at Waterford Institute of Technology is named after Mary O'Connell-Bianconi (*pictured above left*), from Cashel, one of only seven female nurses to be awarded the Military Medal in the war. She was awarded this accolade for her courage under fire, ferrying wounded soldiers from the front during one particularly heavy German bombardment.

A poem by Eva Dobell, based on her experience as a nurse in the Voluntary Aid Detachment during World War I, offers an insight into the true cost of war (*see above*).

Pluck

Crippled for life at seventeen,
His great eyes seems to question why:
with both legs smashed it might have been
Better in that grim trench to die
Than drag maimed years out helplessly.
A child – so wasted and so white,
He told a lie to get his way,
To march, a man with men, and fight
While other boys are still at play.
A gallant lie your heart will say.
So broke with pain, he shrinks in dread
To see the 'dresser' drawing near;
and winds the clothes about his head
That none may see his heart-sick fear.
His shaking, strangled sobs you hear.
But when the dreaded moment's there
He'll face us all, a soldier yet,
Watch his bared wounds with
unmoved air,
(Though tell-tale lashes still are wet),
And smoke his Woodbine cigarette.

Eva Dobell (1876–1963)

The Adelaide Hospital Foundation archives record 22 nurses who served in the War. One of them, Elizabeth Grace Stewart, is commemorated on the Adelaide Hospital World War memorial. Elizabeth, from Limerick, died on February 15, 1916.

The RCN History of Nursing Network in Northern Ireland has produced a publication that outlines the nursing contribution during the Great War. It details the role of nurses from the outbreak of the conflict through to the armistice, examining the impact that the War had on nursing.

Other nurses were killed outside the conflict. English nurse Edith Cavell (*pictured above right)* helped two Irish soldiers escape from captivity in Belgium. For this, she was executed by firing squad in Brussels in October 1915.

Irish nurses contributed significantly to the war effort, tending to the injured and dying both overseas and at home. The memorials throughout the country record the names of those who served and died during the War.

An Irish Airman Forsees His Death

I know that I shall meet my fate,
Somewhere among the clouds above;
Those that I fight I do not hate,
Those that I guard I do not love;
My country is Kiltartan Cross,
My countrymen Kiltartan's poor,
No likely end could bring them loss
Or leave them happier than before.
Nor law, nor duty bade me fight,
Nor public men, nor cheering crowds,
A lonely impulse of delight
Drove to this tumult in the clouds;
I balanced all, brought all to mind,
The years to come seemed waste of breath,
A waste of breath the years behind
In balance with this life, this death

WB Yeats (1918)

Steve Pitman is the INMO head of education and professional development

Managing frailty

If we approach frailty as a long-term condition we should know how to recognise it and how to manage it, writes **Deirdre Lang**

OUR population is ageing rapidly. Between 2015 and 2030, the number of people in the world aged 60 years or older is projected to grow by 56% and by 2050 the global population of older people is projected to more than double in size.[1]

In Ireland, the old population (ie. those aged 65 years and over) is projected to increase very significantly from its 2011 level of 532,000 to between 850,000 and 860,700 by 2026, and to close to 1.4 million by 2046. The very old population (ie. those aged 80 years of age and over) is set to rise even more dramatically, increasing from 128,000 in 2011 to between 484,000 and 470,000 in 2046.[2] As older people have different healthcare requirements, the Irish healthcare system needs to adapt to meet the demands associated with this demographic change. One of the greatest challenges posed by an ageing population is the ability of healthcare professionals, including nurses, to understand, recognise and manage frailty.

Frailty is an increasingly common condition in older people (25-50% of people over 80 years).[3] Frailty is theoretically defined as a clinically recognisable state of increased vulnerability resulting from age associated decline in reserve and function across multiple physiologic systems.[4]

Frailty is increasingly recognised as a distinctive state of health related to the aging process but is not an inevitable part of ageing. It is a long-term condition in the same sense as diabetes or Alzheimer's disease.[5] Clinically, older people who are frail have poor functional reserve, so that even a relatively minor illness or a change in medication can lead to a sudden catastrophic functional decline – causing the person to fall, become immobile or rapidly confused, or to present non-specifically with failure to thrive.[6]

Frailty is a graded abnormal health state that ranges from mildly frail (those who need supported self-management), through those who are moderately frail and would benefit from structured interventions from healthcare professionals, to those who have advanced frailty where anticipatory care planning and end-of-life care may be appropriate interventions. People living with frailty should not be perceived as a problem to the system but, rather, clinicians should support them to maintain their own health for as long as possible.

The potential for serious adverse outcomes is a central problem associated with frailty. For people with frailty even a relatively minor event such as an infection can result in a dramatic change in their health state: from independent to dependent; mobile to immobile; postural stability to falling; lucid to delirious.[7] Further to this, frailty has been shown to be a strong and independent predictor of emergency department visits and hospitalisations,[8] hospital re-admissions[9] and in-hospital mortality.[10] Therefore, this topic has relevance for policy makers, clinicians and nursing staff who need to understand the risk factors for frailty, to enable them to implement programmes for early detection, prevention and management.

Frailty: what we know?

- The recognition of frailty is important and should form part of any interaction between an older person and a healthcare professional
- An individual's degree of frailty is not static. It may improve or deteriorate, and is influenced by factors which include the care received when an individual presents to a health professional
- Comprehensive geriatric assessment (CGA) has been shown to improve outcomes for older people. Identifying older patients who stand to gain from CGA may provide a way of targeting the resource where it is most needed
- Nurses are first responders and education has the capacity to improve their knowledge and understanding of the evolving concept of frailty.

The National Clinical Programme for Older People is partnering with The Irish Longitudinal Study on Aging (TILDA) and collaborating with the Office of the Nursing & Midwifery Services Director (ONMSD), The National Emergency Medicine Programme (NEMP) and The National Acute Medicine Programme (NAMP) in the roll out a National Frailty Education Programme.

The programme aims to provide healthcare professionals with an enhanced

understanding of frailty and frailty assessments, thereby ensuring earlier recognition of frailty, improved healthcare management, and better health outcomes for frail older adults.

Expected learning outcomes

- Understand that frailty is a long-term condition that exists on a spectrum
- Be aware of the availability of validated screening tools as they relate to frailty (e.g. frailty assessment, falls assessment, delirium assessment tools).
- Understand the benefit of CGA and the single assessment tool in planning appropriate health promotion and care pathways to enhance outcomes for older people living with frailty
- Understand the significance of frailty and the impact of a gerontological approach to care.

