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WIN

INMO
Journal of the
Irish Nurses and Midwives Organisation

World of Irish Nursing & Midwifery

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Capacity must be addressed

THE INMO's daily trolley count continues to be a mirror held to the face of those who make decisions about our public health system. It reflects the lack of capacity in our hospitals and the appalling conditions for patients and staff alike. Nurses, midwives and other colleagues can reasonably ask: whose interest are policymakers and employers serving with these unsafe, inappropriate environments? It's certainly not the interests of patients or staff, who are either simply seeking care or trying to provide professional services.

As winter approaches, the Emergency Department Taskforce met but, disappointingly, the HSE did not produce a winter plan. Instead, they tried to justify increased overcrowding, pointing to increased attendances and admissions: this comes close to blaming the patients for being sick.

The INMO highlighted members' concerns at the lack of a winter plan with particular emphasis on the slow progress in plans to increase inpatient capacity. Additional staffed beds are needed this winter, especially in the seven constantly overcrowded adult hospitals and in the children's hospitals affected by emerging overcrowding. The system can and must change: it is not good enough to justify the level of overcrowding without looking at immediate alleviation measures, such as additional capacity, recruitment of staff and fast tracking the implementation of Sláintecare.

This year's budget did have some allocation for Sláintecare – but not enough to instil confidence that any major shift from hospital-based care to community care will happen any time soon. The INMO met with the Department of Health's Sláintecare team after the budget and highlighted this missed opportunity. We strongly support Sláintecare as a model and policy, but without adequate funding it will not deliver the scale of transformation at the pace that is required to meet the healthcare requirements of our growing population.

Nursing and midwifery has a significant part to play in delivering positive change and should be supported in doing so. We believe that the modest allocation in this years' budget should be focused on nursing and midwifery-led services and their role in management of chronic diseases to deliver a new way of providing safe and professional services.

In this issue of *WIN* we highlight some important events and information for our members. First and foremost, we celebrate 60 years of registered intellectual disability nurses. We meet the Section officers, look back at the history of the specialty and discuss the results of a recent study on service access *(see pages 25-29)*.

We provide details on our final event to mark the INMO's 100th year, which will be held on November 28. This will include the Nurse and Midwife of the Year Awards, which – despite the very difficult working conditions we find ourselves in – celebrate the magnificent work nurses and midwives do every day. Tickets for this event are available through branches and sections *(see page 15)*.

We remind members to apply for the better-paid senior staff nurse grade if they have 17 years' experience. Before the strike, this was only open to those with 20 years' experience, so I encourage all eligible members to take advantage of this new benefit. Allowances (backdated to March) and enhanced practice salary scales are now being processed by payroll departments across the country. Ensure you get what you are owed and seek advice from your industrial relations officer or INMO information office if you have any difficulties *(see page 11)*.

Finally, this is also the time of year to ensure you avail of the free flu vaccination. At the ED Taskforce meeting the Minister for Health confirmed that the nursing and midwifery-led peer vaccination programme has been the main positive contributor to the recent increased uptake among healthcare staff. This is another example of real action, real results and real leadership by nurses and midwives.

Phil Ní Sheaghdha
General Secretary, INMO

Your priorities with the president

Martina Harkin-Kelly, INMO president

Overcrowding and uncertainty

AS I write, a number of social and political factors are in focus, not least the ever-increasing winter trolley figures, flu season and – of course – Brexit. Trolley figures reached record highs once again in the past month, with the worst-ever September. Limerick had 82 people on trolleys on October 2, a staggering figure for one hospital and the highest ever recorded. We know what these numbers mean to our members in terms of patients languishing on trolleys in ED or on wards in inappropriate spaces. This is why your union advocates for serious change on a daily basis on behalf of you and your patients – we must curtail services in the short run and increase staffing beyond that.

Meanwhile, with the Brexit debates continuing I am concerned for the many HSE employees living in Northern Ireland and the many cross-border initiatives that patients depend on. With much to play for, we continue to remind the key players that health is, and should always be, a top priority.

European Federation of Nurses

THE European Federation of Nurses (EFN) represents more than three million nurses across the EU. It brings together 36 nursing associations from across the continent to ensure that nurses speak with one voice to the European policymakers, such as the European Commission and Parliament. I attended the EFN general assembly in mid-October with Phil Ní Sheaghdha, INMO general secretary, and Elizabeth Adams, previously of the INMO.

