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WIN

Journal of the Irish Nurses and Midwives Organisation

World of Irish Nursing & Midwifery

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Collective approach the key

IN THIS issue of *WIN* you will read of positive developments in relation to incremental credit for nurse/midwife graduates for the period 2011-2015, and the re-introduction of premium pay for the hours between 6pm and 8pm, payable to members in the acute sector *(see pages 8-9)*.

These positive gains, which put much needed added salary into our members' pockets, came about as a direct result of sustained collective campaigning and negotiations over an extended period. These two developments are also the latest examples of this Organisation securing, on an ongoing basis, the reversal of grossly inequitable cuts imposed unilaterally in recent years by successive governments.

These are, of course, only steps on the road that we must follow, demanding the full reversal of all pay cuts, restoration of all allowances and reduction of work hours, all of which were part of agreements, reluctantly accepted, in recent years.

The Executive Council is aware of the anger and frustration among members at the slow pace of returning salaries cut, the burden of additional, unpaid hours and the excessive and unsafe workloads arising from the ongoing staffing crisis, and severe difficulties with recruitment and retention. That is why the Executive Council, at its meeting in October, initiated a nationwide consultation to hear first-hand members' priorities as we finalise a campaign to address these priority issues.

At the time of going to press, these regional meetings are continuing with much robust and strong debate as to what should be the Organisation's priorities, subject to a democratic mandate, in the coming weeks.

The Executive Council is scheduled to meet again on November 7-8, 2016 to receive feedback from all of these regional meetings, to interpret that feedback and determine what form of campaign will secure the strongest mandate from members, in all areas of the health service, across the country.

The situation is also connected to imminent industrial action by one teacher union and two garda representative bodies, which, at this time, are scheduled to involve days of action running right through the month of November.

Currently of 21 representative bodies in the wider public service, 18 continue to work within the framework of the Lansdowne Road Agreement. However, a growing number of the 18 unions, including the INMO, have indicated that the speed of pay restoration and reduction in working hours must be accelerated as the current timeframe, providing for a €1,000 increase from September 1, 2017, with the agreement running to September 2018, is totally unacceptable.

In this context, the INMO is already in ongoing discussions, with these other public service unions, on the next steps that should be collectively taken by the Public Services Committee to deliver the best possible outcome for all public servants.

The key to whatever campaign strategy is finally adopted by the Executive Council will be a collective, sustained, approach, from all members. Experience has shown, even as recently as securing the restoration of the incremental credit and time and one-sixth issues, that collective, strong and coherent action by the Organisation delivers for members in a meaningful way.

Pay, hours and staffing are obviously all major issues for members at this time. Whatever strategy is determined by the Executive Council will be for the purpose of addressing these issues in a manner which is consistent with the views of members, as indicated by the feedback from these regional meetings.

Members are talking, members are being listened to and, ultimately, members will decide what steps this Organisation takes to address these critical issues. A united approach, fully informed by members, will deliver and that will be the central objective of all decisions to be taken by our Executive Council.

UNITY = STRENGTH

Liam Doran
General Secretary, INMO

Your priorities with the president

Martina Harkin-Kelly, INMO president

I AS president, together with the Executive Council, have heard the call from members, right across the country, that they have had enough and want the Organisation to initiate whatever strategies are needed to secure accelerated pay restoration and greatly improved staffing levels and we are actively working to ensure that this is dealt with. The INMO launched the Organisation's campaign for immediate action on pay and nursing/midwifery shortages at a press conference in October. See updates on this campaign in *WIN (pages 10-11)* and on our website **www.inmo.ie**

Premium pay restored

We are delighted to confirm that premium pay (over 2%) cut from nurses/midwives working between 6-8pm will be restored following implementation of the agreement secured under the Lansdowne Road Agreement in acute hospitals. This will be backdated to January 2016. We will continue to work to ensure that payments removed from nurses/midwives within the social and primary care divisions will also be restored *(see page 8)*.

Graduate Dáil protest

THE pay anomaly for nurses/midwives who graduated from 2011-2015 was one of the cruellest blows to our graduates. The recent Dáil protest loudly and clearly articulated to the government that this was a step too far. As your president, along with first vice president Mary Leahy, we were heartened and proud of the members who travelled from near and far to demonstrate their disquiet by participating in the event. The protest gained the necessary traction and was timely in that it was held during the run up to the Budget. By now you will all know that on October 13 the Minister for Health met with a deputation of INMO officials and graduate members to announce the roll back of this disparity. Strategic vision and planning won out and are key if we want to win the fight in the long run to ensure the survival of the nursing and midwifery professions.

Martina Harkin-Kelly (right) with Mary Leahy at the protest outside the Dáil to highlight the pay anomaly for 2011-2015 graduates

Telephone Triage Nurses Section Conference

I WAS honoured to open and address this timely and opportune conference in Limerick. The conference programme covered areas such as midwifery complications,preparing for HIQA, chest pain,sports injuries,dealing with anxiety and infant skin. It both supported and endorsed the 'preventative gate keeper' role of the telephone triage nurse by providing evidence-based practice. This allows for critical appraisal and the use of scientific evidence for the delivery of healthcare to the population of patients that they serve.

All Ireland Annual Midwifery Conference – Dublin

THIS annual one-day conference held in Dublin this year is a true collaboration of midwifery innovations and research both north and south. Minister for Health Simon Harris, who is working collaboratively with his Northern Assembly counterpart, Michelle O'Neill, addressed the conference. Mr Harris welcomed and reiterated the measures within the *National Maternity Strategy, Creating a better future together, 2016-2026* that will commence the process of setting the issues of mother and child safety right. When introducing the Minister, I made a point of reiterating the need for government commitment to fully implement, resource and underpin the Maternity Strategy by strong management structures, otherwise this would be a lost opportunity to fix the ills in our maternity services.

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

Quote of the month

"Before beginning, plan carefully"
– Marcus Tullius Cicero

This is the hallmark of the INMO working continuously for you

Report from the Executive Council

THE Executive Council met on October 3-4 last. Over the course of the September and October meetings, considerable time was given to discuss and debate the many anomalies that exist for you the members. The Executive Council agreed that the pace of pay restoration and the time scale is too long and too little and we must apply pressure to accelerate pay and improved conditions via the national campaign launched in October.

The INMO strives to support and work for all members at every opportunity with matters pertaining to professional development, industrial relations, fitness to practise and ongoing campaigns like our national campaign which saw nationwide information sessions. This will help secure a future that is bright, better and benefits all nurses and midwives.

The next Executive Council meeting on November 7-8 will receive feedback from the recent nationwide sessions and the valuable information obtained from all members will in turn shape the direction of the campaign.

Don't forget to forward your ideas, advice, and thoughts on how to plan for the Health Summit.

The following Executive Council meeting will be held on December 5-6, 2016 in INMO HQ.

Get in touch

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

Premium pay restored for 6-8pm

Worth more than 2% to members in acute hospitals

PREMIUM pay cut from nurses/midwives working between 6-8pm is to be restored following implementation of the agreement secured under the Lansdowne Road Agreement (LRA) in acute hospitals.

The INMO, SIPTU Nursing and the IMO have engaged with the health service employer (the HSE and the Department of Health) to implement the agreement on the nursing and medical interface under the LRA. The INMO argued that this would allow savings to accrue to cover the costs associated with restoring the premium payment removed from nursing and midwifery (and all other healthcare workers) under the Haddington Road Agreement, and that it should be restored to the nursing/midwifery grades affected.

The INMO did not accept the removal of this premium payment which equates to over 2% of salary for staff who regularly work shift patterns incorporating the hours 6-8pm, and it set about having it restored using all the procedures and processes available.

This has paid off – the first verification process has been completed and the payment is now confirmed as restored in the acute hospital division and a circular from the HSE has issued instructing payment.

This process involved lengthy engagement, chaired independently, after which agreement was arrived at between the Department of Health, the HSE, the INMO, SIPTU Nursing and the IMO, in December 2015, which set out a three-pronged process:

- Firstly, the acute hospitals would introduce the sharing of four tasks identified. The responsibilities for these roles are not removed from medical staff, but are now shared with nursing and midwifery staff. The agreement allowed for nursing/midwifery staffing levels to be taken into account in areas where this would not allow nursing/midwifery staff to take on these roles. Following this a rigorous verification process was undertaken and had to be met on each acute hospital site. This also required site visits and sign off from local hospital directors of nursing/midwifery as well as the national verification group. The national verification group, which has a representative of the Department of Health, the HSE and trade unions (INMO director of industrial relations Phil Ní Sheaghdha is the INMO rep), was established and met with each site in June 2016 and was satisfied that real progress was being made
- Phase two, now commencing will involve the HSE social care division and services outside of the acute hospitals
- Verification is in two phases; the first phase is complete and the second is being undertaken over the next six weeks.

Payment, retrospective to January 1, 2016 is provided for in the agreement. Nurses and midwives in the acute division will have this payment restored from November 1, 2016 with arrears (10 months) payable in January 2017. In calculating the arrears now due in the acute division the INMO has reminded the HSE that provision must be made to calculate:

- Retrospection to January 1, 2016 on actual earnings
- Effect of retrospection on premium pay for annual leave
- Effect of retrospection on pension and lump sum emoluments for those who have retired since January 1, 2016.

A second and final process is required and this is to take place in the acute hospital setting in the coming weeks. The verification group has agreed that not all sites need to be revisited. However, the following hospital groups have been selected :

- Ireland East, St Vincent's Hospital, November 18, 10am
- Midlands Hospital Group, Tallaght Hospital, Nov 18, 2pm
- SAOLTA Group, Galway University Hospital, Nov 28, 10.30am
- Midwest Hospital Group, Limerick, November 28, 3pm.

The HSE is advising these hospital groups of the follow on visit, which is a requirement of the second and final process.

Non-acute hospital sectors

In respect of sectors outside of acute division, the agreement states that: "The HSE will ensure that the payment is applied using the same mechanism to the terms and conditions of members of the INMO and SIPTU Nursing in each sector in which it applied prior to the HRA, in line with this agreement."

Having met with the social care and primary care divisions, the INMO believes delivering patient services within these sectors and reducing the need to transfer patients to acute hospitals for treatment, makes sense to members working in these sectors, from a patient and service perspective. The INMO has reiterated the terms of the agreement which requires these two divisions to engage with a view to ensuring those working in these sectors can fully apply their education and professional ability.

The INMO will continue to engage in the implementation of the December 2015 agreement in these sectors and keep members informed during this process. The next meeting in respect of progressing this part of the agreement is scheduled for November 7, 2016.

The Organisation will continue to work to ensure that payments removed from nurses and midwives in these sectors are also restored in line with the agreement.

INMO director of industrial relations Phil Ní Sheaghdha said: "We believe that this process has demonstrated fully that when nurses and midwives engage with change they do so in a manner that promotes and enhances patient care and makes financial sense."

In the context of the outcome of the verification process, the independent chairman stated: "Progress achieved in firstly agreeing the transfer of tasks developments, and then implementing and verifying the changes through a collaborative process reflects well on the parties to the agreement... It is clear from the deliberations over recent months and the positive feedback from site visits that the transfer of these tasks can result in earlier interventions and consequent earlier discharges. The outcome will be that substantial financial savings can be made in addition to increasing the availability of inpatient beds, without compromising patient care or satisfaction".

Ms Ní Sheaghdha said: "This is another step in restoration of pay for INMO members and was achieved within the terms of the LRA. In addition this will move the role of the nurse/midwife working in all areas of the public health service to a place where there is a greater input into decision making and enhanced autonomy in their role. This will require greater focus by the employer on providing ongoing education, and development of work processes."

Recent graduates protest outside the Dáil for restoration of incremental pay

Full removal of pay anomaly marks a key win for graduate members

Pay increase of up to €1,500 for up to 7,500 recent graduates

THE INMO has reached agreement with Minister for Health Simon Harris for the removal of the pay anomaly affecting nurses/midwives who graduated between 2011 and 2015.

This agreement, secured by the INMO, means that these dynamic new graduates will receive an extra increment from January 2017, worth between €1,200 and €1,500 depending on their current point on the scale. This provides equal treatment with those recruited prior to 2011 and those recruited in 2016 in terms of pay.

The removal of this anomaly, involving the withholding of incremental credit for the fourth year of the undergraduate programme, sees the elimination of this very regressive measure, which was introduced, unilaterally, in 2011.

This development will benefit nurses/midwives, who graduated during this five year period since 2011, who are currently working in the public health service. In addition it will also increase the starting salary of any nurse/midwife who graduated in the same period, who is now working outside the public health service or overseas, and who wishes to take up a position in the public health service.

The INMO, together with other unions representing nurses, has been demanding the removal of this anomaly since its introduction six years ago. This positive development must be the first of a series of measures to help recruit and retain nurses and midwives in the public health service.

Speaking as we went to press INMO general secretary Liam Doran said: "This agreement with the Minister must be welcomed, is long overdue, and we acknowledge his work on this issue since his appointment.

Liam Doran, INMO general secretary, rallying members on outside the Dáil to win a key step in addressing the deepening crisis of nurse/midwife staffing levels in the public health service

"It represents an important first step, which must now be followed by further initiatives, to address the deepening crisis with regard to nurse/midwife staffing levels and this country's inability to retain these professionals in our public health service. The INMO is now contacting all of our new graduate members, who stand to benefit from this agreement to ensure they secure this legitimate, and outstanding, pay increase in January".

At launch of INMO campaign calling for immediate action on pay and nursing/midwifery shortages were (l-r): *Phil Ní Sheaghdha, director of industrial relations; Martina Harkin-Kelly, president; Liam Doran, general secretary; Mary Leahy, first vice president; and Dave Hughes, deputy general secretary*

INMO calling for immediate action on pay and nursing/midwifery shortages

Urgent need for accelerated pay restoration

THE INMO Executive Council held a special meeting early last month at which it spent substantial time considering the Lansdowne Road Agreement and the chronic shortage of nurses and midwives in the context of the improving economic situation.

Following a detailed analysis of the current situation, including feedback from members across the country, the Executive Council reaffirmed its firm view that:

- Current pay levels, following pay cuts and pension levies, are inadequate to attract and retain nursing/midwifery staff
- Current nurse/midwife staffing levels in clinical areas are wholly inadequate to provide safe care for the number of admitted patients/clients requiring services
- Nurses and midwives are working excessively long hours, some of which are unpaid, and are under excessive pressure and in many cases are burned out at the end of their shifts.

The Executive Council stressed that this situation is unsustainable, unacceptable and dangerous for INMO members and is in contravention of the HSE's obligations, as the employer, under health and safety legislation.

In response to these critical and connected issues, the INMO has now prioritised the following strategies to seek immediate acceleration of the reversal of the pay cuts and pension levies imposed under FEMPI legislation, and additional hours (unpaid) imposed on nurses and midwives under the Lansdowne Road and previous agreements.

In addition, in recognition of the deepening crisis with regard to nursing/midwifery shortages, the Organisation is:

- demanding special incentive measures aimed at recruiting and retaining nurses and midwives in sufficient numbers to adequately staff the health service
- Advising and supporting members when they exercise their professional judgement that services must be curtailed to match available staffing levels in the interests of safe patient care
- Seeking agreement from health employers that they will, in future, accept and respect the professional judgement of nurses/midwives in determining staffing levels required to provide safe care through safe practice.

In relation to these matters the INMO has now commenced nationwide consultation with members to finalise the actions necessary to achieve these objectives. A series of 12 regional meetings, was ongoing as we go to press.

The Executive Council will meet again on November 7-8, 2016, to receive feedback from all of these meetings and to finalise the next steps in this campaign for restoration, respect and safe working environments.

The consistent, and growing, message from members is that they cannot cope any longer with reduced salaries, unpaid additional hours and unsafe staffing levels leading to intolerable workloads. These realities are further exacerbated by the constant refusal of management to respect, and accept, the professional judgement of nurses/midwives as to when patient care is compromised and/or unsafe.

Action is also necessary in the context of the abject failure of management to implement numerous agreements, at both national and local level, to fill vacant posts and ensure staffing levels are appropriate in terms of bed numbers and service demands, ie. the national ED Agreement and numerous local agreements in Limerick, Cork, Drogheda and care of the elderly services. Emergency department overcrowding continues with management failing to recognise that the extra admitted patients require additional staff to care for them (7,551 admitted patients in September – *see trolley watch table opposite*).

Further proof of the growing crisis is the latest staff census figures, from the HSE, which confirms that at the end of July there were 309 fewer staff nurses and 41 fewer public health nurses working in the HSE compared to December 2015.

In terms of total staffing there continues to be almost 4,000 fewer nursing and midwifery posts in the health service than there were in 2008 (35,000 now compared to >39,000 in 2008). This confirms that all attempts at recruitment/retention, taken to date, have failed completely to address the haemorrhage of nurses/midwives out of the system, and the damage done by the recruitment embargo of recent years. This reality

explains why our members are now beyond breaking point as a result of the unsafe working environment they face daily.

Commenting on this critical issue INMO president Martina Harkin-Kelly said: "The Executive Council has heard the call from members, right across the country, that they have had enough and want the Organisation to initiate whatever strategies are necessary to secure accelerated pay restoration and greatly improved staffing levels. The intolerable stress levels, being encountered by our members, cannot be ignored. The health and safety of our members is being compromised on a daily basis as a direct result of work related factors, which are being ignored by health employers. We cannot let this continue any longer".

INMO president Martina Harkin-Kelly: "The health and safety of our members is being compromised on a daily basis as a direct result of work related factors which are being ignored by health employers"

INMO general secretary Liam Doran said: "The acceleration of pay restoration, in the context of an improving economy, is now an absolute priority for nurses and midwives and, we believe, all public servants working on the frontline who had their pay reduced by at least 14%.

"The Minister for Finance, in the lead up to the General Election earlier this year, said that the emergency is over. The emergency may be over as far as the government is concerned, but the reality is the emergency continues, every day, for nurses and midwives. Our members want a definite timeframe for the full restoration of pay cuts, imposed by government, and immediate action on special measures to recruit and retain nurses/midwives in sufficient numbers to meet ever growing service demand.