How is frailty identified?

If frailty is suspected, how should nurses and carers react? Is there a standardised, nationwide protocol in place?

CGA is fundamental to the assessment, planning and intervention required to meet the health and social care needs of the older person that is frail or at risk of frailty. Rather than the traditional way of working separately, CGA results in doctors, nurses, physiotherapists, occupational therapists, social workers and other members of the team working closely together to ensure an integrated assessment and response to the older person's individual needs. CGA has the potential to improve the care they receive in hospital, reduce unnecessary hospital admissions, lengths of stay and re-admissions.[11]

What is a comprehensive geriatric assessment?

CGA is an organised approach to assessment designed to determine an older person's medical conditions, mental health, functional capacity and social circumstances. Its purpose is to develop and implement a coordinated and integrated plan for treatment, rehabilitation, support and long term follow up.

CGA is based on the premise that a full evaluation of a frail older person by a team of healthcare professionals may identify a variety of treatable health problems, resulting in a co-ordinated plan and delivery of care leading to better health outcomes.

The benefits of CGA, in comparison to less structured multidisciplinary assessment where each discipline approaches the patient's assessment and plan of care in isolation include:

Table: How is frailty identified?

There are two possible approaches to identifying frailty

Presence of frailty symptoms	*Validated frailty assessment tools*
Falls: eg. collapse, legs gave way, 'found lying on floor'	• Rockwood Clinical Frailty Scale • PRISMA & Questionnaire • Timed up and go test • The Groningen Frailty Indicator Questionnaire • Edmonton Frail Scale
Immobility/ decreased mobility: eg. sudden change in mobility, 'gone off legs', stuck in toilet	
Delirium: eg. acute confusion, 'muddled', sudden worsening of confusion in someone with previous dementia or known memory loss	
Incontinence: eg. change in continence new onset or worsening of urine or faecal incontinence	
Susceptibility to side effects of medication: eg. confusion with codeine, hypotension with antidepressants (British Geriatric Society)	

Word cloud depicting misconceptions of frailty

- Improves diagnostic accuracy
- Optimises medical and rehabilitation treatment
- Enhances health and functional outcomes
- Informs the development of individualised care plans
- Assists in avoiding the potential complications of hospitalisation
- Facilitates effective discharge planning.

The National Clinical Programme for Older People recommends that all older adults identified as being frail or at risk of frailty should have a timely comprehensive geriatric assessment performed and documented in their permanent health record.[11]

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References

1.United Nations. Department of Economic and Social Affairs, Population Division (2015). World Population Ageing. Retrieved from: http://www.un.org/en/development/desa/population/publications/pdf/ageing/WPA2015_Report

2. ESRI. (2017). Projections of Demand for Healthcare in Ireland, 2015-2030: First Report from the Hippocrates Model. Retrieved from: https://www.esri.ie/publications/projections-of-demand-for-healthcare-in-ireland-2015-2030-first-report-from-the-hippocrates-model/

3. Savva G, Maty S, Setti S. (2013). Cognitive and Physical Health of the Older Populations of England, the United States, and Ireland: International Comparability of The Irish Longitudinal Study on Ageing. Journal of the American Geriatric Society, 61 (2), S291–S298

4.Qian-Li Xue. (2011). The Frailty Syndrome: Definition and Natural History. Clin Geriatr Med, 27(1), 1–15

5. British Geriatric Society. (2014). Fit for Frailty: Consensus best practice guidance for the care of older people living with frailty in community and outpatient settings

6. Clegg A, Young J, Iliffe S, Rikkert M, Rockwood K. (2013). Frailty in Elderly People. The Lancet, 381, (9868), 752-762

7. Clegg A, Young J. (2011). The frailty syndrome. Clin Med. 11(1):72–75.

8. McNallan S, Singh M, Chamberlain M, Kane R, Dunlay S, Redfield M, Weston S, Roger V. (2013). Frailty and Healthcare Utilization Among Patients with Heart Failure in the Community. JACC Heart Fail, 1(2), 135–14

9. Pugh, et al. (2014). Influence of Frailty-Related Diagnoses, High-Risk Prescribing in Elderly Adults, and Primary Care Use on Readmissions in Fewer than 30 Days for Veterans Aged 65 and Older. Journal of American Geriatric Society, 62, 291–298

10. Bagshaw, S, Stelfox T, McDermid R, Rolfson D, Tsuyuki R, Baig N, Artiuch B, Ibrahim Q, Stollery D, Rokosh E, Majumdar R. (2013). Association between frailty and short- and long-term outcomes among critically ill patients: a multicentre prospective cohort study. CAMJ. Retrieved from: http://www.cmaj.ca/content/early/2013/11/25/cmaj.130639.full.pdf+html

11. HSE. (2016). National Clinical Programme Older People. Specialist Geriatric Team Guidance on Comprehensive Geriatric Assessment. Retrieved from: https://www.hse.ie/eng/services/publications/clinical-strategy-and-programmes/comprehensive-geriatric-assessment-document-.pdf

Safety first

Robert McConkey highlights the importance of quality and safety in the area of nurse prescribing

NURSE prescribing was first introduced in the US in the 1980s, followed by the UK in 1992. An evolution towards nurse and midwifery prescribing in Ireland culminated with its introduction here in 2007. The drive toward this expanded nursing role emanated from a desire for enhancing efficiency by giving patients more timely access to medications and by better utilising health professional knowledge and skills, ultimately leading to improvements in patient care.[1,2] The evaluation of nurse prescribing has generally been positive;[3,4,5] promoting holistic nursing care, increasing patient's involvement in decision-making about their care, and also increasing nurses' autonomy and job satisfaction.[6]

With this role comes greater responsibility; prescribing is a complex task involving up to 40 steps for a patient to receive a single dose of medication[7] and requires robust systems, processes, and governance structures to enable high quality, safe, effective and cost-effective prescribing.[8,9] Quality in healthcare is synonymous with safety and efficacy and is the primary concern in healthcare delivery.[8] The prevalence of medication errors and adverse reactions, however, is concerning and leads to poor patient outcomes, increased length of hospital stays, increased admissions rates and results in burdensome economic consequences.[11,12,13]

Nurse prescribing is established in legislation and executed by the nurse prescriber as direct patient care. Quality prescribing requires an understanding of the factors that promote or impede its delivery with the aim of improving safe and effective care management, and the prevention of medication errors.