We discussed improving recognition across the EU for nursing qualifications, which – thanks to past work by the EFN – is the subject of a formal EU directive. We also discussed how nurses should have a real input in shaping the new EU system of digital health records, along with plans to expand our professional role further into pain management. The EFN aims to empower nurses across Europe to recognise, assess and treat pain with a greater range of tools than they currently have. There were also elections held at the assembly and I am glad to report that we continue to be well represented in the organisation. Elizabeth Adams was re-elected president, while Ms Ní Sheaghdha was elected to the EFN's six-person Executive Council.

Nursing Now Ireland meeting

NURSING Now Ireland held a meeting with representatives of the Department of Health, the HSE and Higher Education Institutes, with further meetings this year planned for November 12, December 11 and next year on January 8, 2020.

The INMO continues to promote and raise the profile of the Nursing Now campaign, through a growing social media and online presence. For information on the campaign, you can visit **nursingnowireland.ie**

The nomination process for the inaugural Nurse and Midwife of the Year Awards, sponsored by Cornmarket with prizes of €5,000 per winner, has now closed. The awards night will be held on November 28 and we look forward to announcing the winners.

Centenary celebrations

RTÉ's Nationwide team has completed filming a centenary tribute programme, which is likely to air in November. The centenary commemorative tapestry work by the Irish Patchwork Society is progressing and I would urge any member who wishes to get involved in the creation of this once in a lifetime commemorative piece to make contact through the general secretary's office.

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

Quote of the month

"Status quos are made to be broken"

Ray A Davis

Report from the Executive Council

THE National Executive met on October 7and 8, 2019. As always there was a robust agenda dealing with internal and national issues, relevant to our members.

The HSE's disastrous recruitment pause was a key issue at the meeting, with further work planned on ending the pause for nursing and midwifery as soon as possible. The Executive was also made aware that progress had been made on the employment of graduates with over 1,400 offered contracts.

The All-Ireland Midwifery Conference took place this year in Armagh. Eilish Fitzgerald, INMO second-vice president, represented the president's office at this event, as I attended the European Federation of Nursing's (EFN) general assembly alongside Phil Ní Sheaghdha and Elizabeth Adams.

The last meeting of the National Executive Council for 2019 is scheduled for December 2 and 3.

Reminder for members: if you are working in conditions where you cannot provide safe care, please complete the disclaimer forms. This will be your only safeguard in the event of a near miss or an incident.

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

Budget not the 'gamechanger' the health service needs

THE budget is not the 'gamechanger' the health service needs, the INMO has warned.

The union criticised the government's budget for the forthcoming year for failing to fund long-term systemic improvements to the health service – particularly the major funding needed to implement the Sláintecare reform plan.

The union, however, welcomed additional funding for homecare packages, along with commitments to hire extra frontline staff, but called for the HSE's recruitment pause to be ended.

INMO general secretary Phil Ní Sheaghdha said: "This is a business-as-usual budget. It's not the gamechanger that frontline health workers need to end overcrowding and bring staffing up to safe levels.

"We've been bandaging up the health service for far too long. It needs long-term, systemic change, but that comes with an upfront cost. The Sláintecare report set out a clear funding plan to transition to a new system, but the €3 billion transition fund is nowhere to be seen."

On the homecare packages, she said: "New homecare supports are welcome and much-needed, as there have been very few approved since May of this year.

"We now need to lift the HSE's disastrous recruitment pause, if we are to make any dent in the hospital overcrowding crisis. There are over 1,300 unfilled nursing and midwifery vacancies in the public health service."

Ms Ní Sheaghdha continued: "Giving more cash to the National Treatment Purchase Fund is an admission of failure, merely acting as a stopgap. Instead of building capacity in the public health service, the government is effectively investing in overseas and private health services."

INMO representatives have been meeting with Sláintecare management to discuss how to support the change to a new healthcare model. In addition, the union is seeking more detail on funding allocated in this year's budget.

Midwives are Brexit ready with all-Ireland partnership

PROFESSIONAL challenges faced by midwives both in Northern Ireland and the Republic were examined at this year's All Ireland Annual Midwifery Conference, which was held in Armagh last month.