"The campaign, which will be shaped by the feedback from members, will continue until we have addressed these issues. The government must accept that nurses/midwives, and their fellow public servants, have endured more than enough and now expect early restoration of the pay, and other conditions, cut so severely between 2009 and 2013," Mr Doran said.

Table 1. INMO trolley and ward watch analysis (September 2006 – September 2016)

Hospital	Sept 2006	Sept 2007	Sept 2008	Sept 2009	Sept 2010	Sept 2011	Sept 2012	Sept 2012	Sept 2014	Sept 2015	Sept 2016
Beaumont Hospital	310	409	608	830	680	730	280	620	644	732	383
Connolly Hospital, Blanchardstown	211	229	226	176	297	387	317	540	485	327	172
Mater Misericordiae University Hospital	262	366	519	443	446	368	334	187	311	371	350
Naas General Hospital	85	17	243	157	370	230	151	118	249	180	156
St Columcille's Hospital	32	29	152	200	89	240	119	45	n/a	n/a	n/a
St James's Hospital	22	39	178	169	150	114	84	117	329	159	219
St Vincent's University Hospital	459	536	500	389	584	638	405	163	200	419	415
Tallaght Hospital	166	329	383	354	661	175	63	337	312	450	450
Eastern	**1,547**	**1,954**	**2,809**	**2,718**	**3,277**	**2,882**	**1,753**	**2,127**	**2,530**	**2,638**	**2,145**
Bantry General Hospital	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	6	3	25
Cavan General Hospital	74	267	91	262	433	341	142	206	15	180	39
Cork University Hospital	229	235	275	437	567	529	146	304	326	447	441
Letterkenny General Hospital	281	34	16	33	49	25	28	176	130	158	263
Louth County Hospital	19	0	0	24	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Mayo General Hospital	202	72	28	114	147	45	145	57	64	118	206
Mercy University Hospital, Cork	107	71	113	90	195	185	149	134	240	142	220
Mid Western Regional Hospital, Ennis	43	9	17	23	10	3	12	0	n/a	14	16
Midland Regional Hospital, Mullingar	22	4	18	31	116	275	186	146	255	453	380
Midland Regional Hospital, Portlaoise	38	24	6	0	24	254	25	79	44	147	216
Midland Regional Hospital, Tullamore	0	2	8	4	56	113	96	13	508	302	411
Monaghan General Hospital	6	2	22	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	0	2
Our Lady of Lourdes Hospital, Drogheda	349	116	302	323	331	842	626	214	593	606	507
Our Lady's Hospital, Navan	40	47	72	169	7	75	8	57	26	33	49
Portiuncula Hospital	21	9	0	105	33	149	26	36	49	36	98
Roscommon County Hospital	50	60	80	50	113	n/a	n/a	n/a	n/a	n/a	n/a
Sligo Regional Hospital	79	56	8	55	168	153	102	45	200	210	51
South Tipperary General Hospital	34	92	10	64	13	125	123	224	97	107	350
St Luke's Hospital, Kilkenny	n/a	n/a	n/a	n/a	34	47	35	209	128	278	188
University Hospital Galway	126	209	380	321	356	642	271	282	446	514	499
University Hospital Kerry	129	46	11	16	73	68	59	51	91	138	133
University Hospital Limerick	139	166	72	201	502	384	279	345	551	784	825
University Hospital Waterford	n/a	n/a	63	46	164	59	136	152	68	257	333
Wexford General Hospital	189	19	42	178	336	490	53	73	144	35	154
Country total	**2,177**	**1,540**	**1,634**	**2,546**	**3,727**	**4,804**	**2,647**	**2,803**	**3,981**	**4,992**	**5,406**
NATIONAL TOTAL	**3,724**	**3,494**	**4,443**	**5,264**	**7,004**	**7,686**	**4,400**	**4,930**	**6,511**	**7,630**	**7,551**

Comparison with total figure only:
Decrease between 2015 and 2016: -1%
Increase between 2014 and 2016: 16%
Increase between 2013 and 2016: 53%
Increase between 2012 and 2016: 72%
Decrease between 2011 and 2016: -2%
Increase between 2010 and 2016: 8%
Increase between 2009 and 2016: 43%
Increase between 2008 and 2016: 70%
Increase between 2007 and 2016: 116%
Increase between 2006 and 2016: 103%

Health allocation inadequate to meet growing demand

WHILE noting the overall increase in health funding for 2017 announced in the Budget last month, the INMO believes it will prove wholly inadequate in dealing with the current and growing demand for services.

The increase of €457 million, resulting in a total allocation of €14.6 billion, must be compared with the allocation of in excess of €16bn to the health service before the economic crash.

This stark reality confirms that while the increased funding proposed must be welcomed after several years of repeated cuts, it will not allow the health service to expand and develop existing and new services across the country.

While also welcoming the proposal to recruit 1,000 nurses/midwives contained within the health allocation, the INMO said that after six years with a ban on nurse/midwife recruitment leading to a loss of 5,200 posts, two critical questions must be asked:

- Is the recruitment simply an intent to convert existing agency employment which, while correct, will not increase the overall number of nurse/midwife employment in the severely understaffed service?
- In the absence of special measures to recruit and retain nurses and midwives, will the public health service continue to fail to compete with private hospitals and UK employers who are offering recruitment incentives?

It is also disappointing that there appears to be no provision, in the Budget allocation, for the additional nursing/midwifery staff already identified as being required in a range of areas including:

- Emergency departments

Liam Doran, INMO general secretary: "The new Public Service Pay Commission must create the context within which pay restoration can be accelerated and labour market realities acknowledged"

- Theatre
- Midwifery
- Community nursing.

In view of these many unanswered questions arising from the health allocation, the INMO has sought an immediate meeting with Minister for Health Simon Harris to establish how these serious issues will be positively addressed.

Public Service Pay Commission

The INMO's view on the announced establishment of a Public Service Pay Commission is that this Commission must facilitate, through an early report, the acceleration of pay restoration to nurses and midwives, and other public servants on very average incomes.

The Organisation stressed it is not tenable, or sustainable, for INMO members to be expected to wait until September next year for the restoration of €1,000, which was cut in 2009, and until September 2018 for any further restoration measures. The Commission must report swiftly and clearly identify the labour market realities with regard to the recruitment and retention of nurses and midwives. It will inevitably conclude that this can only be addressed by a significant increase in pay levels as soon as possible.

INMO general secretary, Liam Doran said: "Any increase in funding to our under-resourced public health service must be welcomed. However, the allocation proposed will not enable the health service to meet, safely, the ever growing demand.

"The health service still has over 4,200 less nursing/midwifery posts than it had in 2009. It is against this reality that the proposal, without special recruitment and retention initiatives, to recruit 1,000 nurses/midwives in 2017 must be measured."

Mr Doran continued: "It would not appear, from the Budget announcement, that the government is moving to address the severe structural deficits in terms of staffing and capacity, which now exist within our public health service. The INMO will continue with its campaign, commenced last month, aimed at ensuring staffing levels match service activity and no nurse or midwife is left with intolerable workloads and unable to provide safe care.

"Against this background we are seeking an urgent meeting with the Minister to discuss and seek answers to these critically important issues.

"Related to all of this, the government must accept that the current pace of pay restoration to public servants, on ordinary incomes, is unreasonable and must be reviewed. The new Public Service Pay Commission must be empowered to act swiftly on this issue, and create the context within which pay restoration can be accelerated and labour market realities acknowledged."

World news

Nurses and midwives in action around the world

Argentina
- Balestrini Hospital: Abuse and labour persecution

Australia
- Doctors, nurses strike pay deals for 1.5% increases with WA government
- Nurses strike not ruled out for future

Canada
- Fewer and fewer full-time nurses in Rimouski

Costa Rica
- Nurses seeking new collective agreement

France
- Vaccination: So that nurses are heard

Kenya
- Medical services in Busia County paralysed following nurses strike

Paraguay
- Nurses mobilise outside national parliament
- Nurses continue to fight for their rights

Phillipines
- Health workers ask Alvarez: Restore P1.5 billion slashed from public hospitals

Portugal
- Dozens of nurses protest in front of the Ministry of Health

Spain
- SATSE urges the Spanish prime minister to end discrimination of professional nurses
- Nurses' union condemns continued closure of beds in summer in Hospital de Huelva

US
- Striking Minnesota nurses reach tentative agreement
- 53 nurses allege labour violations at Twin Cities Community Hospital
- After 17-hour negotiating session, nurses and Allina Health reach tentative agreement

Dave Hughes, INMO deputy general secretary, stresses the importance of accommodating employees with a disability or injury

A proactive approach to health and safety

THE HSE, between 2013 and 2016, has been forced to pay out €168,000 as a result of three different cases taken due to its failure to provide employees with reasonable accommodation in respect of disability or an injury sustained at work.

Employers, in law, must not discriminate against employees in respect of access to employment, conditions of employment, training or experience in relation to employment, promotion or regrading and classification of posts.

As all employment law explicitly sets a minimum standard expected of employers, it is a serious matter for a state agency, such as the HSE, to have so often been found in breach of the law. The equality officer, in making an award of €85,000 to a claimant, summed it up by stating: "I am cognisant of the irony of an organisation like the HSE, which is a very large and substantial employer within the state, having such an apathetic attitude to the provisions in the employment equality acts in relation to disability and the provision of reasonable accommodation to employees who become disabled during their working lives."

The case concerned in this award was a nurse versus the HSE. The staff nurse had 20 years' service and twice in 1994 and again in 2002 was diagnosed with breast cancer.

The nurse developed lymphoedema under both arms and suffered acute and chronic health difficulties. Determined to work, she returned and worked up to 2009 in a community residential house.

In 2009, she suffered difficulties with a manager which led her to making a complaint of bullying and the pressure which she felt under led to sick leave and work-related stress.

After making that complaint, she and a number of other staff were moved to other locations but she was the only one moved to a locked ward. At that point, both her oncologist and her GP advised against such a move, however this advice was not considered. Under instruction in April 2010, she was moved to the locked unit where she worked for only one day before sustaining an injury which exacerbated her lymphoedema condition.

She returned to work in October 2010 but was assigned to an even more unsuitable location, which was a heavy geriatric male ward of 20 patients. No proper risk assessment was carried out and subsequently, in May 2011, the occupational health department advised that she should be assigned to nursing duties which involved no lifting or risk of personal injury.

The HSE, in response, offered to regrade her as a receptionist. In January 2012, the complainant felt she had no option but to retire early and before the minimum retirement age of 60 years.

In the finding, the equality officer argued that the HSE did not explore the option of getting the staff nurse back to her original work location, where she had reasonable accommodation and had worked for 10 years without difficulty. They failed to take on board the opinion of the occupational health division of the employer or the individual's own oncologist and GP.

Similarly, a medical secretary employed in the HSE since 2001, who had been diagnosed with a debilitating bowel condition and diverticular disease in 2004, was moved from a suitable work environment with adjacent toilet facilities to another area where access to toilet facilities was more difficult.

In spite of GP medical evidence to the employer, the HSE failed to facilitate the worker concerned with a single occupancy close to toilet facilities. Despite repeated requests from the individual, the HSE did not make an effort to accommodate her until her trade union raised the matter as a grievance and there was a six-month delay before accommodating the fairly basic requirements of an individual with a chronic illness. The employee concerned was awarded €65,000.

A paramedic employed by the HSE, who suffered an injury during a road traffic accident while driving an ambulance, returned to work five months later with an instruction from the occupational health department that she must return to modified duties with no manual or patient handling for six to eight weeks.

The HSE insisted that she could only return as a full-time paramedic with the full range of duties, which she did and then subsequently sustained a further injury. The HSE did not consult with the individual paramedic or do an assessment to reasonably accommodate her return to work on lighter or modified duties, until some two years later, after June 2014, when the matter was raised by her union.

When the individual complained that she was victimised and alleged discrimination, the HSE stopped all engagement with her. Again the equality officer in this case was highly critical of the HSE and awarded €18,000.

In another case brought forward against the HSE, a public health nurse who, following a wrist injury, was fit to return to light duties in May 2003, was refused permission by the HSE to do so and so she remained on sick leave and her salary was reduced to half pay. It was five months later before the HSE allowed her to return to work.

The equality officer in that case ordered that the HSE restore full pay to the PHN and revise her sick leave record to show the earlier date from which she was prepared to return to work. In addition, the equality officer ordered €10,000 compensation in respect of the distress the PHN suffered and instructed the HSE to pay the costs of a specialist care course, which the PHN had undertaken while out of work.

The employment equality acts are well established in this country and the HSE has sufficient experience to develop policies and practices which would accommodate people with disability. Managers should be trained and given full understanding of the obligations imposed on employers by the acts and how the courts have interpreted those acts.

Risk assessments and medical reports need to be taken seriously and employees must be consulted and be made aware of the efforts their employers are making to accommodate their needs.

It is in the mutual interest of both employers and employees, given the huge shortage of nurses and midwives, that a proactive approach is taken to the question of health and safety in the workplace and adherence to the principles of the employment equality Acts. Failure to do either is costly for all.

Full speed ahead: Work continues at Richmond Building

Refurbishment work, which will see the Richmond Building transformed into the new INMO Education and Event Centre, is rapidly progressing and is expected to be completed early in the new year. Work on the site began in late July and there will be a formal opening in spring 2017, following completion of refurbishments. Pictured are what will become the function room (top left), the meeting room (bottom left) and the clinical skills room (right), where INMO members will be able to hone their clinical skills while continuing their professional development. Members can keep up-to-date on this refurbishment work via the photo gallery on ***www.inmo.ie***

INMO calls for single-tiered health service

THE INMO was due to meet the Special Oireachtas Committee on the future of healthcare as we went to press.

In both its written submission and opening statement the INMO is calling for a radical transformation of the current two-tiered health system, so that it is single tiered, guaranteeing equality of treatment to all and funded through general progressive taxation. The INMO points out that:

- The transition to a single tiered service would take 10-15 years
- The health service should receive guaranteed public, direct, funding of a minimum of 10% of GDP and 12-14% during the period of transition
- The organisational structure, for the new public health service, should be flattened with autonomy and accountability, for expenditure, devolved to frontline managers
- All new health service staff should be directly employed, including consultants and GPs
- Greatly expanded roles for nurses/midwives, and other health professionals, including direct/cross referrals and nurse/midwife prescribing in all areas of the health service.

The INMO believes that a properly resourced public health service, which treats all citizens equally with access not related to ability to pay, is a powerful social good enhancing the wellbeing of all citizens and acting as a powerful foundation for a growing economy.

Speaking prior to meeting with the committee, INMO president Martina Harkin-Kelly said: "The INMO is calling on the committee to commence a major transformation to our health system, which currently is inequitable with the public health service unable to meet, safely and appropriately, the demands being placed upon it."

Also commenting on the submission, INMO deputy general secretary Dave Hughes said: "The INMO is calling on all politicians to recognise that the current system is simply unfit for purpose and needs radical investment and transformation. We are calling for the public, direct provision, of all health services, funded through a progressive general taxation system, and an end to the creeping privatisation, of healthcare, which has taken place in recent years."

The INMO's written submission, to the special Oireachtas Committee is available at **www.inmo.ie** and was included in full as a supplement to *WIN* in September 2016.

Update on public holiday payments over Christmas and New Year period

The HSE has issued the following arrangements in respect of public holiday premium payments over the Christmas and New Year period 2016/2017.

This year Christmas Day (December 25) falls on a Sunday and St Stephen's Day (December 26) falls on a Monday. While the Organisation of Working Time Act 1997-2015, does not specifically provide for the transfer of a public holiday falling on a Sunday to any other day, the standard practice in the health service is to transfer the Christmas Day public holiday to the following Tuesday, December 27, for the purpose of premium payments, ie. employees rostered to work on Sunday, December 25 will be paid the Sunday premium rate and employees rostered to work on Tuesday, December 27 will be paid the public holiday premium rate.

New Year's Day will fall on a Sunday and public holiday premium payments will be transferred to Monday, January 2. Employees who are rostered to work on Sunday, January 1, will receive the Sunday premium rate and employees rostered to work on Monday, January 2, will receive the public holiday premium rate.

Monday to Friday roster

Employees who work a Monday to Friday attendance regime will normally receive a paid day off on Tuesday December 27 and Monday January 2 in lieu of the two public holidays which fall on a Sunday.

'5 over 7' roster

In summary staff who work a '5 over 7' roster should be granted premium payments for working over the Christmas and New Year as follows:

- Sunday, December 25 – Sunday premium
- Monday, December 26 – public holiday premium
- Tuesday, December 27 – public holiday premium
- Sunday, January 1 – Sunday premium
- Monday, January 2 – public holiday premium

No public holiday premium payment is payable to employees working on days other than Monday 26 and Tuesday 27, December 2016 and on Monday, January 2, 2017.

INMO Information Office

Immediate call to action on nurse shortages in Co Louth

THE HSE's refusal to sanction the filling of vacant staff nurse posts in Co Louth hospitals has resulted in the closure of 18 long-term care beds between two hospitals.

Currently, there are 12 vacant nursing posts between Drogheda Cottage Hospital's transitional care unit and St Oliver Plunkett's Hospital. The failure of the HSE to fill these vacancies represents a stark contrast to the continuing drive to create and fill general management posts in the region, according to the INMO.

The Organisation has criticised the current system, which stipulates that directors of nursing must go through eight layers of management to approve the filling of one nursing post, highlighting that it is inevitably compromising patient care and is unacceptable.

Heading into the busy winter months, patients are left without adequate nursing cover and the resulting bed closures are creating a knock-on effect for other hospitals within the county, particularly for patients in Our Lady of Lourdes Hospital, Drogheda, whereby those on trolleys in the emergency department cannot get access to beds, and those in beds, who are finished the acute phase of their care, cannot be discharged to step down or community facilities.

Tony Fitzpatrick, INMO IRO: "The empowerment of directors of nursing will allow for beds to be reopened for the critical winter months"

The ability of the nurses to provide adequate care is then compromised by the fact that some of the health centres for which they work are dilapidated, inadequate, lack the required IT infrastructure and are not appropriate for nurses to meet with their patients/clients.