Nurse prescribing infrastructure

The legal framework for nurse prescribing is established under the Irish Medicines Board (miscellaneous provisions) Act 2006[14] along with its associated regulations; the Medicinal Products (prescription and control of supply) Regulations 2007 (S,I, No. 201 of 2007),[15] and the Misuse of Drugs Act Regulations 2007,[16] which set out the conditions for medicinal product prescribing by nurses and midwives. The Nurses Rules 2010[17] provide the professional regulatory framework for establishing nurse and midwifery prescribing. In addition, the Nursing and Midwifery Board of Ireland (NMBI) set the education standards required for nurse's prescriptive authority[18] and established the nursing practice standards[9] in collaboration with the Health Information and Quality Authority.

The role of the healthcare provider is to provide local governance aided by policies, guidelines and risk management strategies. The Collaborative Practice Agreement (CPA) defines the prescriber's scope of practice and outlines communication channels in the practice setting,[19] and the NMBI's decision-making framework assists both the employer and the nurse in their decision making about prescribing.[9] These documents are available on the NMBI website. It is incumbent on the nurse prescriber to be familiar with the infrastructure that underpins nurse prescribing and to keep abreast of any amendments to safely prescribe within their boundaries.

Medication errors in Ireland

Shifting the focus to the practical aspects of safe prescribing commences by exploring the incidence of medication errors, the contributing factors associated with these errors and identifying strategies that can be adopted to avoid their occurrence and mitigate their impact.

Most of the evidence on prescribing errors relies on studies from medical prescribers due to a paucity of research investigating non-medical prescribing.[20] While the true number of medication incidents is difficult to ascertain due to severe under-reporting, the Irish Medication Safety Network found that 6,179 medication incidents were reported by eight Irish hospitals between January 2006 – June 2007. This resulted in harm caused to 326 (5%) of the patients involved, with the majority of errors occurring during the prescribing stage (47%).[7] More recently, a review of medication incidents reported in Irish hospitals has recorded 5,505 occurrences in 50 acute Irish hospitals in 2016.[12] The report was particularly critical of the significant nature of under-reporting and its detrimental impact on learning opportunities. In the UK, the estimated prescribing error rate is 7.5%, resulting in one in 15 medication-related hospital admissions, most of which are preventable.[21] The most recent figures for England estimate a staggering 237 million medication errors per year.[13]

With such high incidence of medication errors, the associated patient harm is often due to adverse drug reactions and these have a consequential financial burden on health services.[13] It is therefore important for nurse prescribers to understand the influencing factors on safe prescribing of this high risk, error prone, and complex skill.[20] A review of the evidence of safety and quality in independent prescribing identified the spectrum of skills and competencies nurse prescribers must possess to facilitate safe and effective prescribing. Skills such as taking a comprehensive health history, physical assessment and diagnostic skills not only need to be acquired and consistently applied, but maintained through continued professional development.[4]

Routledge[22] introduces the 'seven Cs' (***Table 1***) which relate to factors that have a bearing on the outcome of quality prescribing. Problems associated with these factors may need to be addressed at an organisation level, or at an individual level, or both. Using the 'seven Cs' is proposed as a useful means of demonstrating the factors influencing quality prescribing.

Communication failures

Poor communication is a contributing factor in medication errors. Effective consultation and history taking skills are essential for nurse prescribers and advanced clinical practice roles.[24] Advanced communication skills are not only essential to the prescriber-patient interactions but also for inter-professional

communications, as well as for reporting suspected adverse drug reactions.[22]

Additionally, medication concordance, the holistic approach to improving patients' adherence to medication regimes, founded on shared decision making, is underpinned by advanced communication skills.[25] Poor concordance results in limited treatment benefits to the patient,[26] with increased associated healthcare cost.[27]

Critical conditions

This factor relates to the impact of human error in medication errors. Two approaches to problems associated with human error have been identified; the person approach, and the systems approach.[28] The person approach is associated with blaming people for their errors whereas the systems approach acknowledges the fallibility of individuals and focuses on the countermeasures and defences that can be put in place to minimise the impact of errors. Unconscious lapses and unsafe acts of commission or omission can lead to patient harm.[22,23] Approaching each prescribing event by employing a deliberate and thoughtful approach to decision making is advocated as a means of reducing human error.[23]

Collaboration with the pharmacy department for advice or medication review has also demonstrated a reduction in adverse events[29] and should be employed by nurse prescribers in practice. It will also contribute to the identification of polypharmacy and inappropriately prescribed medications that are more likely to result in adverse events, particularly in the elderly.[30] The use of screening tools such as the 'brown bag review,'[31] 'BEERS Criteria,'[32] 'SAIL and TIDE' approaches,[33] or 'START/STOPP' criteria[34] to assess polypharmacy is strongly advocated. Medication reviews also provide opportunities to reduce waste and can result in significant budget savings.[35]

Risk management strategies such as reporting adverse events, and audit of practice, are critical components of this factor. Nurse prescribers must commit to using local medication error reporting systems which the healthcare provider will submit to the National Incident Management System (NIMS). The data collected can be used to minimise patient harm by disseminating identified issues back to the health system to promote learning.[12]

Complacency and corner cutting

With prescription writing, both of these factors have the potential to cause harm to patients. As well as setting the standard for communication and ensuring that medicines legislation is upheld in the practice setting, the CPA contains the list of agreed medications that are within the nurse prescribers scope of practice to prescribe.[19] In addition, the prescriber must be familiar with the side effects, interactions, and contraindications of these medications as lack of knowledge of these drug characteristics is a major source of drug error.[23]

Poorly written or incomplete prescriptions where the prescriber assumes that the pharmacist dispensing the medication will act as a safety net also contribute to errors.[22] Following hospital policy, and specifically adhering to legislation as to what constitutes a valid prescription may mitigate this potential source of error. Similarly, cutting corners is associated with failing to check the prescription or medications against a reference source such as the British National Formulary, or a point of care evidence-based online resource such as 'ClinicalKey' which is available online via the HSE library.