In the context of Brexit, the International Trade Union Partnership forged by the INMO and the Royal College of Midwives (RCM), will strengthen the ability of midwives to practise and access education and professional training. This partnership, which was formally launched in January 2018, was the first of its kind between two trade unions across borders and the Irish sea.

Tony Fitzpatrick, INMO director of industrial relations said: "We're proud to stand with our colleagues across the whole island. Working closely with the RCM and its members means that we can move midwifery forward on both sides of the border.

"Midwifery faces real challenges – particularly with Brexit looming. Short staffing, a global shortage of midwives, and unsafe working conditions are problems which our members have to face across Ireland, whether in the HSE, NHS, voluntary or private sectors. Working collaboratively to solve shared problems allows us to deliver effective solutions for the members of both the RCM and the INMO."

RCM director for Northern Ireland Karen Murray said: "The RCM and the INMO have, for over 25 years, worked closely together and our annual joint all Ireland conference is a fantastic way to further strengthen our connection. Bringing midwives together from Northern Ireland and the Republic provides an opportunity for them to share their professional experiences and learn from one another particularly when it comes to best practice, which ultimately goes towards improving the care women and their babies receive."

RCM conference 2019: *INMO general secretary Phil Ní Sheaghdha and INMO head of education Steve Pitman attended the opening day of the Royal College of Midwives Conference in Manchester in September. This two-day conference, which attracted over 3,500 delegates, offered the opportunity to debate the big issues affecting contemporary midwifery care. Pictured were (l-r): Cathy Ashwin, principle editor of MIDIRS; Steve Pitman; Phil Ní Sheaghdha; and Jon Skewes, RCM executive director, external relations*

INMO calls for greater support for women with menopausal symptoms

THE INMO has called for greater workplace recognition and support for women experiencing symptoms of menopause.

Following a motion to its annual delegate conference, the union launched a position paper in conjunction with World Menopause Week designed to encourage discussions and lift taboos around menopause at work.

Key recommendations include:

- Development of workplace policies that promote support of women during menopause
- Education and training regarding the menopause

The INMO believes that the profile of menopause in the workplace needs to be acknowledged, recognised as an important occupational issue and for resources to be invested in supporting women. The INMO calls on the wider trade union movement to embrace and campaign for greater recognition and support on this issue.

The INMO also calls on all healthcare employers, in both the public and private sectors, to develop menopause-friendly workplaces that recognise the importance of menopause. This includes the development of clear policies, training and dedicated resources to support women experiencing the menopause at work.

Unions also have a role to play in challenging attitudes to the menopause, ensuring that employers have procedures in place, and in offering support to women who are experiencing problems. Union representatives should raise the issue with their employer and ensure that the workplace meets the needs of menopausal women.

At the launch of the INMO position paper on Menopause at Work were (l-r): Loretta Dignam, founder of the Menopause Hub, and Steve Pitman, INMO head of education

One of the presenters at the launch was Dr Barbara Taylor of 'Menopause Taylor'

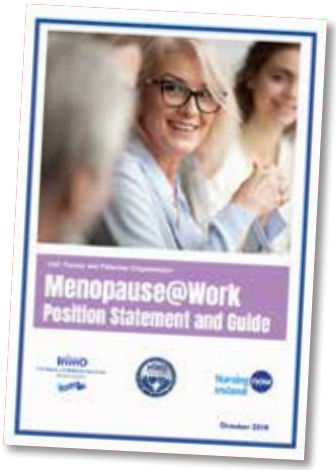
Raising women's health issues in the workplace will show that women can come to the union when they have difficulties.

Menopause is an equality issue and an occupational health issue, where work factors have the potential to impact significantly on a woman's experience of the menopause. The INMO points out that this legislation is covered under the Employment Equality Acts 1998-2015.

The challenges faced by nurses and midwives in the workplace who are transitioning through the menopause is intrinsically linked to the difficulties experienced everyday for nurses and midwives working on wards and in the clinical environment.

Women who are experiencing menopause need support from line management, according to the INMO. "As with any longstanding health-related condition, this is crucial and can make a major difference. The workplace can affect women going through the menopause in various ways, especially if they cannot make healthy choices at work."