The situation in Co Louth is further compounded due to a significant amount of PHN and community RGNs' time being taken up with completing assessments for patients to obtain home help, only for their recommendation to be rejected at administration level. This has resulted in severe frustration on the part of nurses and their patients, and interferes with the clinical judgement of the registered nurse.

Central to all of this is the HSE's ongoing attempt to establish management structures, both in Louth and across the country, which are cumbersome, bureaucratic and don't involve nurses in any operational, managerial role. The INMO is actively opposing this, not only in Louth but nationwide, in favour of flattened management structures that empower frontline professionals.

"The INMO demands that directors of nursing/public health nursing be immediately allowed to fill all frontline nursing posts that are vacant at this time. Our members in Co Louth also call for a comprehensive review of the layered management bureaucracy which has been established and which is adding nothing to the quality of care and the ability of frontline staff to respond to need," said Tony Fitzpatrick, INMO industrial relations officer.

Grave concerns over failure to address staffing deficits at OLOL, Drogheda

THE first review of the WRC agreement reached between the INMO and management at Our Lady of Lourdes Hospital, Drogheda took place on October, 25.

The Organisation outlined grave concern at the failure of management to address staffing deficits throughout the hospital. The INMO also expressed its dissatisfaction at the failure of management to close beds as per the staffing algorithm agreed in the WRC process in July/August, 2016. The INMO suspended industrial action to allow for the immediate implementation of the agreement reached. Management has advertised the provision of two clinical nurse facilitators to assist in the induction and orientation of new recruits to the service. Recruitment is ongoing from the Philippines, India, Spain and Italy to fill deficits at the hospital. However, due to the opening of surge bed capacity, there is redeployment of staff which is causing grave difficulties for the wards where the staff are taken from. Members are actively considering reverting to a work-to-rule at the hospital if clear answers are not obtained from management at the WRC on October 25.

– Tony Fitzpatrick, INMO IRO

In brief...

- **Louth County Hospital arbitration:** The INMO recently wrote to management at Louth County Hospital highlighting grave concerns at its failure to implement three arbitration decisions issued by John Doherty in March, 2016 in Louth County Hospital. Following sustained pressure from the INMO, management has confirmed that the appointments will be made as per the John Doherty arbitration decisions (Circular 17/2013) with retrospection application to October, 2013.

- **Inadequate staffing at Cavan General Hospital:** The INMO has met with management at Cavan General Hospital in recent weeks to outline grave concerns regarding inadequate staffing in several departments throughout the hospital, including theatre, the emergency department, AMAU, surgical 2 and maternity. Several more meetings are outstanding and the INMO is trying to obtain dates for these to meet as expeditiously as possible.

- **Meath Disability Services:** The INMO referred matters concerning Meath Disability Services, including redeployment/reassignment of staff, rosters and residents' social fund to the Workplace Relations Commission. These talks are ongoing with management issuing proposals which have been amended and a further meeting is due to take place in early November.

– Tony Fitzpatrick, INMO IRO

In brief...

- **St Aidan's ID Centre, Gorey:** Following recent industrial action at St Aidan's Centre, Gorey, INMO members have now been placed on the correct increment, recognising previous nursing experience. The WRC continues to assist the parties in recovering retrospective payments due since increments were frozen in 2009.
- **Abbeygale Unit, Wexford:** INMO members have reached agreement meaning that no further beds will open at this centre until additional staff have been recruited. Greater security around contracts for cover of leave has also been secured with the assistance of the WRC conciliation services.
- **St Columcille's Hospital, Loughlinstown:** INMO members in St Joseph's Unit are at an advanced stage of concluding the pilot exercise to assess staffing levels under the Medical/Surgical Taskforce planning review. The review commenced in May 2016.

– Philip McAnenly, INMO IRO

Several CUH wards serve notice of work to rule action

THE INMO, on behalf of its members, has served notice of its intention to commence industrial action in the form of a work to rule, on three wards in Cork University Hospital (CUH) – the orthopaedic/plastic Ward, a general surgical ward and the medical ward.

A further secret ballot has been undertaken on the neurology/stroke unit where members voted overwhelmingly in favour of industrial action.

This action is being taken due to ongoing issues in relation to unsafe and inadequate staffing levels and additional beds being placed on wards, without any commensurate increase in staffing levels. Despite ongoing engagement by the INMO with management, these issues have not been addressed to our members' satisfaction.

The health and safety of INMO members in Cork University Hospital is being compromised on a daily basis due to the intolerable working conditions on these wards. Members believe working in this difficult environment is having a detrimental effect on their health and wellbeing.

Mary Rose Carroll, INMO IRO: "Action is being taken due to ongoing unsafe and inadequate staffing levels and additional beds on wards without any commensurate increase in staffing levels"

Members in CUH have not taken this course of action lightly but feel they have been left with no option but to withdraw from clerical and support duties. This will allow INMO members to prioritise and focus on direct patient care. This action was due to commence on November 1, 2016.

– Mary Rose Carroll, INMO IRO

Action in oncology/radiotherapy

INMO members in the oncology/radiotherapy ward at Cork University Hospital commenced work to rule industrial action on October 5 in relation to ongoing inadequate and unsafe nurse staffing levels on the ward. The members' decision to commence industrial action was based on management's failure to implement three existing WRC agreements of May 2015 and May/June 2016 and their expert clinical knowledge and their concerns in relation to patient safety and their ability to provide safe care.

Subsequently, members in the GB radiotherapy ward, suspended their industrial action when agreement was reached following a lengthy conciliation hearing held under the auspices of the Workplace Relations Commission.

The parties agreed to reconvene under the auspices of the WRC in November to review implementation of the agreements.

Deepening crisis in care of older people services in mid west

THE INMO has received a significant number of complaints from nurses in almost all community nursing units/hospitals in Clare, Limerick and North Tipperary regarding the low number of nurses to patients due to the inability of the HSE to attract and retain nursing staff

While the INMO has had extensive local engagement in individual locations and despite the efforts of the HSE to recruit, it is proving impossible for these locations to attract and retain nurses.

Members have advised the Organisation that the scarcity of nurses is having a negative impact on the quality of care. While some locations are keeping beds vacant on an ad hoc basis, a more formal approach is necessary. The INMO has formally requested a regional union/ management meeting in respect of all care of the older person facilities in CHO 3 area to put contingency arrangements in place to safeguard both our members and residents.

– Mary Fogarty, INMO IRO

Concerns raised over e-rostering project in Letterkenny

IN RECENT weeks, issues of concern for nursing and midwifery staff have arisen with an e-rostering pilot project at Letterkenny University Hospital, Co Donegal. Staff are seeking to have these issues addressed. It is planned to role the e-rostering project out to the maternity department in the new year, however midwives are very concerned that issues that had been raised by staff in the general side of the hospital have not been addressed.

Maura Hickey, INMO IRO said: "Midwives are very concerned that this is an additional matter that will add further stress to their already highly stressed working life. It also has the potential to impact negatively on their work/life balance. With the development of the National Midwifery Strategy, the outcomes from the Galway case and the appointment of directors of midwifery, now might be the appropriate time to pause any further rolling out of this project until a review of the pilot to date has been carried out to see if the e-rostering system is delivering as intended."

Parking at new children's hospital a serious concern

The INMO has raised concerns about the insufficient provision for staff parking in the plans for the National Children's Hospital (NCH). Building has commenced on the St James's Hospital campus, however, the INMO has concerns that the plans do not take sufficient consideration of the parking requirements of shift workers and safety. The new hospital proposes to reduce the carbon footprint, by minimising the number of staff parking spaces on site, assuming that staff will use public transport or cycle to work.

INMO IROs Joe Hoolan and Clare Treacy, together with INMO rep Linda Phelan (Crumlin) met with representatives of the NCH Group. Ms Treacy said: "A high percentage of nurses live outside of Co Dublin and the vast majority are shift workers. It is extremely short-sighted to assume that staff can avail of public transport when they are travelling such distances. The lack of parking will simply become a recruitment and retention issue for the new hospital. We have asked for this to remain on the agenda as an ongoing issue."

Health and safety concerns at St James's offsite parking

THE INMO notified the Workplace Relations Commission (WRC) of a dispute with St James's Hospital over its closure of almost 500 onsite parking spaces without consultation with staff.

As well as concerns about the lack of consultation, the INMO is concerned about the increasing exposure of its members to health and safety risks. Although, some additional parking was made available in offsite carparks, these were not suitable for shift workers due to early closing times and safety concerns.

At an initial meeting with the WRC the INMO sought several assurances, in particular, recognition that shift workers are exposed to health and safety risks due to the early start of shift and late finishing times.

The employer agreed to conduct an immediate risk assessment under health and safety legislation, with particular attention to shift workers, with regards to parking and the general movement of employees. This assessment will include consultation with the INMO and health and safety representatives.

The INMO sought extension of opening and closing times at offsite carparks and the provision of a shuttle bus. Additional security was also agreed as the area in and around St James's Hospital has a high crime rate.

At a report-back meeting to the WRC on October 24 management reported progress including the extended carpark opening hours, a shuttle bus service and additional security. The risk assessment has yet to be completed. A further review meeting at the WRC is scheduled for November 29.

INMO IRO Clare Treacy acknowledged progress had been made in relation to additional parking facilities offsite, together with the shuttle bus service, however, she was extremely disappointed that the health and safety report was yet to be completed.

"We believe that this is a very important report as its key function is to carry out a risk assessment under the health and safety legislation, with particular attention to shift workers," said Ms Treacy.

The INMO also produced figures at the WRC confirming that 42% of INMO members working in St James's Hospital live outside Co Dublin. It is clear that these employees have no alternative but to drive to work and it is important that they are facilitated to do so safely.

The INMO noted that a significant number of nurses have resigned from St James's Hospital citing the parking issue as a key reason.

Cregg House staffing review

Nursing staff at Cregg House HSE, Co Sligo are waiting patiently for the outcome of a staffing review which was to be conducted over a 10-week period.

The nurses deferred industrial action in the form of a work to rule until this report issues.

INMO IRO Maura Hickey said: "Currently staff are very demoralised with the low staffing levels and cannot see light at the end of the tunnel".

As we went to press, a further meeting was scheduled to take place on October 25, at which it was expected that the INMO would be informed when the staffing review report will issue.

Concern at Tullamore staffing levels

CONCERNS have been raised with management over reduced staffing levels within a number of units at the Midlands Regional Hospital, Tullamore.

After meeting with INMO representatives and groups of staff to hear their concerns, INMO IRO Clare Treacy said: "Nurses and midwives are working under terrible conditions with staffing at below acceptable levels in some areas. Nursing midwifery staff are reporting stress as a direct result of working in circumstances of increasing acuity and diminishing staffing levels."

A number of claims have been forwarded to management. Recent correspondence from management confirms that business cases have been submitted for additional staff, and in the case of the renal unit the hospital is seeking a bespoke recruitment campaign. However, the reality is that staff are working short in nearly every area and this is having an impact on individual nurses.

Ms Treacy says the process is simply too slow and our members cannot continue to work under such circumstances. Further meetings are scheduled to take place with members.

The INMO continues to seek permanent contracts for graduate nurses at this workplace and nationwide.

CHO 9 staffing shortages

THE INMO met with management in CHO 9 regarding staffing shortages at all levels of nursing within the community. The INMO advised management that the current workload is intolerable for members and patient care is being compromised due to unsafe staffing levels. The INMO advised management that failure to fill vacant PHN and CRGN posts, and maintain the agreed nurse management structure in the community, will leave INMO members with no option but to ballot for industrial action. Management advised it would revert by October 27 on all issues raised.

– Lorraine Monaghan, INMO IRO

Spotlight on ED Nurses Section

THE first ED Section meeting got underway at INMO HQ on September 20, with discussions, debates and planning sessions for the section. Weighing heavily on the agenda was the continued overcrowding, understaffing and educational needs of the staff.

The Section heard mirrored stories from different EDs around the country. Problems and difficulties were discussed and shared. A reassurance of continued lobbying for a safer environment for both the staff and patients was at the forefront of everyone's agenda. The roll-out of the CNM1s and CNM2s (for admitted patients) and ADON for patient flow is well underway nationwide.

One of the areas highlighted was the vast variances in education across EDs. The differences varied from no facilitator, to intermittent cover, to full facilitator cover. Study leave and the its prioritisation needs urgent addressing in order to maintain safe standards.

A review of staff nurse orientation/introduction to ED programmes will be discussed at the next meeting in December.

A network for linking EDs to communicate concerns, ideas and solutions was suggested and will be reviewed. It is hoped to have an educational component to the meetings going forward.

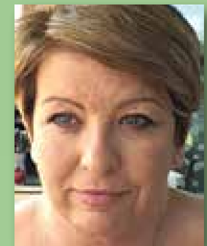
The next meeting of the Section will be held at 11.30am in INMO HQ on Wednesday, December 7.

Section Officers

Chairperson

Bernadette Stenson
beestenson@hotmail.com

Vice chairperson



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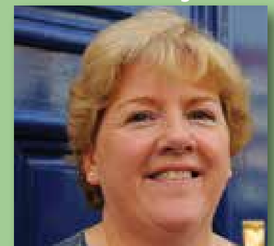

Mary Dunne
marydelaneydunne@gmail.com

Affiliation Form for INMO Section Membership

Name:________________________

INMO membership No:____________________

Home Address:________________________

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____

Tel (work):________________________

Tel (home/mobile):____________________

Email:__________________________

Place of employment:____________________

Job title:__________________________

Second section option (to obtain information only):

____

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

Tick ONE relevant Section you wish to affiliate with

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

Telephone triage nurses/midwives network at annual section conference

At the 12th annual Telephone Triage (TT) Section conference were (l-r): *Carmel Murphy, TT Section chairperson; Hazel James, TT Section education officer; Martina Harkin-Kelly, INMO president; Breege Clarke, TT Section vice chairperson and Claire McMahon, TT Section secretary*

Michelle Russell (centre), independent nurse consultant, who presented on preparing for HIQA inspections, with Carmel Murphy (left), section chairperson and Claire McMahon, TT Section secretary

Mary Guerin Lavin, Southdoc, a prize draw winner

OVER 65 nurses and midwives, from across all out-of-hours doctor services, gathered for the 12th annual Telephone Triage Nurses Section conference which took place on September 29 in Limerick.

INMO president Martina Harkin-Kelly gave the opening address at the conference, which was well received by all in attendance. This address was followed by an update on midwifery complications that present over the phone, which was given by midwife adviser Aparna Shukla.

Delegates also heard presentations on preparing for HIQA inspections from Michelle Russell, independent nurse consultant.

Chest pain, arrhythmias and dealing with anxiety were among other topics covered and the afternoon sessions included infant skin and sports injuries. Attendees also took part in a raffle at the end of the conference.

Each year, the conference proves to be an excellent networking opportunity for nurses and midwives working in the area of telephone triage.

The Telephone Triage Section will hold its AGM in the INMO in Dublin on January 18, and encourages any members affiliated to the section to attend.

RNID conference to focus on empowerment

A PACKED agenda is planned for the RNID Section conference, which is set to take place on November 22 in the Crowne Plaza Hotel, Santry, Dublin.

INMO president, Martina Harkin-Kelly will give the opening address followed by Siobhan O'Halloran, chief nursing officer in the Department of Health, who will then address the conference theme of *'Empowering the RNID'*, focusing on delivering on their potential.

Among other topics to be covered are the community health organisations and realising the potential of the RNID within these emerging structures, which will be addressed by Liz Roche, area director, Nursing and Midwifery Planning and Development, Dublin Mid Leinster.

Mary McCarron, professor of ageing and intellectual disability in TCD, will speak on future-proofing the undergraduate programme for the changing models of service delivery.

Brian O'Donnell, chief executive of the Federation of Voluntary Bodies, will talk about manpower planning – realising the potential of the RNID and the challenge for employers.

Following a panel discussion, John Lonergan, author and former governor of Mountjoy Prison will give a motivational presentation on nurturing happiness and contentment.

The afternoon session will comprise a series of short sessions by RNIDs in the community and some service users. Delegates will also have the opportunity to hear an overview on the Assisted Decision Making Bill, 2013.

Special rates for students are available and all bookings can be made by contacting the INMO or by logging onto **www.inmoprofessional.ie**

CNM/CMM Section: Upcoming meeting

The Clinical Nurse/Midwife Managers Section will meet on Saturday, November 12 to discuss a range of topics including leadership and crisis management.

The meeting will take place in INMO HQ from 10am and finish at approximately 1pm.

Members who wish to attend the CNM/CMM Section meeting are asked to confirm their attendance by contacting Helen O'Connell at Tel: 01 6640616 or email: helen.oconnell@inmo.ie

All Ireland Annual Midwifery Conference 2016: *Pictured at this joint INMO/RCM NI conference were (l-r): Liam Doran, INMO general secretary; Mary Higgins, vice chair, Midwives Section; Máire Devine, senator; Martina Harkin-Kelly, INMO president; Simon Harris, Minister for Health; Breedagh Hughes, director of RCM Northern Ireland; Susan Kent, deputy chief of nursing officer, Department of Health; John Skewes, director of policy, employment relations and communications, RCM UK; Mary Cadell, regional officer, RCM Northern Ireland; Deirdre Daly, conference planning committee; and Colm O'Boyle, conference planning committee.*
See WIN December/January for a detailed report on this conference

Influencing European nursing policies

Elizabeth Adams focuses on international nursing and midwifery initiatives and activities of interest to INMO members

INMO president Martina Harkin-Kelly recently attended the European Federation of Nurses Associations (EFN) general assembly, proactively representing members on their key priorities to strategically influence the European agenda on a number of issues, including: workforce, professional practice, policy, research, education and industrial relations.

European Federation of Nurses Associations

Established in 1971, EFN represents more than three million nurses across 35 European countries represented by national nursing associations. EFN is the independent voice of the nursing profession at European level. It is an important international organisation representing nurses and nursing concerns across Europe.

As a member of the EFN since its inception, the INMO is central to a number of significant projects and policy developments. Issues concerning health, patient care, mobility of health professionals, education, technology and health funding continue to be central to the EU debate and the culmination of these debates result in legislation which all member states have to implement. It is therefore imperative that the EFN, in representing 35 EU countries' national nursing associations, is strengthened and empowered to influence the EU political agenda, particularly in the current economic climate.