Callowness

This relates to a lack of experience in prescribing resulting in medication errors. Drawing on Benner's theory *From Novice to Expert*, newly qualified nurse prescribers are at the novice stage of clinical competence.[36]

Clinical supervision is one of the foundational aspects of nurse prescribing and is an underlining principle in the CPA which ensures communication structures between the nurse prescriber and the collaborating medical prescriber. It is a means for the novice prescriber to gain competency and confidence through an intensive process of supervision which includes articulation of craft knowledge, feedback on performance, observing, listening and questioning, critical dialogue, high challenge support and role modelling.[37] Clinical supervision promotes professional accountability and promotes skill and knowledge development [38] and positively impacts the effectiveness of nurse prescribing.[39]

Courage of conviction and commitment to excellence

The final two factors refer to the nurse prescriber's confidence and leadership qualities. Seeking advice or questioning the directions of senior colleagues in the interest of patient safety is another mode of reducing errors.[40] Commitment to excellence should be a shared goal of both the organisation and the prescriber where new ways of improving quality and safety should be continually assessed.[22]

Table 1: Seven Cs

1. Communication failures
2. Critical Conditions
3. Complacency
4. Corner Cutting
5. Callowness
6. Courage of convictions
7. Commitment to excellence

Conclusion

Quality and safety are the cornerstones of successful prescribing, delivering positive outcomes to patients and avoiding harm. The introduction of nurse prescribing has demonstrated benefits to both patients and to the nursing profession. Prescribing is, however, a complex endeavour and the multitude of medication errors occurring every year cause harm to patients and add a financial burden to an already cash strapped health service. Before a prescription can be issued, the healthcare professional must be compliant with legislation, professional standards and frameworks and organisational governance, policies and guidelines.

To affect safe and quality prescribing in practice, nurse prescribers must possess astute consultation, communication, assessment and diagnosing skills, which must be continuously developed and updated through a commitment to professional development. Clinical supervision is a fundamental aspect of competency and confidence development. Risk management strategies, error reporting and audit are proposed as fundamental contributions to quality prescribing.

Additionally, nurse prescribers must operate within their scope of practice and in accordance with their CPA. The use of evidence-based clinical decision supports is also advocated to help mitigate the inevitability of human error with the ultimate goal of avoiding harm to the patient. Employing leadership qualities and striving for excellence are means of promoting the highest standards of patient safety. The benefits to the patient have been stated, and additional benefit to the organisation through the reallocation of resources achieved from alleviating the financial burden of medication errors is also an important outcome.

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References
1. ABA. Guidance to Nurses and Midwives on Medication Management. [Online] An Bord Altranais. Available www.nmbi.ie/Standards-Guidance/Medicines-Management Accessed 11/03/2018. 2007
2. Kroezen M, van Dijk L, Groenewegen PP, Francke AL. Nurse prescribing of medicines in Western European and Anglo-Saxon countries: a systematic review of the