INMO general secretary Phil Ní Sheaghdha said: "There are



over 300,000 women working in Ireland between the ages of 45 and 64, and around 80% of those will experience symptoms leading up to menopause. We would like to work with employers to create positive employment policies, as we do with other health and wellbeing-related issues. Currently there is an absence of policies on this issue.

"We have issued a position paper to assist our members and other women who might find they require assistance and support during this time in their lives."

Loretta Dignam, founder of the Menopause Hub, said: "Education is central to removing taboos around menopause. We are all about helping women lead healthy and satisfying lives through the menopause both in work and at home, and this means having conversations and finding solutions.

"We are hoping that this event will help many people understand how best to support themselves and the women in their lives, and ultimately help them begin their own conversations around menopause."

The INMO *Menopause@Work Position Statement and Guide* is available to download at **www.inmo.ie**

Tony Fitzpatrick, INMO director of industrial relations, reports on issues

National Joint Council

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

The INMO plays a pivotal part on the NJC staff panel, which also includes SIPTU, FORSA, IMO, MLSA, Connect and Unite. The purpose of the staff panel is to use the collective might of all the unions involved to work as one on behalf of all our members within the health sector. The most recent meeting of the NJC took place on October 2, 2019. I have written to the NJC chair seeking to progress a number of matters raised in that forum. Issues emanating from the acute division, community nursing, social care and intellectual disabilities nursing were all discussed at the meeting. An update on the issues discussed are outlined below.

Pension issues

The NJC staff panel wishes to meet with the HSE regarding pensions before the end of October 2019. The unions wish to highlight significant issues such as delays in receiving pensions, calculations and matters pertaining to retirement on grounds of ill health.

Investigations unit

The unions outlined their ongoing concerns about investigations units. These include delay, non-adherence to policies, non-agreement on investigators and terms of reference, lack of coordination between commissions and investigations units, inability to communicate with the investigations unit, etc. The unions made a proposal, which was acceptable to management, that an agreed person with the relevant IR experience would be commissioned to meet with the unions to hear their issues of concern, subsequently meet with the unit, and then make recommendations to address the matter. The HSE committed to reverting within seven days with a proposed person to conduct this review as well terms of reference for consideration.

Staff mobility/transfer panel

The HSE committed to arranging a meeting on this issue with the staff panel before the end of October 2019.

Temporary appointments

The chair of the NJC committed to the WRC offering a date for conciliation on this matter. The unions remain dissatisfied that over 2,000 individuals are acting up in a higher capacity as per HSE circular 017/2013. The circular clearly outlines that after 12 months the post should be permanently advertised, however this has not occurred, and individuals have acted up for as long as eight years. These individuals have rights with regards to the post they have been filling.

The HSE agreed to revert within seven days on the staff panel's request that none of the posts occupied by individuals acting up in a temporary capacity should be advertised, pending conclusion of the WRC process. Furthermore, the fact was raised that successful adjudication outcomes are being impeded by the HSE with regards to regularisation of individuals into these posts.

Agency

The staff panel outlined the continued excessive use of agency staff, with over €200 million being paid to agency to date, based on the data shared prior to the meeting. The HSE is to share its policy on converting the agency staff to direct employment which has not been shared to date. The HSE is to provide details as a matter of urgency. A meeting will be arranged in regard to this matter.

Red weather alerts

The HSE is to revert with regards to its engagement with the Brothers of Charity regarding issues during the red weather alert and also on matters raised with regard to the incomplete application of the red weather alert circular in the National Ambulance Service.

Intellectual disability service

The HSE is to arrange a plenary national meeting with voluntary bodies regarding intellectual disability services. The staff panel is to submit an agenda and the meeting will be convened as a matter of urgency.

NiSRP

The staff panel outlined that issues of concern remain with regards to the appropriate payment of staff within the eastern region through the National Integrated Staff Records and Pay Program (NiSRP). It also highlighted concerns about the lack of local engagement involving trade unions and HR management. The staff panel suggested there should be no further roll out of this programme in the south east, pending the matters in the east being addressed. The staff panel will revert with specific issues of concern that remain outstanding.