European Federation of Nurses Associations general assembly

Prof Máximo A González Jurado, president of the Spanish General Nursing Council, hosted the 104th EFN general assembly from October 20-21, 2016 in Madrid. With more than 70 representatives meeting, there were a number of important strategic agenda items discussed including the:

- EFN Strategic and Operational Lobby Plan 2014-2020, which sets the priorities for the strategic direction
- Directive 2013/55/EU and the Delegated Act – the revision of the Directive 2005/36/EC on Mutual Recognition of Professional Qualifications (amended by Directive 2013/55/EU), published in the *Official Journal* on December 28, 2013, with the requirement to be transposed into national law by EU Member States by January 18, 2016. Article 31 of the Directive allows for the development of the Delegated Act, which will provide detail of the competencies required for general nursing
- EFN Workforce Matrix 3+1, which provides guiding definitions and qualifications for specialist nurse and advanced practice nurse roles across Europe
- Recruitment and retention – the current drive for extensive recruitment of nurses within the EU and the significant issues with retention, particularly in countries such as Ireland, was discussed in detail
- WHO Global Workforce Strategy – the new strategy was discussed and the implications for the profession in relation to the EU Commission Action Plan were explored
- Antimicrobial resistance (AMR) – strategies to combat AMR and proposals for concrete recommendations in relation to the role of nurses in combating AMR were discussed. An EFN Position Paper and Policy Statement has been developed and agreed
- Value of health systems – increasing

*EFN Executive Committee for 2016-2018, (front row, l-r): Roswitha Koch, Swiss Nurses Association, Switzerland; Elizabeth Adams, vice president, Irish Nursing and Midwives Organisation, Ireland; Marianne Sipila, president, Finnish Nurses Association, Finland; Milka Vasileva, treasurer, Bulgarian Association of Health Professionals in Nursing, Bulgaria; and **(back row, l-r)**: Paul De Raeve, EFN general secretary; Janet Davies, Royal College of Nursing, UK; and Sineva Ribeiro Vardforbundet, Sweden*

unmet healthcare needs, within a context of budgetary constraints, create a need for the nursing profession to clearly formulate an understanding and definition of 'value-driven health systems'. This was discussed against a performance-measurement system, leading to cuts and expectations of doing more with less.

EFN Professional Committee

The EFN Professional Committee, on which I am chair, met on October 20 as part of the general assembly. The revision of the Directive 2005/36/EC on Mutual Recognition of Professional Qualifications (amended by Directive 2013/55/EU), published in the *Official Journal* on December 28, 2013, with the requirement to be transposed into national law by the EU Member States by January 18, 2016 was discussed in detail. However, many member states have not yet transposed the Directive into national legislation, and are far from translating Article 31 into the nursing curricula.

The European Commission will make an assessment of the new/amended national legislations and will plan infringement procedures, if necessary. It is within this context that the EFN is planning to measure the (non) compliance with the Directive based on an online questionnaire with a set of legal/professional questions.

Equally important is the development of a Delegated Act to update Annexe V of the Directive, detailing the current core curriculum and the new content. It is essential that all nursing schools and universities interpret the competencies listed in Article 31 in the same way. The eight competencies are:

- Independently diagnose, plan, organise and implement care
- Cooperate with other players from the health sector
- Empower patients towards a healthy lifestyle and self care
- Independently initiate measures to save lives
- Independently advise, instruct and support
- Ensure the quality of nursing care
- Communicate comprehensively and cooperate with members of other professions in the health sector
- Analyse the quality of care.

The EFN has developed a competency framework in order to provide a common understanding from the national nursing association's perspective. The EFN, in the framework, defines competence as the "intersection between knowledge, skills, attitudes and values, as well as the mobilisation of specific components in order to transfer them to a certain context".

Pictured at the recent EFN general assembly in Madrid, Spain: Martina Harkin-Kelly, INMO president (second row) and Elizabeth Adams, INMO director of professional development and newly elected EFN vice president, with Prof Maximo Gonzalez Jurado, president, Spanish Nursing Council (front row, left) and representatives from national nursing associations

European Nursing Research Foundation

Prof González Jurado, founding director of the European Nursing Research Foundation (ENRF) and president of the General Nursing Council, provided an update to the EFN general assembly on the Foundation.

The ENRF was officially established as a legal structure under Belgian law and as a non-profit organisation in May 2013. With its own constitution, the objective of the ENRF is to analyse and compile what already exists in terms of nursing research in the EU member states in order to convert existing data into evidence-based advocacy for the EU policy-making process.

Initially and for a period of three years, the ENRF will receive financial support from the EFN, however, the goal is to be self-sustainable and source funding through various research bids, such as the European Horizon 2020 programme and funding partners.

Prof Jurado stated that the aims of the Foundation are to: "Contribute to improving healthcare quality and safety" and "the promotion and development of nursing through research for Europe".

In December, the governing body of the Foundation will meet in Madrid, at the headquarters of the General Nursing Council, to develop the three-year strategic plan (2017-2020) that will be presented for approval at the next EFN general assembly.

EFN Executive Committee elections

The EFN Executive Committee is constituted by seven members: the president, vice president, treasurer and four delegates elected by the EFN members' national nurses' associations. They meet at least twice a year (in between each general assembly) to discuss key issues for the EFN, to prepare recommendations for the general assembly and to follow-up on the general assembly decisions.

This year, I was honoured to be elected, by 35 European member countries, as vice president of the EFN Executive Committee. Two members of the Executive Committee were elected for a two year term 2016-2018: Janet Davies, Royal College of Nursing (UK), and Veronica Di Cara, Czech Nurses Association (Czech Republic), and for a one-year term 2016-2017, Sineva Ribeiro Vardforbundet, (Sweden) was elected.

Elizabeth Adams is INMO director of professional development

International congress

International Council of Nurses Congress 2017

The International Council of Nurses (ICN) 2017 Congress will be held in Barcelona, Spain, from May 27 to June 1, 2017.

The ICN has worked in partnership with Prof González Jurado and his team to deliver one of the largest dynamic and innovative congresses for nursing globally. The theme is *'Nurses at the forefront: transforming care'*.

Details of the scientific programme and themes can be accessed at **www.icncongress.com**. The plenary sessions will be dedicated to exploring the theme, with particular focus on the Sustainable Development Goals, human resources for health, universal health coverage and safe staffing.

Featured main sessions will offer the most recent expertise on patient-centred healthcare, evolving scopes of practice, climate change, infectious and non-communicable diseases, mental health, migration, human rights, patient safety, policy, technology, leadership, education and history. Themes for abstract submissions (concurrent sessions, symposia and posters) will address these issues plus developments in healthcare systems, health promotion, nursing workforce, disasters and regulation.

The Congress will also be the venue for ICN network meetings. The deadline for early registration is **February 17, 2017**. Registration is now open on **www.icncongress.com**

Bulletin Board

With INMO director of industrial relations Phil Ní Sheaghdha

Query from member

I understand from my manager that there are currently talks ongoing to introduce a performance achievement model for the HSE. Is the INMO involved in this, and if so, is there any further information on this topic?

Reply

Yes, the public service agreement required performance achievement measures to be introduced. The INMO and all other health service unions have engaged with the HSE to develop a mechanism which would allow staff have a supportive appraisal of their performance. Following lengthy negotiations, the unions are now satisfied that the performance achievement model has the correct emphasis on support and development to be of use to HSE staff. The unions' main concern was that if performance appraisal/achievements was incorrectly applied and if managers carrying them out had not been trained correctly, performance achievement could be negatively perceived by staff and would not help to develop and support staff in their work.

Therefore, the unions concentrated on ensuring that prior to any roll-out, performance achievement training would be provided to all managers who would then be expected to meet with staff they manage annually to discuss staff objectives, supports they would require in reaching those objectives and work together towards a personal development plan.

At the most recent meeting on this matter on October 11, the unions raised a number of outstanding concerns/questions that require attention, prior to roll-out of the performance achievement process. These concerns include:

- The model proposed will apply only to HSE staff and will not extend to voluntary hospitals or section 38 organisations. The unions believe this will affect implementation and we have sought further input from the HSE on this matter
- The unions have sought clear direction to employers on the intended and agreed purpose of the performance achievement model, to ensure that it will in no way interfere with or be used as a means to discipline or sanction employees.

Three further meetings are scheduled for November and further communication will be issued to members. In the meantime, there is currently no agreed performance review system in place in the health service for nursing or other grades, and until such time as the steering committee set up to oversee the roll-out and evaluates same, is satisfied that the agreement brokered between the employer and the trade unions is being adhered to, it will not commence.

It is agreed that a steering group consisting of employer and union reps for health service workers would be established and meet regularly to monitor the roll-out of performance achievement across the health service, and the operation of performance achievement over the first 12 months, with a view to ensuring it is being rolled out in the manner intended.

Query from member

Can you please advise if there is a dress code or uniform policy in the HSE. I am increasingly confused in respect of a variety of uniforms that exist and also dress codes for non-uniformed staff. I am not aware of a uniform policy and require information on the subject.

Reply

As part of the ongoing consultation, the staff panel of trade unions engages with the HSE to discuss all policies and procedures prior to implementation. This is one such policy that has been forwarded for consultation and comment by the end of October. As we went to press, the INMO Executive Council was in the process of reviewing the draft policy.

The draft policy has been developed with a view to creating a positive and professional image observant of health and safety concerns, particularly infection control. The draft policy sets out requirements cognisant of individuals who may have sensitivities or allergies. Likewise, cultural and religious requirements are considered and stipulate they comply with infection control and health and safety policies. Non-uniformed staff are also covered in this policy, as part of the dress code. The overall intent would be to ensure staff are easily identified particular to their grade and level of responsibility.

The trade unions are currently considering this draft policy and are due to meet with the HSE with a view to amending/improving it. The aim is to have it endorsed at the next National Joint Council meeting on November 7. Following this if the policy is agreed, it will then be communicated within the HSE, made available on the HSE website and would be included as part of the corporate and local induction policy, and would be reviewed as required. Further information will follow when the policy has been fully reviewed.

ED reps updated on health and safety issues

INMO organiser **Albert Murphy** focuses on ED rep health and safety and the advanced nurse rep courses

THE second emergency department health and safety rep course was held at INMO HQ in September and proved a great success. The course was attended by over 20 representatives from EDs from acute hospitals across the country. This follows on from the first course which was held in May 2016.

INMO deputy general secretary Dave Hughes gave ED reps an overview of the recent ED Agreement from a health and safety perspective. He spoke of the need for the INMO safety representatives, the importance of health and safety registration and also on the additional measures which have been taken in the recent ED Agreement.

Marian Geoghegan, senior training officer from the Financial Services Union, gave a lecture on the role of the safety representative. She stressed to participants that the registration confers a number of important legal rights to safety representatives without the responsibilities falling personally on the rep. It is clear under legislation that the major duty of care rests with the employer to ensure that all workplaces are safe and healthy for employees regardless of their occupation.

Fergus Whelan of the Irish Congress of Trade Unions focused on risk identification in EDs and presented a case study based on a redacted health and safety assessment.

Pictured at the second health and safety training course for emergency department representatives at INMO HQ in September were (back, l-r): Arthur Doran, Barry Hussey, Padraig Heffernan, Kellie Walsh, Finbarr O'Mahony, Eric Lawsin, Sarah Watkins, Liam Conway and (front, l-r): Carmel Hardy, Siobhan Rochford, Liz McManus, Sarah Sheehan, Sinéad Joyce and Jackie Egan

The INMO will be forming a network of ED health and safety representatives and it is expected that a dedicated second newsletter will issue to these reps.

Good luck to all our new ED health and safety representatives in our acute hospitals.

Advanced nurse rep course

The INMO is running an advanced nurse rep training course on November 10-11 at HQ. This will build on the basic rep training course which has been running over the past number of years. Any current reps, particularly those who have been on training courses in the past two years under the revised format, are encouraged to apply to attend the course. All interested reps are asked to contact Martina Dunne at Tel: 01 664 0624 or email: martina.dunne@inmo.ie to reserve a place on the course.

Pictured at the second ED health and safety training course were back row (l-r): Michelle Stoke, Claire Hoobin, Ellen Looby and Helen Crehan, front row (l-r) Emer Ward, Brid Jordan-Murphy, Michelle Stubbs

Basic nurse rep training

A basic rep training course for the southeast was held in Kilkenny on October 5-6, which was attended by seven representatives.

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

Is your INMO membership up to date?

Important message from the INMO

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

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

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

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

Management of head injury

In the latest update in this continuing professional development series, **Catherine Lewis, Nina Thirlway** and **Gerry Morrow** focus on head injuries

THIS clinical update on head injuries includes initial assessment and examination of people presenting with head injury. It also explains the concepts of 'red flags' and potential complications of head injuries.

Head injury is defined as any trauma to the head other than superficial injuries to the face.[1] Most head injuries are caused by falls, sports-related incidents and motor vehicle collisions. Approximately 10,000 new head injuries occur in Ireland each year.[2]

The majority of people who attend emergency departments with head injury will have a minor injury, although approximately 20% of these will be admitted to hospital.[3] The majority of people with a minor head injury will recover without specific or specialist intervention.[1]

However, trauma is the leading cause of death in people under the age of 45 years, and up to 50% of these deaths are as a result of a head injury.[3] The majority of deaths from head injury are in people who present with a moderately or severely impaired consciousness level.[1]

Assessment

The assessment of a person with a head injury consists of taking a history and an examination, including a Glasgow Coma Scale score. When assessing a person who has a head injury you should ask how and when the head injury occurred. If possible you should ask about recent alcohol or drug intake, current anticoagulant medication, pre-injury level of consciousness and functioning.[1,3] People who have dementia, for example, may have different levels of pre-injury cognitive functioning to those without dementia.

It is important to note that people who present with loss of consciousness, amnesia, vomiting, headache or neck pain are more likely to have a serious head injury. The following circumstances are more likely to cause serious head injury:

- Falls from a height of greater than one metre or five stairs
- High-speed motor vehicle collisions, either as a pedestrian, cyclist or vehicle occupant
- Rollover motor accidents or ejection from a motor vehicle
- Accidents involving motorised recreational vehicles or bicycle collision
- Diving accidents.

In children you should consider the possibility of non-accidental injury if:

- The child is not yet independently mobile (crawling, cruising, walking)
- The bruise is on any non-bony part of the face (including eyes or ears)

Table 1: Glasgow Coma Scale for adults and verbal children

Behaviour	Response	Score
Best eye response	Does not open eyes	1
	Opens eyes in response to painful stimuli	2
	Opens eyes in response to voice	3
	Opens eyes spontaneously	4
Best verbal response	Makes no sound	1
	Incomprehensible sounds	2
	Inappropriate words	3
	Confused and disorientated	4
	Orientated and converses normally	5
Best motor response	Makes no movement in response to pain	1
	Extension in response to painful stimuli	2
	Abnormal flexion in response to painful stimuli	3
	Flexion or withdrawal in response to painful stimuli	4
	Localizes painful stimuli	5
	Obeys simple commands	6

Table 2: Glasgow Coma Scale for children unable to verbalise

Behaviour	Response	Score
Best eye response	No eye opening	1
	Eyes open in response to pain	2
	Eyes open in response to voice	3
	Eyes open spontaneously	4
Best verbal response	No vocal response	1
	Inconsolable or agitated	2
	Inconsistently consolable or moaning	3
	Cries, but is consolable or inappropriate interactions	4
	Smiles and orients to sounds, follows objects and interacts	5
Best motor response	Makes no movement in response to pain	1
	Extension in response to painful stimuli	2
	Abnormal flexion in response to painful stimuli	3
	Flexion or withdrawal in response to painful stimuli	4
	Localizes painful stimuli	5
	Obeys simple commands	6

- The injury is to both sides of the face or head
- The bruises are at variance to the explanation given by the parents or carers
- Retinal haemorrhages or injury to the eye (in the absence of major confirmed accidental trauma or a known medical explanation) should also be considered a 'red flag' for non-accidental injury.[5]

Examination

Examine the person to assess their level of consciousness, using the Glasgow Coma Score *(see Tables 1 and 2)*. Look for signs of breathing difficulties or shock such as increased heart rate, low blood pressure or reduced capillary refill time.

Examine the patient for signs of visible trauma to the scalp, skull, head and neck. Check pupil size and that pupils are reacting normally to light. Look for any problems with vision or speech disturbance, understanding speech, reading or writing.

If the person has been standing check for any problems with balance or walking. Ask about and test for any numbness in the upper or lower limbs. Test reflexes and look for any loss of muscle power. If appropriate, assess the person's neck for tenderness and movement ability. Safe examination of the neck should only be performed if the person was not involved in a high-energy injury, is comfortable in a sitting position, has been walking at any time since the injury, has no tenderness along the spine, or describes a problem with delayed onset neck pain.

Signs of very serious injury include:
- Clear fluid (possible cerebrospinal fluid) leaking from the ear(s) or nose
- Bruising around the eyes (with no associated damage around the eyes)
- Bleeding from one or both ears
- Blood behind the ear drum
- New deafness in one or both ears
- Bruising behind one or both ears.[1]

Glasgow Coma Scale

The Glasgow Coma Scale (GCS)[3] is used internationally in clinical practice to assess the depth and duration of impaired consciousness and coma.

It is used to assess the level of consciousness in all people who have received a head injury (including people who appear intoxicated). People are scored on three different aspects of behavioural response: eye opening, verbal and motor responses. Each area of assessment is evaluated independently of the other and graded, with the lowest possible score being 3 (deep coma or death) and the highest being 15 (fully awake).

For example, a person with a best score of 4 for eye response, 5 for verbal response, and 5 for motor response should be recorded as E4, V5, M5 and the total score of 14/15 given.

People with dementia, chronic neurological disorders or learning difficulties may have a pre-injury baseline GCS score of <15, which should be taken into account during clinical assessment.

The Glasgow Coma Scale score can be translated into severity of the head injury:
- Mild – score of 13-15
- Moderate – score of 9-12
- Severe – score of 8 or less.