literature. BMC health services research 2011;11(1):127
3. Latter S, Courtenay M. Effectiveness of nurse prescribing: a review of the literature. J Clin Nurs 2004;13(1):26-32
4. Latter S. Safety and quality in independent prescribing: an evidence review. Nurse Prescribing 2008;6(2):59-66
5. Gielen SC, Dekker J, Francke AL, Mistiaen P, Kroezen M. The effects of nurse prescribing: a systematic review. Int J Nurs Stud 2014 Jul;51(7):1048-1061
6. Bradley E, Nolan P. Impact of nurse prescribing: a qualitative study. J Adv Nurs 2007;59(2):120-128
7. ISMN. Medication Safety in Ireland (review of data between 1/1/06 & 30/6/07) Irish Medication Safety Network [Online] Irish Medical Journal. Available: http://www.imsn.ie/images/publications/imsn-medication-safety-in-hospitals.pdf [Accessed: 15/03/2018]. 2009
8. BPS. Ten principles of good prescribing. [Online] British Pharmacological Society Available: https://www.bps.ac.uk/BPSMemberPortal/media/BPSWebsite/Assets/BPSPrescribingStatement03Feb2010.pdf Accessed 15/03/2018
9. NMBI. Practice standards and guidelines for nurses and midwives with prescriptive authority (3rd Edition) [Online] Nursing and Midwifery Board of Ireland Available: https://www.nmbi.ie/NMBI/media/NMBI/NMBI-Practice-Standards-Prescriptive-Authority_1.pdf Accessed 31/03/2018
10. HIQA. National Standards for Safer Better Healthcare [Online] Health Information and Quality Authority Available https://www.hiqa.ie/system/files/Safer-Better-Healthcare-Standards.pdf Accessed 08/03/2018
11. DOH. Final Report of the Implementation Steering Group (ISG) on the recommendations of the Report of the Commission on Patient Safety and Quality Assurance [Online] Department of Health. Available: http://health.gov.ie/blog/publications/final-report-of-the-implementation-steering-group-isg-on-the-recommendations-of-the-report-of-the-commission-on-patient-safety-and-quality-assurance/ 2011 Accessed: 15/03/2018
12. Kennedy M. Review of medication incidents reported in Irish hospitals [Online] State Claims Agency. Available: http://stateclaims.ie/wp-content/uploads/2017/11/Medication-Incidents-Report-2016.pdf 2016. Accessed: 15/03/2018
13. Elliott R, Camacho E, Campbell F, Jankovic D, Martyn St James M, Kaltenthaler E, et al. Prevalence and Economic Burden of Medication Errors in The NHS in England. Rapid evidence synthesis and economic analysis of the prevalence and burden of medication error in the UK. [Online] Policy Research Unit in Economic Evaluation of Health & Care Interventions (EEPRU) 2018. Accessed 01/04/2018
14. Government of Ireland. Irish Medicines Board (Miscellaneous Provisions) Act 2006 (No.3 of 2006) Stationery Office. Dublin. 2006
15. Government of Ireland. Medicinal Products Prescription and Control of Supply (Amendment) Regulations (2007) (SI No. 201 of (2007). Stationery Office. Dublin. 2007.
16. Government of Ireland. Misuse of Drugs (Amendment) Regulations (2007), Statutory Instruments No. 200 of (2007). Stationery Office. Dublin. 2007.
17. Government of Ireland. S.I. No. 689/2010 - Nurses Rules, 2010. Stationery Office. Dublin
18. NMBI. Prescriptive authority for nurses and midwives: standards and requirements. [Online] Nursing and Midwifery Board IrelandÅ Available: www.nmbi.ie/Standards-Guidance/Prescribing-Standards Accessed 15/03/2018. 2015.
19. NMBI. Collaborative practice agreement guidance for nurses and midwives with prescriptive authority (4th Edition, 2016). [Online] Nursing and Midwifery Board Ireland. Available: www.nmbi.ie/Standards-Guidance/Prescribing-Standards Accessed 31/03/2018. 2016.
20. Cope LC, Abuzour AS, Tully MP. Nonmedical prescribing: where are we now? Therapeutic advances in drug safety 2016;7(4):165-172
21. Garfield S, Barber N, Walley P, Willson A, Eliasson L. Quality of medication use in primary care-mapping the problem, working to a solution: a systematic review of the literature. BMC medicine 2009;7(1):50
22. Routledge PA. Safe prescribing: a titanic challenge. Br J Clin Pharmacol 2012;74(4):676-684
23. NPC. Top tips for GPs. Strategies for safer prescribing. Provided by NICE. [Online] National Prescribing Centre. Available https://seguridadmedicamento.sanidadmadrid.org/pdf/10_top_tips_for_gps.pdf 2011.Accessed 30/03/2018
24. Young K, Franklin P. Effective consulting and history taking skills for prescribing practice. British Journal of Nursing 2009;18(17):1056-1061
25. Clyne W, Granby T, Picton C. A competency framework for shared decision-making with patients. Achieving concordance for taking medicines. [Online] www.ehealthnurses.org.uk/pdf/Prescribing%20Competency%20Jan%202007.pdf 2007. Accessed 10/02/2018
26. Nieuwlaat R, Wilczynski N, Navarro T, Hobson N, Jeffery R, Keepanasseril A et al. Interventions for enhancing medication adherence. The Cochrane Library 2014
27. Al-Lawati S. A Report on Patient non adherence in Ireland. [Online] www.pfizer.ie/UserFiles/file/news_releases/Adherence%20Report%20Final.pdf 2014. Accessed 03/02/2018
28. Reason J. Human error: models and management. BMJ 2000 Mar 18;320(7237):768-770
29. Kearney A, Halleran C, Walsh E, Byrne D, Haugh J, Sahm LJ. Medication Reviews by a Clinical Pharmacist at an Irish University Teaching Hospital. Pharmacy 2017;5(4):60
30. Kim J, Parish AL. Polypharmacy and Medication Management in Older Adults. Nurs Clin North Am 2017 Sep;52(3):457-468
31. O'Connell MB, Chang F, Tocco A, Mills ME, Hwang JM, Garwood CL, et al. Drug Related Problem Outcomes and Program Satisfaction from a Comprehensive Brown Bag Medication Review. J Am Geriatr Soc 2015;63(9):1900-1905
32. Campenelli C. American Geriatrics Society updated Beers Criteria for potentially inappropriate medication use in older adults. J Am Geriatr Soc 2012;60(4):616-631
33. Mukete BN, Ferdinand KC. Polypharmacy in older adults with hypertension: a comprehensive review. The Journal of Clinical Hypertension 2016;18(1):10-18
34. O'Mahony D, O'Sullivan D, Byrne S, O'Connor MN, Ryan C, Gallagher P. STOPP/START criteria for potentially inappropriate prescribing in older people: version 2. Age Ageing 2015;44(2):213-218
35. Barry M. Economies in drug usage in the Irish healthcare setting. [Online] Department of Health and Children (DOHC) Available www.lenus.ie/hse/bitstream/10147/66358/1/economies_drug_usage.pdf .2008. Accessed 05/04/2018
36. Benner P. From novice to expert. USA: Addison-Wesley; 1984
37. Jukes M, Millard J, Chessum C. Nurse prescribing: a case for clinical supervision. Br J Community Nurs 2004;9(7):291-297.
38. Brunero S, Stein-Parbury J. The effectiveness of clinical supervision in nursing: an evidenced based literature review. Australian Journal of Advanced Nursing, The 2008;25(3):86
39. Stenner K, Courtenay M. The role of interprofessional relationships and support for nurse prescribing in acute and chronic pain. J Adv Nurs 2008;63(3):276-283
40. Dornan T, Ashcroft D, Heathfield H, Lewis P, Miles J, Taylor D, et al. An in-depth investigation into causes of prescribing errors by foundation trainees in relation to their medical education: EQUIP study. London: General Medical Council 2009:1-215

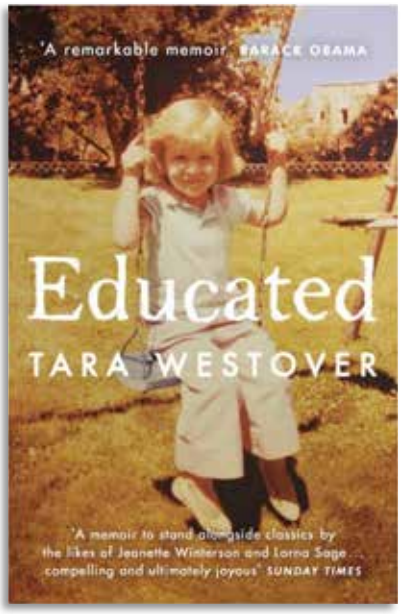
Transformation through education

WITH the #MeToo movement and the Kavanaugh controversy, we have been hearing so much about the treatment of women in many walks of life throughout the US. Tara Westover's memoir *Educated* could be viewed as a tale of how one woman escaped the patriarchal suppression of a rural Mormon fundamentalist upbringing, but this work is so much more than that.

The youngest of seven, Tara suffered gut-wrenching tough love and neglect at the hands of her parents in rural Idaho. Her survivalist father, convinced the world was going to end, focused his energy preparing his family for the 'End of Days' when they would take to the hills with all the emergency supplies necessary for survival.

Tara and her closest siblings had not been registered for a birth certificate, had no school records due to 'home schooling' of sorts, and no medical records because her father didn't believe in doctors or hospitals. According to the state and federal government, she didn't exist.

With unswerving loyalty, Westover's mother deferred to her husband, in spite of some doubts about his beliefs and sanity. She finds some escape in her roles as a faith healer and as an experienced but unlicensed midwife. Descriptions of the latter births, many witnessed by Tara as a child, will undoubtedly make many *WIN* readers uneasy.