Employment control measures

The HSE has failed to engage with the staff panel which represents the staff working within the health service with regards to the employment control measure being put in place at their inception. The staff panel was advised previously that this was a temporary measure, however, it continues to be in place and therefore a meeting is required between relevant senior management across the various pillars of the HSE and the staff panel.

Homecare support services

A meeting on homecare support services should involve all the unions and grades that link to these services. The unions are awaiting a date for this meeting from the HSE.

Breastfeeding breaks

Breastfeeding breaks within the health sector are to be increased from six months to 24 months. This follows a claim lodged by the unions on behalf of employees. The unions welcomed that the HSE has developed a policy with regards to same. The staff panel has provided feedback with regards to the policy and seeks an implementation date for its introduction.

Termination of pregnancy

Some specific matters on termination of pregnancy

discussed at the latest NJC forum and other national IR issues

services remain outstanding for particular unions. The unions have sought a meeting to review termination of pregnancy services since their introduction earlier this year.

Joint declaration on life-long learning

The unions were seeking a meeting to be convened before the end of October 2019 as the joint declaration on lifelong learning committed to by the HSE remains outstanding. The staff panel is awaiting contact from the HSE in order to convene this meeting.

Time and one-sixth

The HSE is to make contact with the chair of the staff panel to arrange a meeting between the parties on time and one-sixth retrospective payments. Unions are requesting that the remaining six-month retrospection is paid. In addition to the above, retrospection of time and one-sixth at St John of Gods, Kerry is outstanding.

Overcrowding

The unions are seeking high-level engagement with the HSE on overcrowding in emergency departments and hospital wards throughout the country, as it affects all levels of the service including pre-hospital care, acute hospital care and step down, including primary and social care.

The staff panel highlighted the significant risks within the system as a result of unprecedented overcrowding and the need for an urgent response from the HSE. Furthermore, the staff panel is seeking the early publication of the HSE winter plan, noting that plans have already been announced by the NHS in the UK.

Scan for surgery

Scan for surgery in St James University Hospital and other voluntary hospitals was raised:

The unions will write to the HSE outlining the details with regards to same.

Cervical Check audits/ liaison teams

The unions are to receive details from the HSE with regards to this team and also details with regards to the recruitment process for same.

Non replacement of maternity leave

In the Recruitment and Retention Agreement of 2017, it was agreed that all staff on maternity leave should be replaced. However, the HSE is not complying with this and is failing to replace many staff on maternity leave.

This issue of non-replacement has been further hampered by the employment control measures currently in place. This issue will be discussed at upcoming meetings regarding the employment control process and overcrowding.

Cath labs

This matter has been referred to the WRC and the chair of the NJC is to seek an early date with regards to same.

Candidate advanced nurse practitioners

The matter of non-compliance with the HSE circular in Cork University Hospital is being looked at by Paul Byrne who will revert to the staff panel.

Bereavement leave

The staff panel raised the matter of the Labour Court Recommendation which increased the quantum of bereavement leave from five working days to 20 working days, and from three working days to five working days. The parties met for two conciliation conferences where agreement could not be reached.

The staff panel outlined its dissatisfaction that the Department of Health issued a circular with regards to this matter which is not agreed and is disputed.

The staff panel has objected to the inclusion of "collective agreements" and footnotes regarding calendar days rather than working days. The unions will be seeking that the WRC conciliation officer would refer the matter back to the Labour Court for clarification. However, the chair of the NJC, Anna Perry, called on the parties to engage again in order to get a resolution so that the matter need not be returned to the Labour Court. The HSE is to revert with a date for this meeting.

Members urged to check for all pay increases due

THE INMO is urging members to ensure that they receive all pay increases due to them that were secured as part of the nursing and midwifery strike settlement.

The union noted that the HSE was extremely slow to issue the circular to the system on the implementation of the two Labour Court Recommendations. However, the circulars have now been issued and it is important that INMO members seek their entitlements contained in these from their employer.