Complications

There are multiple possible physical, thinking (cognitive) and psychological complications following head injury, which may have an impact on a person's ability to function and return to normal activities.

Up to half of all adult inpatients with a head injury experience long-term psychological and/or physical disability.[3]

Complications of head injury include concussion, which is a disturbance in the function of the brain caused by a direct or indirect force to the head. It typically results in the rapid onset of short-lived impairment, which resolves spontaneously.

Post-concussion syndrome can also occur and may include multiple physical symptoms such as headache, dizziness, nausea, balance and co-ordination problems, changes in appetite, sleep, vision, and hearing, and cognitive and behavioural symptoms such as fatigue, anxiety, depression, irritability, problems with memory, concentration and decision-making.

Additional complications may include problems with walking (gait), mobility, muscle weakness, seizures, communication, swallowing, depression and anxiety, and signs of post-traumatic stress disorder.

Some people experience cognitive impairment which may include problems with memory, attention and concentration, planning, problem-solving, language, and perception. People who have had a head injury may display challenging or disinhibited behaviour, which can include inappropriate vocalisation or sexualised behaviour. Delayed presentation of intracranial complications is rare after mild traumatic brain injury, and usually occurs within 24 hours of the injury.[4]

Prognosis

Most people who have persistent symptoms of mild traumatic brain injury recover within two to three months of the injury[4] and most people with post-traumatic amnesia of less than 24 hours duration recover good cognitive function within three months of the injury.[3]

Factors which may increase the risk of a poor prognosis following mild traumatic brain injury include female sex, age over 40 years, persistent physical illness and/or a pre-existing neurological condition, previous head injuries, co-morbid mental health problems, such as anxiety and depression, and a lack of social support.[4]

Information and self-care advice

When discharging someone from hospital who has had a head injury, you should provide them with appropriate written 'safety-netting' information about their head injury. This should include advice on:
- Seeking medical advice if they have any ongoing or worsening symptoms, such as vomiting or headaches
- Taking appropriate pain relief if necessary, such as paracetamol or ibuprofen as appropriate
- Ensuring a gradual return to normal activities.

The Scottish Intercollegiate Guidelines Network provides several advice leaflets including advice for the person taking a patient home, advice for a patient allowed home after a head injury and advice for carers of children who have sustained a head injury. All these leaflets can be accessed at **www.sign.ac.uk**

Headway (Ireland) – Brain Injury Services and Support (**www.headway.ie**) is a charity that supports people affected by a head injury. It runs a telephone helpline, 1890 200278, a network of support groups and offers rehabilitation programmes, carer support, community outreach and respite care.

Dr Catherine Lewis is a clinical author at Clarity Informatics, Nina Thirlway is an information analyst at Clarity Informatics and Dr Gerry Morrow is editor and medical director at Clarity Informatics

Clarity Informatics is contracted by the National Institute for Health and Care Excellence (NICE) to provide clinical content for the Clinical Knowledge Summaries service available through the Clarity Informatics Prodigy website at: prodigy.clarity.co.uk

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CPD Quiz

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

1. Which type of accidents are more likely to cause a serious head injury?

A) Fall from a height less than one metre
B) Low speed motor vehicle collision
C) Rollover motor accidents
D) Diving accidents

2. Signs of serious head injury include:

A) Clear fluid leaking from ears
B) Bruising behind ears
C) New deafness
D) Vomiting

3. Which Glasgow Coma Scale Score indicates a severe head injury?

A) 8 or less
B) 13-15
C) 9-12

4. Which factors may increase a poor prognosis following mild traumatic brain injury?

A) Age over 40 years
B) Age under 40 years
C) Female sex
D) Male Sex

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

Clarity informatics

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

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

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*For every new member or re-joining member recruited, you receive a €20 One4all Gift Card.

Common goals of cancer care

Ahead of a new series of oncology programmes coming to the INMO PDC, **Nuala Hannon** outlines the common goal of making patients' cancer experience easier

HAVING set up a training business in oncology in 2014, I have had the pleasure of working with many different people involved in cancer care. It is easy to see that everyone from frontline clinicians, community professionals, scientists, researchers, pharmaceutical personnel, insurers and more all have one common goal: to make the cancer experience for patients better, easier, smoother and kinder. It is very motivating to see this in such a challenging and often sad specialty.

My oncology career started in the 1990s on a respiratory ward in St James's Hospital, Dublin. At that time, respiratory physicians looked after patients with lung cancer and this is where my education in oncology began, learning about chemotherapy, radiotherapy and the huge impact of a cancer diagnosis on a family.

I also worked as an oncology nurse adviser for a pharmaceutical company, a role which brought me to most of the hospitals around Ireland and experience how, as a nation, we care for our loved ones with cancer. Hooked by this experience, I decided to do a postgraduate degree in oncology in St Luke's Radiation Centre, Dublin and returned to St James's in 2006 as a chemotherapy CNS, where I worked for eight years.

Then an idea came. At this stage I was deeply involved in cancer care like so many other nurses, and was attending conferences and meetings nationally and abroad. I could see how many disciplines were involved in planning, delivering and advancing cancer treatments and care but inter-professional opportunities to meet and share all this knowledge were scarce. Service demands on clinicians has resulted in a big reduction of attendances at conferences etc. Nurses now just don't get the same opportunities to collaborate with other disciplines due to service needs.

My oncology training business collates all this knowledge and, combined with my own clinical experience, can inform and update everyone from frontline clinicians and community professionals to scientists and researchers.

My vision is that by bringing the information together everyone working in oncology will know what is going on outside their direct area and that this will impact services for the better.

I had an opportunity recently to meet a research scientist who was fascinated to hear some real patient stories. By keeping up to date myself scientifically, I can relay to patients new exciting developments in treatments providing hope and optimism at a difficult time for them. By delivering nurse education sessions on the many targeted therapy drugs and areas of rapid development, I hope I have helped nurses to learn about these drugs in a practical way.

I mentioned the huge impact of a cancer diagnosis on an individual and their families and I've no doubt we have all helped someone with cancer outside of our hospitals as a family member, a friend or a neighbour. We understand that patients need psychological support as well as help with childcare, household chores, lifts to hospital appointments and many other practicalities.

Research and projections tell us that cancer rates are rising globally. Bearing this in mind, how will we continue to meet the needs of patients, both clinically by delivering treatments and socially by supporting them through their illness? I certainly don't have all the answers but I am encouraged by our common goal, that is, to make the experience easier and kinder.

Ní neart go cur le chéile. There is no strength without unity.

Nuala Hannon worked as a clinical nurse specialist for seven years and then set up Hannon Oncology Education in 2014

Introduction to Oncology Programmes

These programmes are intended to give nurses and midwives the knowledge needed to care for cancer patients. An overview of cancer care in Ireland will be provided and key topics discussed. The programmes also provide an opportunity to develop communication skills around cancer discussions with patients.

From Symptom to Specialist
Monday, February 27, 2017

The following topics will be covered:
- Introduction to oncology – what is cancer?
- Carcinogenesis
- Patient pathway
- Staging and grading
- Preparing a patient for treatment

Solid Tumours and Treatments
Tuesday, February 28, 2017

The following topics will be covered:
- Breast, prostate, colorectal & lung cancer overview
- Treatment choices
- Side-effects of treatments
- Management of side-effects
- Oncological emergencies

Fee per day:
€90.00
INMO members
€145.00
non-members

For more information on each of these programmes log on to www.inmoprofessional.ie or call 01 6640641 or 01 6640618

Staff shortages at crisis level

A call for action on staffing and pay levels, and bed closures in Co Louth hospitals were among some stories to hit the headlines this month. **Ann Keating** reports

THE *Evening Echo* (October 7) covered the INMO's recent press conference under a headline **INMO calls for action on pay, staffing levels**. "The Irish Nurses and Midwives Organisation has called for immediate action on pay and staffing shortages, arguing that current staff levels in some hospitals are violating health and safety legislation.

"Following a meeting of the union's Executive Council, the union has revved up calls for an immediate reversal of the pay cuts and pension levies imposed under the public sector Financial Emergency Measures in the Public Interest legislation.

"The nurses are also hitting out at the additional unpaid hours required under the Lansdowne Road and previous agreements. They are calling for special incentive measures aimed at recruiting and retaining nurses and midwives in sufficient numbers to adequately staff the health service.

"The INMO has committed to a nationwide consultation with members to finalise actions necessary to achieve these objectives, which will be followed by a nationwide ballot seeking a mandate to commence action if bed numbers/services are not reduced in line with available staffing levels."

"INMO president, Martina Harkin-Kelly, said that the Organisation has heard the call from members, right across the country, that they have had enough and want the organisation to initiate whatever strategies are necessary to secure accelerated pay restoration and greatly improved staffing levels."

Incremental credit restored

The *Irish Times* (October 14) reported **Recently graduated nurses to receive €1,000 pay boost**. "Nurses who graduated between 2011 and 2015 are to receive a pay boost of more than €1,000 after the government agreed to restore incremental credit for the 36 weeks they spent on placement in hospitals as students. Minister for Health, Simon Harris said the payment of more than €1,000 would take effect from January 1, 2017, and that about 4,000 nurses would benefit. The Irish Nurses and Midwives Organisation said the initiative could be worth up to €1,500 and that up to 7,500 could benefit. The move effectively reverses a previous government decision that such an incremental credit arrangement should only apply to nurses who graduated in 2016, and not to those who finished their degrees in the years between 2011 and 2015."

Bed capacity

Harris to review bed capacity amid nursing deficit was a headline in the *Irish Examiner* (October 25). "The Minister for Health has said his department is to order a review of bed capacity in hospitals to try to bring the number of working nurses to 'adequate levels' after nurses last week called for bed closures at University Hospital Limerick, claiming there are not enough of them. Responding to nurses' calls for bed closures at UHL, Simon Harris said: 'We're going to address this by carrying out a bed capacity review, where we are going to look at all of our bed stock right throughout our hospitals, and indeed throughout our community primary healthcare settings'."

Recruitment

The *Herald* (October 15) reported **€10k packages and higher pay on offer to lure nurses abroad**. "Irish nurses will be lured abroad with tempting packages, just days after budget measures to hire more nursing staff for Irish hospitals were announced.

"The different packages cover areas of expense such as travel costs, shipping of furniture, estate agents' fees as well as funded education courses… The Beacon Hospital in Dublin has a term-time work policy for staff which allows employees take up to 13 weeks off per year to spend time with their families. The Mater Private Hospital also said it was actively recruiting nursing staff. A bonus scheme was launched 12 months ago and has been extended until December 31.

"Health Minister Simon Harris secured funding to hire 1,000 full-time nurses in the Budget… However, the Irish Nurses and Midwives Organisation has since questioned whether the headline figure will actually make much difference on the wards given that there is a huge reliance on agency staff at the moment."

Bed closures in Louth

Nurse shortage crisis deepens says the INMO was a story carried in the *Dundalk Democrat* (October 11). "According to the INMO there are currently nine beds in Drogheda Cottage Hospital Transitional Care Unit and nine newly refurbished beds in St Oliver Plunkett's Hospital, Dundalk closed due to the refusal of the HSE to sanction the filling of vacant staff nurse posts… The current reality is that directors of nursing have to await eight layers of management to approve the filling of one nursing post.

"In the meantime, patients are left without adequate nursing cover and now beds have been closed in Louth as we head into the busy winter months. The bed closures in Louth are having a direct impact on patients in Our Lady of Lourdes Hospital, Drogheda."

Cork University Hospital (CUH)

Industrial action, in the form of a work to rule, in the oncology/radiotherapy ward at CUH was reported in the *Evening Echo* (October 5). IRO Mary Rose Carroll said: "The union has engaged with hospital management on an ongoing basis since December, but concerns have not been adequately addressed… There has been absolutely no agreement reached and no firm offer put on the table… the work to rule will continue until agreement can be reached."

Ann Keating is INMO media relations officer
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Quality & Safety

A column by Maureen Flynn

Making data meaningful to drive better quality decisions

THIS month we focus on the use of data to measure and report on nursing contributions to patient outcomes. Healthcare organisations are becoming more aware of the importance of providing a culture of patient safety and quality, resulting in the drive to increase transparency and demonstrate systems that monitor and measure quality care.[1,2,3] Performance measurement has become an integral part of modern healthcare systems. Internationally healthcare organisations have adapted Donabedian's classical framework to assess quality of care.

What is the Donabedian framework?

The Donabedian framework has three categories of information: structure (work environment), process (how care is delivered and implemented) and outcome (effects of care on the patient). By measuring and understanding the relationships between these categories of information a fuller picture of the quality of care provided can be obtained.[4] Each category is influenced by the previous, making the components interdependent *(see Figure 1)*.

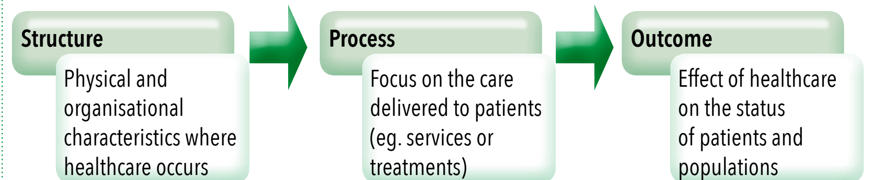
How is the framework used?

Many organisations struggle to turn data into an actionable plan to improve quality, becoming data rich and information poor.[5] To overcome this, the medical division at Letterkenny University Hospital (LUH) has brought together information generated from the electronic rostering system and the quality care metrics reports to make data more meaningful for ward managers, staff and patients, using data from the following sources:

- Structure – 'Health Roster' (staffing required versus actual on roster)
- Process – quality care metrics report
- Outcome – patient experience, 'red flags' (safety clues – care left undone events) and clinical incidents.

This approach shows how each category is influenced by the previous, eg. how staffing levels influence the processes and the processes influence patient outcomes. The 'red flags' mirror the safety clues referred to as 'care left undone events'.

Figure 1. Donabedian framework



The quality care metrics report contains standardised data covering the following processes: medication storage and custody, medication administration, documentation, nursing assessment (pressure ulcer assessment, falls, restraint, patient observations, nursing care plan, discharge planning, nursing evaluation, environment, and provision of information).

To be easily accessible and meaningful for clinical nurse managers (CNMs) and teams, clinical dashboards are currently being developed within the medical division to display the information from different sources. The nurse management team is working closely with staff to review how the data is displayed and interpreted at ward level. Dashboards provide frontline staff with a quick visual of data relating to their unit making it more meaningful and easier to interpret. This promotes engagement and motivates staff to improve practices.

Benefits

By linking quality care metrics and electronic rostering data, service managers are supported to build business cases to improve nursing services and improve nursing practice. This holistic approach to monitoring and measuring quality care gives managers the tools to measure, contribute to and develop quality profiles that support service developments. This data can empower managers by demonstrating the value of the nurses' role in quality care and also inform decision making when prioritising areas for improvement.

Understanding the links between structure, processes and outcome information, empowers CNMs to make decisions and changes to improve nursing practices at ward level. This is achieved by making data visible and discussing actionable plans monthly with ward team members. The key to success when generating data is to make it meaningful and visible at ward level. Staff engagement in monitoring quality facilitates ownership of results and celebration of improvements.

Opportunity to get involved

At your next ward, team, department or directorate meeting you might like to talk about how you measure the quality of care provided? What information sources do you have readily available; do you have data related to structure, process and outcomes? How could you bring this data together to give you a fuller picture of the quality of your care? Could you display this information together on a clinical dashboard?

To learn more about the experience at LUH contact Sinead Fisher, CNM3, medical division at: sinead.fisher@hse.ie. To find out more about nursing and midwifery quality care metrics contact Anne Gallen, director, nursing midwifery planning and development unit, at: anne.gallen@hse.ie or follow the link to the ONMSD webpage at: **www.hse.ie**

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

Acknowledgement
With thanks to Sinead Fisher, CNM3 medical division, LUH, and Michelle Donnelly, eRostering project manager, Saolta University Healthcare Group, for sharing their experience and assistance in preparing this column

References on request (Quote: Quality & Safety 2016 (Nov): 24(9): 48)

HSE
Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive
Quality Improvement Division

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

Tús Áite do Shábháilteacht Othar
Patient Safety First

Optimal cord clamping – key role of the midwife

Anne Murray, 2016 CJ Coleman Research Award winner, discusses the findings from her research paper on optimal cord clamping and the importance of trusting midwives to provide the highest quality of care

AS MIDWIVES who have worked for many years caring for pregnant and birthing mothers and newborn babies will know, the miracle of childbirth never ceases to amaze. However, within the Irish obstetric-led model, we have lost sight of that miracle. Mothers and babies are being overlooked, while more emphasis is placed on buildings, staff, financial resources, patient turnover and work practices that are considered suitable to the institution. We are losing sight of providing quality individualised care, with choice and dignity for our families.

Midwifery care has been prejudiced by decades of obstetric influence and childbirth has become part of the medicalised framework that midwives have been forced to work within. Care has evolved from accepting a normal process to accepting interference in childbirth as the norm. At present, midwives have difficulty asserting their professionalism and working as autonomous practitioners within this medical structure.

Labour management and interventions

Birth is a physiological event in a healthy mother and baby and, while intervention is appropriate in risk situations, it is not necessary for all women.

Active management of labour which includes immediate cord clamping (ICC) was supported by the NICE Guidelines 2007 and Cochrane Report 2008. This has dominated maternity care to the extent that women are instructed rather than provided with choice.

Active management of labour has its place, and access to it has undoubtedly saved many lives and reduced maternal morbidity, even in developed societies where postpartum haemorrhage remains a major contributor to maternal morbidity and mortality. Nevertheless, it has brought much interference and technology which may not always prove to be in the best interest of the mother and baby.

The timing of clamping and cutting the umbilical cord has been one of the practices in maternity care, developed because of appropriateness, history, custom and practice. Despite the fact that this has been challenged and discussed for centuries, only recently has it been the focus of the rigours of science and research. Immediate cord clamping has been seen as a flawless action at birth. However, it can also be seen as interference in the natural physiology of the transition at birth that deprives the newborn of vital blood.