As she grew older, her father became more radical, and her brother more violent. Westover gradually makes her way out of all of the dangers of her upbringing, escaping car crashes, workplace 'accidents' in her father's scrapyard, physical abuse from her brother, as well as ingrained mental torment about her body and place in society as a female of the species.

With no formal education and little by way of home schooling, she manages to study her way to college, struggling against her ignorance of the most fundamental of things (such as what the Holocaust was or even basic hygiene), to Harvard and to eventually do a PhD at Cambridge.

Educated is a tale of fierce family loyalty and the grief that comes with cutting off all ties with everything you once accepted as 'normal'. This is a moving coming-of-age story that gets to the heart of what an education is and what it offers – the perspective to see one's life through new eyes and the ability to change it.

– Tara Horan

Educated by Tara Westover is published by Hutchinson, 978-1786330512, RRP STG £14.99

CROSSWORD Competition

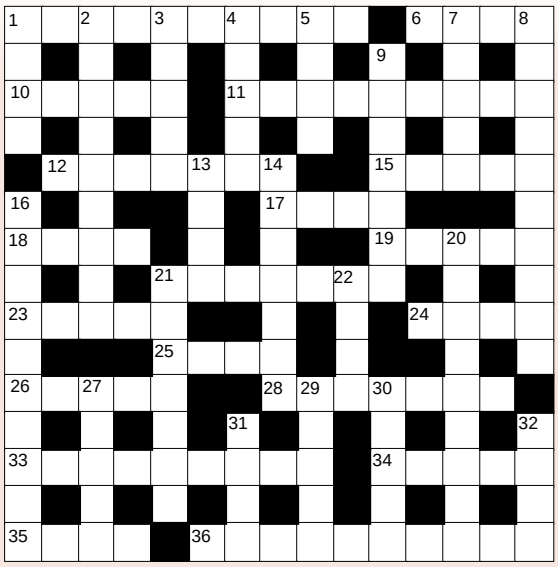
WIN a €30 gift voucher

Across

1 The survivor notices marks on the skin (5,5)
6 Fortified wine (4)
10 & 19a As ever, salads need to be refreshed with green sauce (5,5)
11 Upon those people, finish recuperating (2,3,4)
12 Training shoe (7)
15 Unsteady (5)
17 A small case, suitable for holding needles, etc (4)
18 Beasts of burden love to kiss cardinals! (4)
19 See 10 across.
21 Trip, falter (7)
23 Nobleman with a pub aboard (5)
24 The young salmon is, on average, right (4)
25 It's Ms Kournikova, whichever way you look at her (4)
26 Will one motion for physical fitness if one won't stand down? (3-2)
28 I strove to get around an Italian city (7)
33 Raise the stakes (2,3,4)
34 & 27 down Ant? Treat it to a French treat! (5,5)
35 & 5 down Infants! They don't add up to much! (4,4)
36 Game wherein you loop string over the fingers (4,6)

Down

1 'Inventory (4)
2 Willing recruit (9)
3 Tear a form of lasso (5)
4 Would not an amateur be able to provide this surgical instrument? (5)
5 See 35 across.
7 La Boheme, perhaps (5)
8 Some dryad beset by cuddly toys (5,5)
9 Meditative about the writers I have written (7)
13 A nautical mile per hour (4)
14 As sold by a communist butcher? (3,4)
16 A dalmatian digestive or collie cookie, perhaps? (3,7)
20 Gave peace of mind (9)
21 Is the youngster a photographer? (7)
22 Mislay (4)
27 See 34 across.
29 Waterside plants (5)
30 One who exercises franchise (5)
31 Have a yen for Ms Ni Bhraonain? (4)
32 In this place (4)



October crossword solution

Across: 1 Popemobile 6 Chic 10 Borax 11 Snare drum 12 No trump 15 Laser 17 Aria 18 Ring 19 Teach 21 Ingrate 23 Unlit 24 Eton 25 Amok 26 Drool 28 Algarve 33 Medicinal herbs 35 Nays 36 Liver salts

Down: 1 Pubs 2 Personnel 3 Mixer 4 Besom 5 Leaf 7 Hares 8 Comprehend 9 Deflate 13 Upon 14 Paprika 16 Groundsman 20 Antiviral 21 Italics 22 Tang 27 Oddly 29 Lille 30 Athos 31 INRI 32 Isis

The winner of the October crossword is: Mary Fullam Bandon, Co Cork

You can now email your entry to us at nursing@medmedia.ie by taking a photo of the completed crossword with your details included.
You can also post your entry to: Crossword Competition, WIN, MedMedia Publications, 17 Adelaide Street, Dun Laoghaire, Co Dublin, A96E096
Closing date: November 30, 2018

Name:
Address:

Shopping around for health insurance

Dermot Wells discusses the common challenges consumers face when renewing health insurance

MORE than one million customers in Ireland will renew their health insurance over the next five months as we head into the busiest time of the year for renewals.[1]

2018 has been quite an unusual year for health insurance. Unlike previous years, the market has seen a number of rate reductions and price freezes, which is good news for consumers. Despite this, you could still be overpaying for your cover.

A simple rule of thumb is that if you have been on the same plan for the last two years or more, then you may be overpaying.

You could also be overpaying if you have your family on the same plan or if you are aged between 20 and 25 as you could be availing of young adult discounts ranging from 10-50%. Insurers differ in the range of plans to which young adult discounts are made available, so it is certainly worth reviewing.

If you do nothing, your policy could automatically renew. This is why it's important to pick up the phone to ensure you get the right plan and price for you and your family.

Corporate plans

Corporate plans are designed primarily for large multinational companies. They are packed with many additional benefits not normally available on individual consumer plans. The good news is that corporate plans are available to everyone.

Some key benefits available on most corporate plans include the following:

- Access to all public and private hospitals
- Access to the two high tech hospitals for cardiac and special procedures (The Blackrock Clinic and The Mater Private)
- A lower excess for day case and overnight procedures. An excess is the amount of the claim you pay towards the procedure. Typically this ranges from €50-€125 for a day case procedure and €75 to €150 for an overnight procedure
- Strong day-to-day benefits, ie. an ability to claim back a contribution towards GP, consultant, physio and alternative practitioner visits
- Access to minor injury clinics such as Affidea, My Medical or Swiftcare
- Employee assistance benefits. While you may not be an employee, this service can offer over the phone and six face-to-face consultations for support in the areas of anxiety, mental health, counselling etc
- International Second Opinion Service. This can offer an independent review of diagnosis and treatment in a choice of world renowned medical services
- Online/digital doctor provides access to a GP by phone or face-to-face video seven days a week with an ability to email a prescription to your local pharmacy.

Switching plans or health insurer

It is important to note that if you decide to change your plan or insurance company at your renewal, you will not have to re-serve any waiting periods. This is a common barrier to consumers moving providers as many mistakenly think that they have to re-serve waiting periods. You will be credited with time already served.

Waiting periods clarified

The following three scenarios are subject to waiting periods when you take out health insurance or upgrade the level of your cover:

- When you take out cover for the first time, there is usually a 26-week period before you are covered for new conditions. Accident and emergency issues are covered immediately
- As health insurance is community rated, with everyone paying the same base premium regardless of age, a waiting period is applied for pre-existing conditions. This is put in place to protect the community rating pool and avoid scenarios where someone waits until they are really sick before taking out health insurance. For example, if you have a pre-existing cardiac condition and you take out a health insurance policy for the first time, that condition would not be covered for a period of five years
- Similarly, to avoid a scenario where consumers wait until they are sick before upgrading their cover, a two-year rule applies. This rule only relates to pre-existing conditions. To take the above example, if you have a pre-existing cardiac issue and your current plan does not have access to the two high tech hospitals and you move to a plan that does offer cover in these hospitals, it would be two years before you could access the two new hospitals for that cardiac issue. New conditions would be covered immediately.

New policies

If you are thinking of taking out health insurance for the first time, there are many options available for you to choose from, with prices ranging from €500 to 950 per adult. It is important to note that the use of public hospitals is not free and without having health insurance you could be subject to a payment of €80 per night up to a maximum of €800.

For a similar amount you could avail of a comprehensive plan, offering cover in most if not all public and private hospitals.

With more than 330 plans on the market across the three health insurers, comparing cover remains a challenge for consumers. Cornmarket's Health Insurance Comparison Service can review all the available cover options from all the providers. We can provide a documented comparison of your existing plan against our recommendation so it's easy for you to compare. For more information contact Cornmarket at Tel: 01 4086212.

Dermot Wells is the general manager of health insurance Cornmarket Financial Services Ltd

1. HIA.ie, August 2018. Cornmarket cannot be held responsible for information contained in external websites

Practice nurse of the year announced

Eilish O'Sullivan is "one in a million," according to nominating GP

EILISH O'Sullivan, from the Riverside Medical Centre, is "one in a million," according to her nominator for the prestigious GP Buddy 'practice nurse of the year' award.

The award recognises a practice nurse who has made an outstanding contribution to his or her community. Dr Pixie McKenna presented the award on September 24 at the National GP Awards in Dublin.

Together with her colleague Helen, Eilish, a practice nurse for almost 30 years, has expanded the nursing role to take ownership of many areas of the practice. This has had a positive impact on the workload of the GPs at the practice and their service to the community.

Eilish's intuition, experience, energy and enthusiasm make her an asset to her practice. She is described as calm in a crisis and an expert in picking up patients' concerns, especially those of new mothers.

Patients love Eilish and she makes sure that they feel understood. She treats them with compassion and follows up with them to ensure no stone is left unturned.

Her nominating GP said: "Our practice is incredibly fortunate to have such an excellent nurse with a passion for nursing and providing care in the community."

The INMO would like to congratulate Eilish on her achievement, which is a fitting recognition of the key role played by practice nurses in the delivery of primary care to communities throughout the GP network. INMO head of education and professional development Steve Pitman said: "Many of the educational and learning opportunities now offered by the INMO are highly relevant to practice nurses and we are open to developing tailor made programmes to meet identified needs of members in GP services. Practice nurses are key health professionals in the community and the INMO is keen to promote recognition and support for the role as part of the delivery of Sláintecare."

Eilish O'Sullivan pictured receiving the Practice Nurse of the Year award in Dublin

Report recommends modification of RNID roles

THE *Shaping the Future of Intellectual Disability Nursing in Ireland* report was launched on September 19 by Minister of State for Disabilities Finian McGrath.

The report was sponsored by the HSE Disability Services and the HSE Office of Nursing & Midwifery Services Division in partnership with Prof Mary McCarron and her team at Trinity College Dublin. The RNID Section played a leading role on the project steering group. The INMO continues to be at the forefront of promoting the role of the registered nurse in intellectual disabilities. The Organisation has highlighted the fundamental contribution of the RNID in optimising the lives and health of individuals and the importance of ensuring a planned workforce for people with an intellectual disability.

The report sets out four themes:

- Planning and person-centredness
- Supporting the health and social care needs of people with disabilities
- Developing nursing capacity, capability and professional leadership
- Improving outcomes and experience for individuals with an intellectual disability.

The report recognises that RNIDs are key in the provision of health and social care supports for people with an intellectual disability. The educational and experiential preparation of the RNID is centred on people with intellectual disabilities. ID nursing is a registered and accountable profession and defined by its core values of compassion, care and commitment.

The report provides a pathway for the sustainability and advancement of the role of disability nursing in Ireland. At its core is the contribution made by nurses to ensure the best possible social and health care for people with an intellectual disability. The report recognises the need to develop the role of the RNID across primary, secondary and tertiary care settings.

This development will be built on workforce planning needs to ensure that every person with an intellectual disability has access to the specialist knowledge of a RNID. The report identifies the need to further develop the roles of advanced nurse practitioner and clinical nurse specialist in areas such as:

- Autism
- Early-onset dementia
- Early detection of deterioration in mental or physical health
- Complex needs
- Palliative care
- Acute liaison
- Maternity liaison
- Children with life-limiting conditions
- Health promotion.

Improving the experience and outcomes for individuals with an intellectual disability is crucial, and involves the following factors:

- Quality care metrics
- Caring behaviours assurance system Ireland
- Staff engagement.