Transition of the newborn from intrauterine to extrauterine life is one of the most powerful dynamic interludes in the life cycle. The transition from total dependence on the mother for every life-sustaining requirement, from oxygen to nutrition, to adapting to total independence, necessitates remarkable physiological changes from mother and baby.

For each individual newborn infant, this transition may take minutes, hours or days. Once the baby is born, the transition begins and should continue uninterrupted as the umbilical cord continues to pulsate allowing the blood from the umbilical vessels to flow to the baby for the first few minutes. This is called placental transfusion.

Blood volume of the neonate varies depending on cord clamping practices.[1] Newborns subjected to ICC have around 70ml less blood volume per kilogram, compared to newborns following optimal cord clamping, who have an increase of 30-40%. This means that they have up to 90ml per kg[2,3] more, amounting to an extra 270ml of blood for a 3kg baby.

Optimal cord clamping

Several studies have indicated that

newborns who are subjected to ICC have anaemia in infancy compared to newborns who are not subjected to the intervention of ICC. Iron-deficient anaemia in early childhood is associated with developmental abnormalities.[4]

Many studies have shown that optimal cord clamping improves blood pressure in the first hours after birth. Studies show that newborns require less blood transfusions and volume expanders. The increased blood volume following optimal cord clamping provides newborns with a larger amount of haematopoietic stem cells, which have huge potential for healing and repairing.

Optimal cord clamping allows newborns a natural stem cell transfusion. Red blood cells are increased by up to 60% following a delay of clamping for three minutes.[5,6] This is of major importance as red blood cells play an essential role in the transport of oxygen. Evidence substantiates that extra blood is necessary for the newly established pulmonary circulation.[3,7,8]

The author conducted research at Portiuncula Hospital, Ballinasloe, Co Galway, which explored the effects of delayed cord clamping (DCC) on oxygen saturation levels (SpO2) and heart rate in the first 10 minutes of life. The research concluded that SpO2 levels in the first 10 minutes of life are enhanced with DCC.

The research found fewer incidences of low heart rates in the early minutes after birth, in addition, to establishing that newborns with nuchal cords don't have low one minute Apgar scores when DCC is the practice. Previous research found low one minute Apgar scores in newborns with nuchal cords when subjected to ICC. It is for these reasons that a body of evidence widely endorses the benefits of optimal cord clamping regarding anaemia, blood volume, the smooth transition to extrauterine life and improved overall outcome for the newborn.

Midwifery care

Midwives aspire to provide the most excellent care supported by high-quality evidence for mothers and babies to ensure that families have the best possible outcomes. Decisions made by midwives while supporting and caring for women at this time are extremely important and influence a variety of childbirth outcomes. Optimal cord clamping is one such judgment.

Most midwives know that optimal cord clamping is the ideal care during the third stage of labour, yet it must be asked why is it not being universally adopted as standard care? This may be due to a number of reasons.

Initiating change

Firstly, initiating change is challenging and requires all staff working in maternity units to become involved. Care for birthing mothers encompasses many disciplines from obstetricians, midwives, nurses and paediatricians to neonatologists. These specialists all have differing views about management of the umbilical cord at birth.

The building of trust and the use of excellent communication skills within all disciplines is vital. To facilitate transformation, a change agent is required to organise the venture and monitor progress. Education about current evidence on optimal cord clamping must be provided to all the stakeholders.

Resuscitation

Secondly, the problem of resuscitation arises. Most midwives who practise midwifery in the home environment would resuscitate newborns at the perineum with the cord intact. They know that resuscitating while the cord is still pulsating provides continued placental respiration for the newborn.

Traditionally, resuscitation in the hospital setting at the bedside is not the norm. Resuscitaires are usually positioned away from the parents; believing it protects parents from the trauma of resuscitation at birth. Parental choice should be our first consideration. Birth and death are poignant and personal life events and patients and families should have as much autonomy as possible concerning these.

Denying parents the right to see their vulnerable loved newborns in the moments before death, contravenes the principal of autonomy. Bedside resuscitation in close proximity to parents would make for better communication and reassurance, in seeing that everything that could be done was done.

Most resuscitations have excellent outcomes and parents feel privileged to have witnessed the care, love and kindness shown to their precious newborns by health professionals.

Equipment is now available to provide optimal ventilation with the cord intact at the bedside. On site at Portiuncula Hospital, a bedside resuscitation trolley by LifeSTART is used.

The WHO recommends resuscitation with the cord intact if possible. This resuscitaire allows optimal care by allowing resuscitation with the cord intact.

The practice standards of the NMBI are part of a midwife's code of professional ethics. Similar principles and values run through each standard. As midwives, if we adhere to these standards we will provide better collaboration, education and choice for our mothers during childbirth.

Figure 1. A LifeSTART resuscitation trolley is used on site at Portiuncula Hospital, Galway to provide a stable, warmed platform for recusitation of the newborn baby at the bedside. It ensures optimal ventilation with the cord intact, which is better for the newborn as the pulsating cord provides continued placental respiration

Mothers will become informed about optimal timing of cord clamping and the importance of the establishment of respiration prior to cord clamping. This will empower mothers and thus enable them to make informed decisions regarding their care and interventions in labour and childbirth. Childbirth would be returned to its rightful owners and autonomy of the mothers and midwifery would be rediscovered.

Anne Murray is a clinical midwife specialist at Portiuncula Hospital, Ballinasloe, Co Galway. This article is based on her research paper, Neonatal pulse oxygen saturation levels (Sp02) and heart rates for the first 10 minutes of life following delayed umbilical cord clamping, which won the INMO CJ Coleman Research Award 2016

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Pathway to respectful care

Deirdre Munro reviews the recently published monumental *Lancet* paper, *Beyond too little, too late and too much, too soon*

BEYOND too little, too late and too much, too soon: a pathway towards evidence-based, respectful maternity care worldwide[1] is the second in a series of six papers about maternal health in *The Lancet* Midwifery Series published in September.

This is an extremely important publication for maternity care globally. The full paper by Miller et al is highly recommended as vital reading for maternity workers globally *(see www.researchgate.net/publication/308149742)*. The authors report two extreme situations in the continuum of maternal healthcare:

- *Too little, too late* (TLTL), which describes care with "inadequate resources, below evidence-based standards, or care withheld or unavailable until too late to help". TLTL is described as an "underlying problem associated with high maternal mortality and morbidity"
- *Too much, too soon* (TMTS), which describes the routine over-medicalisation of normal pregnancy and birth. It also includes "unnecessary use of non-evidence-based interventions, as well as use of interventions that can be life saving when used appropriately, but harmful when applied routinely or overused".

Births in facilities are on the increase, and the authors report that TMTS interventions cause harm as well as increasing health costs with the added influx of disrespect and abuse. TMTS is usually attributed to high-income countries and TLTL to low-income and middle-income ones, yet social and health inequities facilitate coexisting occurrences in many countries. This paper highlights a global approach to quality and equitable maternal health, supporting urgent implementation of respectful, evidence-based care for all.

This monumental paper presents a systematic review of evidence-based clinical practice guidelines for routine antenatal, intrapartum, and postnatal care, categorising them as: Recommended; Recommended only for clinical indications; and Not recommended. The authors present prevalence data from middle-income countries for specific clinical practices, indicating TLTL and increasing TMTS. Healthcare providers and health systems need to safeguard all women to ensure high-quality, evidence-based, equitable and respectful care. Maternity care must be guided by the right amount of care needs to be offered at the right time, and delivered in a manner that respects, protects, and promotes human rights.

Although progress is being made to reduce global maternal mortality, the authors of this paper suggest a broader focus is needed to optimise health status and quality as well as reducing maternal deaths. Respectful care is always possible. Guidelines need to reflect local disease burden, local priorities and a shift towards improved screening for prevention, early detection and early treatment during antenatal care. Guidelines are needed with the specific focus to minimise TMTS care. TMTS may not improve outcomes, and can actually cause avoidable harm, increase costs and inequities.

Individuals, professional associations, facilities and systems can create a path beyond TLTL and TMTS through 'implemented' evidence-based guidelines for routine maternal healthcare.

Guidelines are only that – guides. Maternity care is only as good as the caregiver implementing care for mothers and newborn babies; this has a direct effect on outcomes and experiences (good or bad). We need clear, concise, comprehensible steps to co-design and implement safe maternity care.

Key messages from the Lancet Midwifery Series (Sept 2016)[1]

- Preventable maternal morbidity and mortality is associated with the absence of timely access to quality care, defined as too little, too late (TLTL)– ie. inadequate access to services, resources or evidence-based care – and too much, too soon (TMTS) – ie. over-medicalisation of normal antenatal, intrapartum, and postnatal care
- Although many structural factors affect quality care, adherence to evidence-based guidelines could help healthcare providers to avoid TLTL and TMTS
- TLTL, historically associated with low-income countries, occurs everywhere there are disparities in socio-demographic variables, including, wealth, age and migrant status. Often disparities in outcomes are due to inequitable application of timely evidence-based care
- TMTS, historically associated with high-income countries, is rapidly increasing everywhere, particularly as more women use facilities for childbirth. Increasing rates of potentially harmful practices, especially in the private sector, reflect weak regulatory capacity as well as little adherence to evidence-based guidelines
- Caesarean section is a globally recognised maternal healthcare indicator, and an example of both TLTL and TMTS – with disparate rates between and within countries, and higher rates in private practice and higher wealth quintiles. Caesarean section rates are highest in middle-income countries and rising in most low-income countries. Although researchers partly attribute the increase and variable rates to a shortage of clear, clinical guidelines and little adherence to existing guidelines, multiple factors – economic, logistical and cultural – affect caesarean section rates
- Quality clinical practice guidelines need to be developed that reflect consensus among guideline developers, using similar language, similar strengths of recommendation, and agreement on direction of recommendations
- Strategies for enhanced implementation and adherence to guidelines need multi-sectorial input and rigorous implementation science
- A global approach that supports effective and sustained implementation of respectful, evidence-based care for routine antenatal, intrapartum and postnatal care is urgently needed

Deirdre Munro is Education Officer of the INMO Midwives Section and is founder of Global Village Midwives. Twitter @DeirdreMunro

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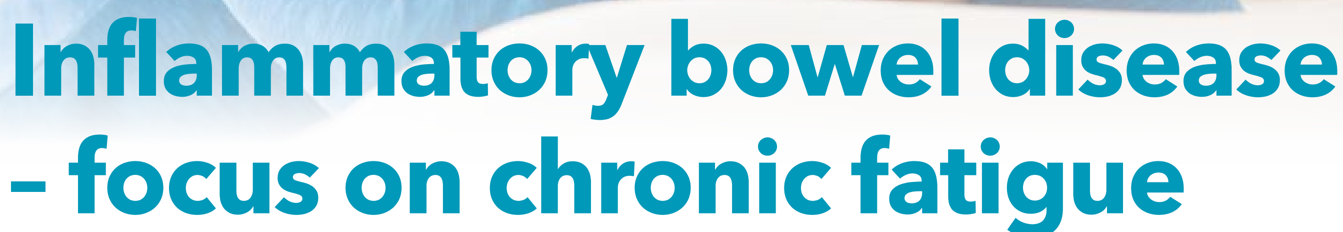


Inflammatory bowel disease – focus on chronic fatigue

The nature of IBD being typically a young person's disease may lead to an underestimation of fatigue in a young cohort, writes **Cathy Walsh**

INFLAMMATORY bowel disease (IBD) is a chronic condition that affects approximately 20,000 people in Ireland. It is the umbrella term for ulcerative colitis and Crohn's disease.

IBD is a chronic, relapsing and unpredictable condition that typically affects an age group of 15 to 35-year-olds. It is a condition with periods of being very well to periods of repeated flare-ups. There is no cure and treatment varies from person to person. Treatments have improved considerably for patients diagnosed with IBD over the past 10 years but chronic conditions and the related symptoms can be difficult to come to terms with.

Chronic fatigue

Fatigue is a problem associated with chronic conditions[1,2,3] and may be underestimated in young people with IBD. Farrell and Savage highlight that the symptoms are a complex phenomenon that have adverse effects on an individual's life.[4]

There is a lack of clarity on the terminology used in relation to IBD and fatigue[2] and multiple definitions of fatigue exist.[2,5] Put simply, fatigue is also called exhaustion, tiredness or lethargy and a feeling of lack of energy and motivation that can be physical or mental or both. Many features of chronic conditions contribute to fatigue, including muscle weakness, pain, anxiety and disturbed sleep.[6]

Chronic fatigue is a common symptom of chronic conditions[2] and has a major impact on quality of life and the ability to function.[6] It is a problem for patients because of the duration and its impact on quality of life. Fatigue, which is a common concern for IBD patients, is managed inadequately in Ireland.[1,6]

The very nature of IBD being typically a younger person's condition, may lead to an underestimation of fatigue in this cohort.

Objectives

While studying fatigue and IBD, three objectives were identified:

- To assess fatigue in patients diagnosed with IBD related to relapse or remission status
- To assess symptom reporting of fatigue by healthcare professionals
- To raise awareness and provide a patient information leaflet.

Fatigue severity scale

Fatigue is subjective and difficult to measure. Until recently, fatigue has not been measured routinely in many conditions. Various measures of fatigue are available[7] but are not specific to IBD at the time of this study.

The 'fatigue severity scale' *(see Figure 1)* designed by Krupp[8] in 1989 was chosen as the scale of choice. It is a reliable and validated score designed to assess disabling fatigue in all individuals and to look at the connection between fatigue intensity and functional disability.[9] It is easy to administer and can be completed quickly.

The 'fatigue severity scale' is used to measure fatigue in a variety of medical and neurological conditions. It consists of nine questions, using a seven-point scale, ranging from 'strongly disagree' to 'strongly agree'. The scores are totalled from each question – a lower score indicates less fatigue in everyday life; a high score (mean > 4.0) indicates severe fatigue.

Methodology and results

A questionnaire was developed that included age, diagnosis, remission or relapse status, and whether the patient was asked about fatigue as a symptom by a healthcare professional. The fatigue severity scale was included with the questionnaire for completion. All questionnaires were anonymous.

A total of 52 questionnaires were completed by patients who attended the IBD outpatient department over a four-week period. Criteria included patients who had a diagnosis of IBD for one year or more. The age range was 19-68 (mean age of 42). A total of 24 males (46%) and 28 females (53%) completed the questionnaire.

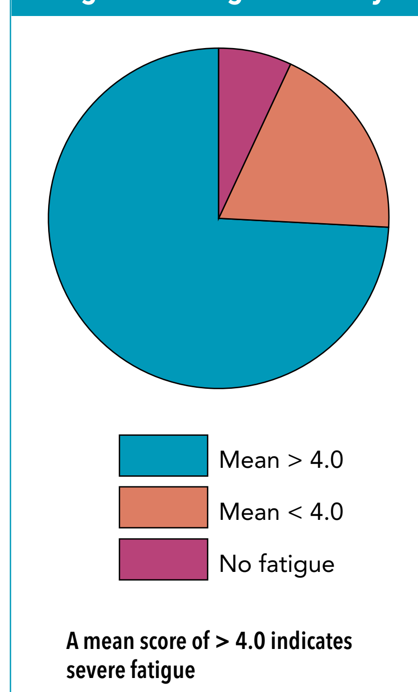
In the diagnosis question, 18 (34%) had ulcerative colitis and 48 (66%) had Crohn's disease. Of those who completed the questionnaire, 73% considered their condition to be in relapse and 27% considered their condition to be in remission.

Figure 1. Fatigue severity scale

During the past week I have found that:	Disagree ⟷ Agree						
1. My motivation is lower when I am fatigued	1	2	3	4	5	6	7
2. Exercise brings on my fatigue	1	2	3	4	5	6	7
3. I am easily fatigued	1	2	3	4	5	6	7
4. Fatigue interferes with my physical suffering	1	2	3	4	5	6	7
5. Fatigue causes frequent problems for me	1	2	3	4	5	6	7
6. My fatigue prevents sustained physical functioning	1	2	3	4	5	6	7
7. Fatigue interferes with carrying out certain duties or responsibilities	1	2	3	4	5	6	7
8. Fatigue is among my three most disabling symptoms	1	2	3	4	5	6	7
9. Fatigue interferes with my work, family, or social life	1	2	3	4	5	6	7
	Total score:						
FSS mean score = total score for nine items divided by nine	Mean score:						

Source: Krupp LB, et al. Aron Neurol. 1989; 46: 1121-1123; 1989, American Medical Association

Figure 2. Fatigue severity



A mean score of > 4.0 indicates severe fatigue

Fatigue severity was measured using the fatigue severity scale. Only 7% reported no fatigue, with 19% reporting a mean score of < 4.0, which indicates that they suffer from fatigue. Severe fatigue (mean > 4.0) was reported by 74% of the respondents *(see Figure 2)*.

A review of fatigue in relation to relapse/remission status revealed that patients in relapse had a higher mean score than those in remission. A total of 69% had a mean score of > 4.0, indicating severe fatigue during relapse.

Symptom reporting of fatigue revealed that 38% were asked by a healthcare professional about fatigue as a symptom and 62% were not asked. This is in keeping with findings by Czuber-Dochan,[1] who found that patients who reported symptoms of fatigue were not taken seriously by healthcare professionals and fatigue was not addressed during consultations.

Discussion

Fatigue has been identified as a problem for patients diagnosed with IBD.

Patients who are in relapse are more fatigued than those in remission, which is in keeping with the findings of Czuber-Doochan.[10] The findings indicated that fatigue is not only related to relapse but is ongoing for patients in remission.

Symptom reporting is inadequate from healthcare professionals. Czuber-Doochan[1] highlighted that participants struggle to describe fatigue and that it is a poorly understood symptom that is frequently overlooked by healthcare professionals.

Symptom assessment from the patient's perspective is recommended as best practice.[11] Healthcare professionals need to consider fatigue as a symptom during assessment and give appropriate advice. Providing relevant written information on the management and treatment of fatigue would be considered appropriate for patients to understand the condition.

Fatigue in IBD patient leaflet

I was asked in 2013 by the Irish Society of Crohn's and Colitis to write an article for the quarterly magazine on a subject of choice. Fatigue was the immediate choice as I had noted the significant effects and impact of fatigue on patients with IBD.

The feedback on the article, which acknowledged fatigue as a factor in IBD, was extremely positive from patients and healthcare professionals.

A review of the literature relating to information on IBD and fatigue was unavailable for patients at this time.

I developed the fatigue in IBD patient information leaflet in 2014. It is currently distributed to all gastrointestinal units in Ireland by Tillotts Pharma, which produces IBD information booklets for patients.

Conclusion

Fatigue is a neglected component of IBD and is a real symptom for patients during relapse and remission. IBD is predominantly a young person's condition and dealing with chronic fatigue as well as a chronic condition can have major implications on quality of life.

The fatigue and IBD patient information booklet provides information for patients on fatigue and how to manage it.

Since then, Crohn's and Colitis UK have completed an extensive four-year study on fatigue and developed a fatigue assessment score specifically for IBD patients.[10] The study has advised that all patients with IBD should be screened for fatigue.

Cathy Walsh is a colorectal clinical nurse specialist at Letterkenny University Hospital, Co Donegal

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Standardising the nursing home transfer form

By using a standardised nursing home transfer form, patients can receive more person-centred care, writes **Jean Barber**

THERE is no single standardised nursing home transfer letter available nationally in Ireland. Some nursing homes send very detailed letters, others photocopy the patients care plan and unfortunately, a few nursing homes send transfer letters with very little information in them.

Hospital staff then often have to spend unnecessary time contacting nursing homes for pertinent baseline information and many medical and nursing decisions are based on this information.

The objective of a standardised letter is to ensure that the information that nursing homes send with their patients on transfer to an acute hospital is relevant for the patients' nursing and medical assessments. It also helps in formulating the nursing care plan and ensures that each patient receives a person-centred approach to care.

Content of transfer letter

The one-page document illustrated consists of personal and medical information, plus basic baseline information. Personal information is given in the first section. The 'medical information' section contains a line asking nurses to state the reason the patient is being sent to hospital. Included in this section is a reminder to send the patient's medication list and any previous medical history. There is also a section which requests information on whether the patient has any specific palliative care or end-of-life needs or has a DNR order in place.

Why information on the following is important

- Infection risk, eg. MRSA: If present, the hospital can instigate timely precautionary measures early, eg. use of a single room
- Falls prevention strategies can be implemented earlier
- Safeguards with regards to transfer and mobility issues can be addressed sooner
- Information on the level of mobility that the patient has gives the staff a baseline to which they can aim once the acute phase of the illness is over
- The Waterlow score will determine if a pressure relieving mattress is required and if a referral to the tissue viability nurse is warranted
- The functional level (Barthel) score indicates how independent the patient was and is a helpful guide for rehabilitation
- Diet modification information can prevent aspiration pneumonia. This information will also trigger a referral to the speech and language therapist
- The patient's weight and MUST score can prompt an earlier referral to the dietitian
- Previous continence history can prevent the inappropriate use of incontinence products
- If a urinary catheter is *in situ*, information on the type, size and the date that it is due to be changed is provided and noted
- Cognitive assessment information provides a baseline when differentiating between dementia, delirium and delirium superimposed on dementia. The patient's normal communication level is also noted.

St Vincent's Healthcare | UCD

NURSING HOME TO ACUTE HOSPITAL TRANSFER FORM

Primary Care Information

Nursing Home: ______________________
Phone Number: ______________________
Fax number: ______________________
GP Name: ______________________
GP Phone No: ______________________

Personal Information

Name: ______________________
DOB: __/__/__
Specified NOK: ______________________
NOK Phone No: ______________________

Medical Information

Referral reason: ______________________

Medicines list attached *(please circle)*: Y / N | Medical History attached *(please circle)*: Y / N

DNR order attached *(please circle)*: Y / N | Specific Palliative Care/End of Life needs attached: Y / N

Infection Risk: Y / N Antibiotic resistant organism identified e.g. MRSA Specify: ____________

Healthcare-associated infection e.g. *C. Difficile* infection: Specify: ____________

Eradication protocol attached *(please circle)*: Y / N | Patient aware: *(please circle)*: Y / N

Physical Information

Mobility *(please circle)*: Independent Stick Frame Assistance 1 or 2 Wheelchair Immobile
Transfer *(please circle)*: Independent Assistance 1 or 2 Standing Hoist Full Hoist
Falls Risk *(please circle)*: Low Medium High
Functional level (Barthel): __/20
If unsure, please describe:
Skin Integrity *(please circle)*: Intact Grade 1 Grade 2 Grade 3 Grade 4
Location (if applicable) ____________ Waterlow Score: __/47
Nutrition Weight ____ kgs MUST Score: ____
Diet Modification *(please circle)*: Diet: Normal Texture A Texture B Texture C Texture D
Fluids: Normal Grade 1 Grade 2 Grade 3 Grade 4
If unsure, please describe: ______________________
Continence *(please circle)*: Incontinent of urine: Day Night Day & Night
Incontinent of bowel: Day Night Day & Night
Urinary Catheter: Y / N Next change date: __/__/__
Type: Size:
Cognition: MMSE __/30 AMTS __/10
If unsure, please describe: ______________________
Communication *(please circle)*: Normal Functional verbal communication Limited verbal No verbal
Accompanying patient *(please circle)*: Spectacles Hearing Aid Dentures
Any other relevant information included *(please circle)*: Y / N (Please attach on a separate sheet)

Signed____________ **Grade:**______ **Date:**___/___/______

Outcome

By using a standardised transfer letter the patient can receive a more person-centred approach to care. A grant has been given by the Irish Hospice Foundation to expand the use of this standardised nursing home to acute hospital transfer letter.

A copy of the transfer letter is available on the homepage of St Michael's Hospital website **www.stmichaels.ie** under 'referral information'. It is also available on the 'medicine for the elderly' section of the St Vincent's University Hospital website **www.stvincents.ie**

EpiCare also has a copy on its website.

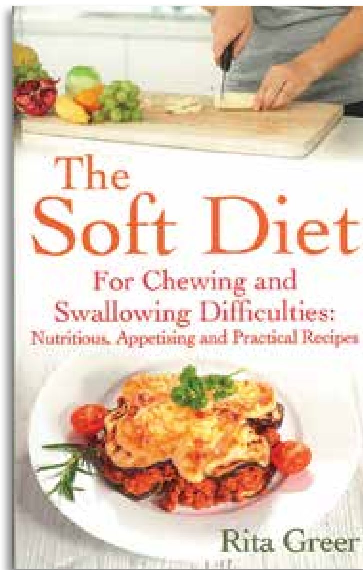
Jean Barber, CNS palliative care/CNS gerontology, St Michael's Hospital, Dun Laoghaire, Co Dublin

A caring cuisine

PROBLEMS with chewing or swallowing because of disability, dental problems or illness are widespread. Inspired by caring for her husband who had such a difficulty, Rita Greer developed recipes for people on exclusion diets and has designed a 'new cuisine' specifically for adults to provide a balanced and stimulating diet.

In the introduction, Ms Greer recounts how necessity was the mother of invention. When caring for her husband who was unable to chew and who spent many years in hospitals and nursing homes, she said she felt she had been thrown in at the deep end. Unable to find a suitable cookbook and knowing how the standard 'soft diet' had failed him, she said she had no choice but to face the serious nature of the problem and set about experimenting and trying to understand the implications of such a regime.

Her book aims to avoid 'baby-food' creeping on to the menu, which can disappoint and depress the adult patient and often fail to provide adequate nourishment. *The Soft Diet* offers ideas and a variety of recipes for anyone who is on a soft diet. It is based on providing proper nutrition, with vegetables and fruit, salads,



bread and cakes, cereals, cheese, fish and meat, poultry and eggs, while offering enough variety to stimulate the appetite.

The author stresses that balance is just as important as for an ordinary diet, or even more so, and this cannot be achieved by using just a few convenience foods.

Rita Greer has decades of practical experience, not only as a health writer, but also in the food industry, which makes *The Soft Diet* useful for those caring for someone at home as well as for caterers in hospitals and care homes. It aims to improve the quality of life for anyone who has problems with chewing and swallowing.

As well as providing the recipes for soft versions of old favourites and classic dishes – from lasagne to a roast dinner – the book includes chapters on nutrition, a balanced diet and healthy eating advice. It includes a useful list of cooking equipment and techniques for food preparation, pointing out that soft options cuisine is concerned with fine chopping rather than just liquidising and blending. As well as chapters with recipes broken up into the various meal types, there is what describes itself as an 'over-the-top' chapter on treats and celebration food, aimed at balancing the moderation of the rest of the book. Recipes in this chapter include 'spaghettini al salmone' – a rather special starter with smoked salmon and cream.

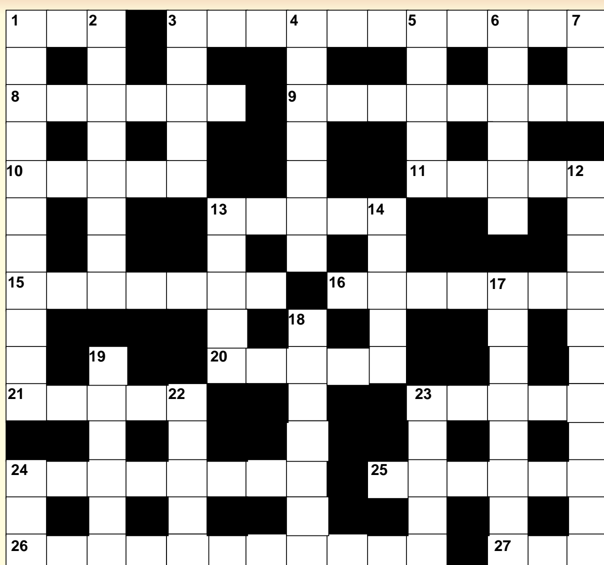
The Soft Diet, a practical and easy to follow book, aims to make food and cooking a pleasure again for anyone who has had to adjust to a soft diet and their carers.

– Tara Horan

The Soft Diet. Rita Greer. Souvenir Press. ISBN: 9780285643529. £9.99

Crossword Competition

WIN A €30 BOOK TOKEN



Across

1. Part of a fish - the dorsal, perhaps (3)
3 & 25a. Where senior army officers buy stamps? (7,4,6)
8 & 9. Auburn plectrum broken during spinal tap (6,8)
10. Confess, admit (3,2)
11. Wetland (5)
13. Melody (5)
15. This summit should let the First Lady take it easy (7)
16. Pasta dish found in the middle of a Sinatra violin concerto (7)
20. Cardinal direction (5)
21. Holy person (5)
23. Cheer to support come Cabra volunteers (5)
24. A string's tangled up in astrological categorisation (4,4)
25. See 3 across
26. Some lions and Ms Adamson - they're the most special! (5,3,3)
27. Female sheep (3)

Down

1. As energetic as cowboys after a hackneyed campfire meal? (4,2,5)
2. Put someone's name forward (8)
3. Take hold of; understand (5)
4. Non-stop train or bus (7)
5. With which to tie up your shoes (5)
6. Pertaining to the eye (6)
7. Golf peg (3)
12. The Epoch of the Broken Stolen Piece (11)
13. Craftsman in stone (5)
14. Collision (5)
17. Orange is required - so arrange it (8)
18. Did earn a change, being utterly exhausted (7)
19. How I'd wail for the Hindu Festival of Lights (6)
22. Flavour (5)
23. Vampire slayer played by Sarah Michelle Gellar (5)
24. Something given to pacify someone (3)

Name: ....

Address: ....

The prize will go to the first all correct entry opened.
Closing date: **Monday, November 21, 2016**
Post your entry to: **Crossword Competition, WIN, MedMedia Publications, 17 Adelaide Street, Dun Laoghaire, Co Dublin**

Solutions to October crossword:

Across:
1. Brute force 6. Hard 10. Chair 11. Influenza 12. Foreleg 15. Toxin 17. Ouzo 18. Lung 19. Nests 21. Praises 23. Cadre 24. Fiji 25. Rent 26. Bluff 28. Help out 33. Attempted 34. Space 35. Dire 36. Thermostat

Down
1. Back 2. Unadorned 3. Eyrie 4. Ovine 5. Cuff 7. Annex 8 & 32d. Diagnostic test 9. Buttons 13. Lear 14. Goliath 16. Blackboard 20. Stimulant 21. Perfume 22. Evil 27. Utter 29. Eider 30. Pesto 31. Itch

The winner of the October crossword is:
Mary Roche Fermoy Co Cork

A leap forward for cardiac services

HELEN Connaughton has become the first clinical nurse specialist in Ireland in the area of inherited cardiac conditions. Ms Connaughton's success marks an important milestone for cardiology and nursing services, both nationally and in Tallaght Hospital.

As the first Irish clinical nurse specialist in inherited cardiac conditions, Ms Connaughton is now a national leader in this area and demonstrates the investment and advancements that have taken place in cardiac services at Tallaght Hospital.

Ms Connaughton was a clinical nurse manager in the cardiac risk in the young (CRY) unit for eight years. The CRY unit aims to provide comprehensive specialist evaluation of those diagnosed with or at risk from inherited cardiac conditions, including families who have lost someone to sudden cardiac death.

The unit was developed as a collaboration between Tallaght Hospital, St James's Hospital, St Vincent's University Hospital and Trinity College Dublin and is located at Tallaght Hospital.

Pictured in Tallaght Hospital at the announcement of Helen Connaughton becoming the first clinical nurse specialist in Ireland in the area of inherited cardiac conditions were (l-r): Deirdre Ward, consultant cardiologist; Helen Connaughton, clinical nurse specialist in inherited cardiac conditions; Hilary Daly, director of nursing, Tallaght Hospital; and Berneen Laycock, assistant director of nursing, all Tallaght Hospital

Ms Connaughton's post was initially funded by the Patches Trust and for the past five years she has been funded by the charity Cardiac Risk in the Young, which fund much of the activity at the CRY unit.

"It is a great honour to achieve this success and to be part of this great leap forward for cardiac services in Ireland," Ms Connaughton said.

Hilary Daly, director of nursing at Tallaght Hospital, added: "Tallaght Hospital has a strong ethos of 'people caring for people' and Helen achieving this professional accreditation enables us to put this ethos into place all the more clearly, in the area of cardiac services."

*In the 52-week trials, SPIOLTO® administered once daily in the morning provided clear improvement in lung function within 5 minutes after the first dose compared to tiotropium 5 µg (mean increase in FEV_1 of 0.137 L for SPIOLTO® vs. 0.058 L for tiotropium 5 µg [p<0.0001]).[3] †SPIOLTO® resulted in statistically significant improvements in SGRQ total scores and responder rates vs. both monotherapies (p<0.05) after 24 weeks. Response defined as a ≥4 change in SGRQ score. Pooled analysis of the pivotal phase III TONADO™ 1 and 2 studies.[3] ‡As measured by the Mahler Transitional Dyspnoea Index (TDI) focal score at 24 weeks. Pooled analysis of the pivotal phase III TONADO 1 and 2 replicate studies.[3] An increase in Mahler TDI score indicates an improvement in breathlessness.[2] Mahler TDI focal score increased by 1.983 units with SPIOLTO® compared to baseline, 1.627 units with Spiriva® compared to baseline and 0.356 units with SPIOLTO® compared to Spiriva® (22% improvement vs Spiriva®; p<0.05).[3]

References:
1. SPIOLTO® Respimat® Summary of Product Characteristics. **2.** Beeh K-M *et al. Pulm Pharmacol Ther* 2015;32:53–59. **3.** Buhl R *et al. Eur Resp J* 2015;45:969–979. **4.** Boehringer Ingelheim. Data on file TOL15 02(c). **5.** Spiriva® Respimat® Summary of Product Characteristics. **6.** Spiriva® HandiHaler® Summary of Product Characteristics. **7.** Dalby R, Spallek M, Voshaar T. *Int J Pharm* 2004;283:1–9. **8.** Pitcairn G *et al. J Aerosol Med* 2005;18:264–272. **9.** Hochrainer D *et al. J Aerosol Med* 2005;18:273–282.