The report provides a framework to support the implementation of quality metrics for all areas of intellectual disability. RNIDs will need to work in partnership with individuals with an intellectual disability and other stakeholders to identify structure, process and outcome metrics/key performance indicators in relation to the care/service they provide. Minister McGrath said: "This report outlines details of the findings which suggest a clear requirement for the role of the registered nurse in intellectual disabilities in the future to support the implementation of policy, which will enhance the service delivery model in an interdisciplinary environment."

In order for this report to become a reality, it will require funding to be guaranteed, and a partnership approach between all stakeholders. The INMO looks forward to the report's implementation and the modification of the roles of the RNID in continuing to deliver excellence in care.

Every breastfeed makes a difference

Investment in breastfeeding benefits the economy, finds new study

LAST month's National Breastfeeding Week saw more than 125 events take place around the country.

Coffee mornings and support groups were organised to promote the importance of breastfeeding. A visit by breastfeeding mothers to Áras an Uachtaráin also took place.

On the HSE's dedicated website, **www.breastfeeding.ie**, there is a range of supports available for breastfeeding mothers and their families, including the free 'ask our expert' service and live web chat provided by lactation consultants.

According to HSE national breastfeeding co-ordinator Laura McHugh: "Breastfeeding is a natural process, however mothers may require support, knowledge and education. A recently published study tells us that when support is offered to breastfeeding mothers with healthy term babies, it increases the duration and exclusivity of breastfeeding.

"**Breastfeeding.ie** provides answers to all your questions, and support and information is available to help you and your baby. The breastfeeding videos at the site provide guidance on positioning and attaching baby; expressing milk; what to expect in the early days; and tips from other mothers.

"We also have a HSE breastfeeding Facebook page, which provides a community support for mothers. There are 290 breastfeeding support groups around the country, details of which are available at **breastfeeding.ie**. Some of these groups are organised by PHNs, others by lactation consultants in the hospitals or trained breastfeeding support volunteers. They are a great source of information, support and friendship."

Pictured at the Cork University Maternity Hospital (CUMH) Breastfeeding Support Group at the SMA Parish Hall Wilton Cork, to mark HSE National Breastfeeding Week

The HSE also highlighted recently published research into the social return on investment from PHN-facilitated breastfeeding groups in Ireland. The study, which was funded in part by the Institute of Community Health Nursing, was carried out by Sinead Hanafin, Kieran O'Dwyer, Mary Creedon and Catherine Clune Mulvaney. It shows that, for every Euro spent on breastfeeding groups facilitated by PHNs, there is a significant return of €15.85.

Social return on investment is a type of cost-benefit analysis that allows the social, economic and environmental value of services provided to be measured in ways that are relevant to stakeholders. Essentially, it reveals the economic value of social and environmental benefits and balances them against the cost of the intervention provided.

According to Dr Sinead Hanafin, visiting research fellow at Trinity College and co-author of the report: "The findings from this study clearly highlight a number of benefits for everyone involved and shows a very positive impact on the health of mothers and infants from attending groups facilitated by public health nurses.

"The study also shows that attendance at a breastfeeding group can result in improvements in the mental health of new mothers and can also help mothers to breastfeed for a longer period of time."

New booklet published ahead of World COPD Day 2018

WORLD COPD Day takes place on November 21 and to mark it, COPD Support Ireland is undertaking a number of initiatives to raise awareness of the disease.

Chronic obstructive pulmonary disease is caused primarily by smoking, but can also be the result of inhalation of dust or chemicals, or exposure to pollution.

People with an existing illness like chronic asthma may be more prone to developing COPD. Others are pre-disposed to it due to a hereditary lung condition called alpha-1 antitrypsin deficiency.

More than 17,500 people were admitted to Irish hospitals as a result of COPD in 2017 and to support these patients, the charity has released a new booklet, *COPD & Me,* which outlines the 'top seven tips for minding your COPD':

- Give up smoking
- Breathe easy
- Get active
- Eat well
- Know your medications
- Avoid flare-ups
- Mind your feelings.

Other initiatives by the charity will include the introduction of a series of community-based exercise programmes in 12 counties across the country, and the distribution of public information packs, including posters and leaflets.

These packs will be made available to people who get in touch with COPD Support Ireland directly.

For more information on the work of COPD Support Ireland, visit **www.copd.ie** or contact the charity at Tel: 086 0415128 or email: info@copd.ie

November

Saturday 10
Radiology Section meeting. SVUH. Following the Radiology Association Conference. Contact jean.carroll@inmo.ie for further details

Friday 16
Third Level Student Health Nurses Section workshop. INMO HQ. 10am-4pm. Contact jean.carroll@inmo.ie for further details

Saturday 17
PHN Section meeting. INMO HQ. 11am-1pm. Contact jean.carroll@inmo.ie for further details

Saturday 17
Community RGN Section meeting. INMO HQ. 11am-1pm. Contact jean.carroll@inmo.ie for further details

Monday 26
OHN Section tools for safe practice session. Richmond Education and Event Centre. 10am-2pm. Contact deborah.winters@inmo.ie to book your place.

Wednesday 28
CPC Section meeting. INMO HQ. 10.30am-12.30pm. Contact jean.carroll@inmo.ie for further details

December

Wednesday 12
RNID Section meeting. INMO HQ. 11am-1pm. Contact jean.carroll@inmo.ie for further details

January

Saturday 19
PHN Section meeting. INMO HQ. 11am -1pm. Contact jean.carroll@inmo.ie for further details

Saturday 19
Community RGN Section meeting. INMO HQ. 11am-1pm. Contact jean.carroll@inmo.ie for further details

Saturday 19
ODN Section AGM and meeting, from 11.30am in the Mater Hospital. Contact jean.carroll@inmo.ie for further details

Wednesday 23
Telephone Triage Section AGM. Midland Park Hotel, Portlaoise. 11am-1pm. Contact jean.carroll@inmo.ie for further details

Thursday 24
Retired Nurses Section AGM. INMO HQ. 11am-1pm. Contact jean.carroll@inmo.ie for further details

February

Saturday 2
Midwives Section AGM. INMO Cork University Maternity Hospital. Contact jean.carroll@inmo.ie for further details

Saturday 2
School Nurses Section AGM and sepsis information meeting. INMO HQ. Contact jean.carroll@inmo.ie for further details

INMO Membership Fees 2018

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

Condolences

❖ The INMO and colleagues at Sligo University Hospital would like to extend their deepest condolences to former vice president Ann McGowan on the death of her mother May McGowan. RIP