SPIOLTO® RESPIMAT® (tiotropium/olodaterol)
Inhalation solution containing 2.5 microgram tiotropium (as bromide monohydrate) and 2.5 microgram olodaterol (as hydrochloride) per puff. **Action:** Inhalation solution containing a long-acting muscarinic receptor antagonist, tiotropium, and a long-acting beta$_2$-adrenergic agonist, olodaterol. **Indication:** Maintenance bronchodilator treatment to relieve symptoms in adult patients with chronic obstructive pulmonary disease (COPD). **Dose and Administration:** Adults only aged 18 years or over: 5 microgram tiotropium and 5 microgram of olodaterol given as two puffs from the Respimat inhaler once daily, at the same time of the day. **Contraindications:** Hypersensitivity to tiotropium or olodaterol or any of the excipients; benzalkonium chloride, disodium edetate, purified water, 1M hydrochloric acid (for pH adjustment); atropine or its derivatives e.g. ipratropium or oxitropium. **Warnings and Precautions:** Not for use in asthma or for the treatment of acute episodes of bronchospasm, i.e. as rescue therapy. Inhaled medicines may cause inhalation-induced paradoxical bronchospasm. Caution in patients with narrow-angle glaucoma, prostatic hyperplasia or bladder-neck obstruction. Patients should be cautioned to avoid getting the spray into their eyes. They should be advised that this may result in precipitation or worsening of narrow-angle glaucoma, eye pain or discomfort, temporary blurring of vision, visual halos or coloured images in association with red eyes from conjunctival congestion and corneal oedema. Should any combination of these eye symptoms develop, patients should stop using Spiolto Respimat and consult a specialist immediately. In patients with moderate to severe renal impairment (creatinine clearance ≤50ml/min) use only if the expected benefit outweighs the potential risk. Caution in patients with a history of myocardial infarction during the previous year, unstable or life-threatening cardiac arrhythmia, hospitalised for heart failure during the previous year or with a diagnosis of paroxysmal tachycardia (>100 beats per minute) as these patients were excluded from the clinical trials. In some patients, like other beta-adrenergic agonists, olodaterol may produce a clinically significant cardiovascular effect as measured by increases in pulse rate, blood pressure and/or symptoms. Caution in patients with: cardiovascular disorders, especially ischaemic heart disease, severe cardiac decompensation, cardiac arrhythmias, hypertrophic obstructive cardiomyopathy, hypertension, and aneurysm; convulsive disorders or thyrotoxicosis; known or suspected prolongation of the QT interval (e.g. QT >0.44 s); patients unusually responsive to sympathomimetic amines; in some patients beta$_2$-agonists may produce significant hypokalaemia; increases in plasma glucose after inhalation of high doses. Caution in planned operations with halogenated hydrocarbon anaesthetics due to increased susceptibility of adverse cardiac effects. Should not be used in conjunction with any other long-acting beta$_2$-adrenergic agonists. Immediate hypersensitivity reactions may occur after administration. Should not be used more frequently than once daily. **Interactions:** Although no formal *in vivo* drug interaction studies have been performed, inhaled Spiolto Respimat has been used concomitantly with other COPD medicinal products, including short-acting sympathomimetic bronchodilators and inhaled corticosteroids without clinical evidence of drug interactions. The co-administration of the component tiotropium with other anticholinergic containing drugs has not been studied and therefore is not recommended. Concomitant administration of other adrenergic agents (alone or as part of combination therapy) may potentiate the undesirable effects of Spiolto Respimat. Concomitant treatment with xanthine derivatives, steroids, or non-potassium sparing diuretics may potentiate any hypokalaemic effect of adrenergic agonists. Beta-adrenergic blockers may weaken or antagonise the effect of olodaterol. Cardioselective beta-blockers could be considered, although they should be administered with caution. MAO inhibitors, tricyclic antidepressants or other drugs known to prolong the QTc interval may potentiate the action of Spiolto Respimat on the cardiovascular system. **Fertility, pregnancy and lactation:** There is a very limited amount of data from the use of tiotropium in pregnant women. For olodaterol no clinical data on exposed pregnancies are available. As a precautionary measure, avoid the use of Spiolto Respimat during pregnancy. Like other beta$_2$-adrenergic agonists, olodaterol may inhibit labour due to a relaxant effect on uterine smooth muscle. It is not known whether tiotropium and/or olodaterol pass into human breast milk. A decision on whether to continue/discontinue breast-feeding or to continue/discontinue therapy with Spiolto Respimat should be made taking into account the benefit of breast-feeding to the child and the benefit of therapy for the woman. Clinical data on fertility are not available for tiotropium or olodaterol or the combination of both components. **Effects on ability to drive and use machines:** No studies have been performed. The occurrence of dizziness or blurred vision may influence the ability to drive and use machinery. **Undesirable effects:** Common (≥1/100 to <1/10): Dry mouth. Uncommon (≥1/1,000 to <1/100): Dizziness, insomnia, headache, atrial fibrillation, palpitations, tachycardia, hypertension, cough, constipation. Serious undesirable effects include anaphylactic reaction and consistent with anticholinergic effects: glaucoma, constipation, intestinal obstruction including ileus paralytic and urinary retention. An increase in anticholinergic effects may occur with increasing age. The occurrence of undesirable effects related to beta-adrenergic agonist class should be taken into consideration such as, arrhythmia, myocardial ischaemia, angina pectoris, hypotension, tremor, nervousness, muscle spasms, fatigue, malaise, hypokalaemia, hyperglycaemia and metabolic acidosis. Prescribers should consult the Summary of Product Characteristics for further information on side effects. **Pack sizes:** Single pack: 1 Respimat inhaler and 1 cartridge providing 60 puffs (30 medicinal doses). **Legal category:** POM. **MA numbers:** PA 775/9/1. **Marketing Authorisation Holder:** Boehringer Ingelheim International GmbH, D-55216 Ingelheim am Rhein, Germany. Prescribers should consult the Summary of Product Characteristics for full prescribing information. Additional information is available on request from Boehringer Ingelheim Ireland Ltd, The Hyde Building, The Park, Carrickmines, Dublin 18. **Prepared in** June 2015.

Adverse events should be reported to the Health Products Regulatory Authority at www.hpra.ie or by email to medsafety@hpra.ie. Adverse events should also be reported to Boehringer Ingelheim Drug Safety on 01 291 3960 or by email to PV_local_uk_ireland@boehringer-ingelheim.com

Date of preparation: March 2016 IRE/SPRES-161038a

Pivotal role of the PAU model of care

THE inaugural pre-admission unit (PAU) conference, entitled 'Operation excellence – sharing solutions', saw 168 delegates, representing 41 hospitals throughout Ireland, gather in the Clarion Hotel, Sligo to demonstrate the interest and enthusiasm among nursing, anaesthetic, surgical and allied healthcare professionals regarding the pre-admission process.

Dr Colm Henry, national clinical advisor and group lead for the acute hospitals, outlined the pivotal role of PAUs in ensuring service efficiency, patient safety and positive patient experiences within the elective surgical and orthopaedic services.

Among other topics discussed at the conference were the work encompassing the PAU model of care, the forthcoming nurse education curriculum for PAUs, and the challenges of informed consent prior to admission. Medication safety in the PAU, the importance of resilience for healthcare professionals and the relevance of commencing the discharge planning process at the PAU were also covered.

Pictured at the inaugural PAU conference were (l-r): Marion Ryder, interim director of nursing; Mr Justin Lane, orthopaedic consultant; Rosaleen White, HIPE; Teresa Donnelly, CNM2 theatre, Therese Gallagher, UNO/SM; Charlotte Hannon, clinical facilitator, nurse practice development unit; Alison Smith, TPot co-ordinator; and Noreen Casey, allocations liaison officer, nurse practice development unit, all from Sligo University Hospital

Vaccinating against seasonal influenza

Pictured at the launch of the Community Health Organisation (CHO) Area1 Flu Vaccine Campaign, which was launched by RTÉ's northern editor, Tommie Gorman, on October 10 were (l-r): Mags Moran, community infection prevention control nurse manager, Donegal; Clodagh Keville, community infection prevention control nurse manager, Sligo/Leitrim; and Martina Harkin-Kelly, INMO president. The launch, which took place in An Clochar, Health Campus, Ballyshannon, aims to raise awareness of the importance of at-risk people getting vaccinated against seasonal influenza and was attended by HSE staff and representatives from various agencies. The at-risk category includes healthcare workers; everyone aged 65 and over; anyone over six months old with a long-term illness; pregnant women; and nursing home residents

HSE launches breastfeeding resources

IN CONJUNCTION with National Breastfeeding Week, which took place in October, the HSE launched a number of new resources, all of which are available at **www.breastfeeding.ie**

Among the resources launched are:

- Ask our expert – email a question to a lactation consultant via the HSE 'ask our expert' service or through webchat
- A new HSE breastfeeding Facebook page, which provides a support community, with information and tips from the 'ask our expert' lactation consultants
- New Irish breastfeeding videos, which provide guidance for mothers on topics such as positioning and attaching baby, expressing milk and what to expect in the early days.

These new resources provide invaluable information, support and friendships for families, and the HSE aims for the new supports to reach more families and improve access to user-friendly breastfeeding help and information.

In Ireland, 57% of mothers are breastfeeding their babies on discharge from maternity hospital, however in the first few days and weeks at home, may experience challenges which often prompt them to stop breastfeeding sooner than they planned. It is important for families to be aware that there is breastfeeding support out there from the maternity services, public health nurses and voluntary breastfeeding organisations in the community.

Support needed for mistreated nurses

NEW research has revealed that nurses need more help dealing with disrespectful behaviour from colleagues if patient care is to be maintained.

The study, which was led by Dr Roberta Fida from the University of East Anglia, argues that in order to retain high-quality nurses it is important to understand what factors might protect them from the negative effects of workplace mistreatment.

This new study, conducted with Dr Heather Laschinger from the University of Western Ontario, Canada, investigated whether individuals' beliefs about their ability to deal with workplace-specific stressful events can protect nurses from these negative effects. It is part of a wider research project on nursing work environments led by Dr Laschinger.

Published in the journal *Health Care Management Review*, the results show that self-efficacy does have a protective role. The more nurses believed in their capability to cope with stressful interpersonal situations at work, the less they perceived incivility from co-workers and supervisors.

Nurses with higher levels of self-efficacy also experienced less emotional exhaustion and cynicism a year after they were first surveyed and reported fewer mental health issues. However, self-efficacy was not significantly related to later intentions to leave the job.

Supporting nurses and midwives to monitor and improve quality of care

THE HSE Office of Nursing and Midwifery Services Director (ONMSD) has commenced research to identify specific and relevant nursing and midwifery quality care metrics for acute hospital care, midwifery, children's, community and public health nursing, as well as mental health and intellectual disability nursing.

A key priority is supporting nurses and midwives to measure, monitor and improve the quality of nursing and midwifery care.

The purpose of the study is to develop a suite of nursing and midwifery quality care metrics and their indicators, which can be used to measure the quality of nursing and midwifery clinical care processes.

The study, co-ordinated through the Nursing and Midwifery Planning and Development Units (NMPDU), is academically supported by three universities – University College Dublin, University of Limerick and the National University of Ireland, Galway.

The participation of nurses and midwives in the research is vital to its success and expressions of interest to participate in the study and have a say in the development of nursing and midwifery sensitive indicators are being sought.

Nurses and midwives will be invited to advise the researchers on what they feel are the important aspects of care delivery, contributing to a quality and safe care experience for patients, clients, families and carers.

A systematic review will be carried out by the research team to ensure all metrics and indicators have a strong evidence base. Questionnaires will be issued to nurses and midwives as part of a 'Delphi' process to identify relevant metrics and indicators.

A national quality care metrics working group will review the Delphi findings to prioritise the metrics and indicators and this will be reissued to nurses and midwives to obtain feedback and consensus.

The research team is aiming to encourage nurses and midwives of all grades across all fields and disciplines to engage in the study. Details of the submission process will be provided shortly.

Further information on the research study is available from the NMPDU or by contacting national lead, Anne Gallen at email: anne.gallen@hse.ie

Raising money for premature babies

IRISH Premature Babies, a national charity set up to support the families of pre-term babies and to support the work of neonatal intensive care units, has launched a 2017 calendar last month to raise money for 10 hospital grade breast pumps, which cost approximately €22,000.

The charity delivers frontline services to families and supports the work of the neonatal intensive care units around Ireland by buying and providing vital equipment towards the care of pre-term babies.

Since 2009, the charity has implemented a parent-friendly breastfeeding programme and bought 11 hospital grade pumps and currently rents them to new mothers of pre-term babies.

The charity has fundraised and donated 15 hospital grade pumps to some of the neonatal units around Ireland. Currently, it does not have enough pumps to meet the demands of new pre-term mothers and it is hoped that the calendar launch will raise enough funding to buy 10 more hospital grade pumps and meet demands.

The calendars can be purchased for €10 at **www.irishprematurebabies.com**

Pictured (L-R) at the recent Irish Association of Directors of Nursing and Midwifery annual conference were: *Martina Harkin-Kelly, INMO president; Thomas Kearns, executive director, Faculty of Nursing and Midwifery, RCSI; and Suzanne Dempsey, director of nursing, Children's University Hospital, Dublin and group director of nursing, Children's Hospital Group. The conference, the theme of which was 'Coming back to what we know – a future of care and complexity', was held on October 6- 7 in the Radisson Blu Hotel, Athlone*

40 years of orthopaedic nursing education

OVER 100 guests gathered on October 20 for an official reception in the Lady Martin Auditorium in Cappagh National Orthopaedic Hospital, as the nursing department celebrated 40 years in orthopaedic nursing education.

Official records of education date from 1976, with the Cappagh National Orthopaedic Hospital's orthopaedic nurse education programme, which was the only certificate programme recognised by An Bord Altranais (Nursing and Midwifery Board of Ireland) when it commenced.

Over the 40-year period from 1976 to 2016, 62 programmes were held, with a total of 479 nurses completing the programmes.

Some 234 nurses graduated with a certificate in orthopaedic nursing, 124 with a diploma in orthopaedic nursing, 78 graduated with a higher diploma in nursing studies (orthopaedic nursing) and 43 graduated with a postgraduate diploma in orthopaedic nursing.

MONEY MATTERS

Choosing a health insurance policy

Ivan Ahern advises on getting the right health cover at the right price

APPROXIMATELY 2.12 million people in Ireland now have health insurance. While the public healthcare system offers fantastic treatment once a patient is in the system, getting access can be a challenge.

Recent figures show that 430,573 people are on waiting lists to be seen for the first time through the public system.[1] These are patients who have been referred after an initial consultation with their GP. In addition, there are 77,800 patients waiting to have their procedure carried out as an inpatient/day case procedure. Waiting times will vary depending on whether a patient is classed as routine or urgent.

Currently, there are more than 18,000 people waiting over 18 months for their initial hospital appointment and, while every effort is being made to improve these numbers, it is not going to happen overnight as the public system is currently struggling to meet demand.

If you have health insurance cover or are considering taking cover out, before looking at price, it is essential that you have the right health insurance. Decide what is important to you and make out a list of questions to ask about your cover.

Tips for choosing the right cover

- Make sure you choose a health insurance plan with some access to private hospitals. Plans with cover in public hospitals only do not always guarantee fast access to treatment
- Check the inpatient/day case excess on your plan. This is the amount you pay and can vary substantially, depending on whether this amount is calculated per admission or per night
- Check that you have full cover for day case treatment such as chemotherapy, radiotherapy and colonoscopies in private hospitals
- Ensure you have cover for major cardiac procedures in the Blackrock Clinic, Mater Private and Beacon hospitals
- Consider cover for day-to-day benefits such as a GP, physiotherapist or dentist visits – check the cover for each benefit and how many visits are covered on your plan.

Managing the cost of health insurance

Outlined below are some tips and factors to consider in managing the cost of health insurance:

Age

Lifetime community rating applies a loading to those taking out cover for the first time after the age of 34, which increases the cost of your premium. This loading is 2% per year for every year, eg. a 35-year-old will pay an extra 2%, a 40-year-old an extra 12% etc. This loading remains for the lifetime of the policy.

Split your cover

You can have every family member on the one policy but all on different levels of cover, which could help you save money.

Young adult discounts

Many insurance companies offer discounts on health insurance for young adults. You could be paying a full adult price for an 18-year-old dependent when as much as a 50% discount could be available.

Child discounts

Most insurers will offer discounts or special terms at various times of the year on child prices so it is important to always ask about possible discounts.

Policy excess

Taking on a policy excess is one of the best ways of reducing health insurance costs. Price reductions of at least 10% may be possible by accepting a small excess for private hospitals.

Private rooms

A private room in a private hospital is never guaranteed. Unless a private room is a necessity for you, consider dropping this benefit for similar cover to make big savings.

Corporate plans

Corporate plans tend to be the most competitively priced plans on the market and are worth considering before you renew your cover. They normally cover public and private hospitals and usually include some level of day-to-day cover for your routine medical costs.

Expert advice

Health insurance is complex but it's also arguably one of the most important insurance plans to have. Don't cut corners with your cover – seek expert advice from a qualified adviser to ensure that your plan is the best value cover that meets your exact requirements.

Shop around

Think of your health insurance cover like you would think of your car or home insurance. Do your homework each year prior to your renewal to get the best deal possible and if you're satisfied that it meets your requirements, then switch.

Ivan Ahern is a director of Cornmarket Group Financial Services Ltd

Cornmarket compare all health plans in the market so that you choose the plan that suits you. Call Cornmarket at Tel: 01 470 8098. Cornmarket Group Financial Services Ltd is regulated by the Central Bank of Ireland. Cornmarket is part of the Great-West Lifeco group of companies, one of the world's leading life assurance organisations

Reference

1. National Treatment Purchase Fund 2016

November

Sunday 6
Retired Nurses and Midwives Section four-night autumn break to Galway Bay Hotel. Full details available from **www.inmo.ie** or Tel: 01 6640616

Wednesday 9
Research Nurses Section meeting. Venue to be confirmed.Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Saturday 12
CNM/CMM Section meeting. 10am. INMO HQ. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Tuesday 22
RNID Section conference. Crowne Plaza Hotel Santry, Dublin. Log onto **www.inmoprofessional.ie** to book your place or contact jean.carroll@inmo.ie or Tel: 01 6640616 for further details

Tuesday 29th
Please note change of date
National Children's Nurses Section meeting. INMO HQ. 11am. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

December

Tuesday 6
Care of the Older Person – What Matters to me IHF. INMO HQ 10am. Cost €45 members/€100 non-members. Maximum capacity of 16 people so please ensure you book early. Log onto **www.inmoprofessional.ie** or contact jean.carroll@inmo.ie or Tel: 01 6640616 for further details

Wednesday 7
Emergency Department Section meeting. 11.30am. INMO HQ. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

January

Wednesday 11
Care of Older Person Section AGM. INMO HQ. 11am. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Wednesday 18
Telephone Triage Section AGM. 11am. INMO HQ. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Saturday 21
ODN Section meeting and AGM. Cavan General Hospital. 11.30am. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Saturday 21
School Nurses Section meeting and AGM. INMO HQ. 10.30am. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

February

Friday 3
Nurse/Midwife Education Section AGM and meeting. INMO HQ. 11.30am. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Saturday 4
Midwives Section AGM and meeting. Cork University Maternity Hospital. 2pm. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Training and education

- One-day ear irrigation training programmes with Category 1 NMBI approval and four CEUs will be held on November 17, 2016 in the Education and Conference Centre, Royal Victoria Eye and Ear Hospital, Adelaide Road, Dublin 2. For further details contact Sabrina Kelly, nurse tutor at Tel: 01 6644652 or email: sabrina.kelly@rveeh.ie
- The Irish Stoma Care and Colorectal Nurses Association study day will take place on Friday, March 24, 2017 at the Mater Misericordiae University Hospital, Dublin. The title of the study day will be 'colorectal innovations: a fusion of clinical excellence. The study day programme will be issued in the coming months. For further information email@stomacare@mater.ie

INMO Professional Development Centre

Library Opening Hours

November
Monday-Thursday: 8.30am-5pm
Friday: 8.30am-4.30pm

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

INMO Membership Fees 2016

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

www.nurse2nurse.ie

Know your rights and entitlements

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

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

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