Members should ensure to contact their payroll/HR departments in regard to:

- If you are in receipt of a qualification/location allowance, it was due to increase by 20% retrospective to March 1, 2019
- Those eligible for new allowances, ie. maternity, community etc, should ensure that they have received this allowance and, again, with retrospection back to March 1, 2019
- If individuals have had incremental progression since March 1, 2019 or indeed are due an increment, they should seek the appropriate HR form from their line manager/HR department and submit same. Once submitted and signed off by the director of nursing/midwifery and HR, they should be issued with a contract for signing and they should be paid on the enhanced salary scale. Also, retrospection with regards to this is due back to their increment date arising after March 1, 2019
- It is vitally important and time sensitive that individuals apply for the senior staff nurse/midwife and indeed the enhanced senior staff nurse/midwife scale before November 2019. The previously required 20 years' service has been reduced to 17 years. Therefore, those with 17, 18, 19 and 20 years or more should apply if they are not currently on the senior staff nurse/midwife scale. Also, those at senior staff nurse/midwife scale are eligible to move onto the enhanced senior staff nurse/midwife pay. It is important that members pursue these matters as it is their pay that is due to them.

All of these measures ensure significant increases in pay, which members should seek and secure.

'Beyond unsustainable': record numbers on trolleys amid deepening staffing crisis

SEPTEMBER was the worst month of 2019 so far for hospital overcrowding, with 10,641 admitted patients, including 101 children, left without beds across the country.

According to the monthly INMO trolley and ward watch analysis *(see below)*, the figures for September were the highest they have been since records began in 2006, and twice as high as the same month 10 years ago.

The worst affected hospitals in September were:

- University Hospital Limerick – 1,405 patients
- Cork University Hospital – 936 patients
- University Hospital Galway – 884 patients
- University Hospital Waterford – 707 patients
- Mater Misericordiae University Hospital – 639 patients.

INMO general secretary Phil Ní Sheaghdha said: "These are simply astonishing figures – especially outside of the winter months. It's placing a massive strain on our members on the frontline and is seriously worsening patient care.

"We have now seen 80 consecutive days where the trolley figures are higher than 2018 – often by as much as 50%. This is equivalent to the bed capacity of Beaumont Hospital 15 times over.

"This is absolutely beyond unsustainable. At the root of the problem is capacity. We need more hospital beds and more nurses and midwives to staff them. The HSE's disastrous recruitment pause quite simply has to go.

"Ireland needs to reform its health service and Sláintecare is the clear path forward. But it needs to be more than reports and press conferences. It takes real investment and a major shift towards primary care."

Table 1. INMO trolley and ward watch analysis (September 2006 – 2019)

Hospital	Sept 2006	Sept 2007	Sept 2008	Sept 2009	Sept 2010	Sept 2011	Sept 2012	Sept 2013	Sept 2014	Sept. 2015	Sept 2016	Sept 2017	Sept 2018	Sept 2019
Beaumont Hospital	310	409	608	830	680	730	280	620	644	732	383	254	268	296
Connolly Hospital, Blanchardstown	211	229	226	176	297	387	317	540	485	327	172	205	294	186
Mater Hospital	262	366	519	443	446	368	334	187	311	371	350	373	392	639
Naas General Hospital	85	17	243	157	370	230	151	118	249	180	156	212	340	379
St Colmcille's Hospital	32	29	152	200	89	240	119	45	n/a	n/a	n/a	n/a	n/a	n/a
St James's Hospital	22	39	178	169	150	114	84	117	329	159	219	108	102	152
St Vincent's University Hospital	459	536	500	389	584	638	405	163	200	419	415	257	210	325
Tallaght Hospital	166	329	383	354	661	175	63	337	312	450	450	448	365	275
National Children's Hospital, Tallaght	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	3	4
Our Lady's Children's Hospital, Crumlin	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	29	38
Temple Street Children's University Hospital	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	27	59
Eastern total	**1,547**	**1,954**	**2,809**	**2,718**	**3,277**	**2,882**	**1,753**	**2,127**	**2,530**	**2,638**	**2,145**	**1,857**	**2,030**	**2,353**
Bantry General Hospital	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	6	3	25	36	32	54
Cavan General Hospital	74	267	91	262	433	341	142	206	15	180	39	78	33	246
Cork University Hospital	229	235	275	437	567	529	146	304	326	477	441	628	781	936
Letterkenny General Hospital	281	34	16	33	49	25	28	176	130	158	263	459	502	615
Louth County Hospital	19	n/a	n/a	24	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Mayo University Hospital	202	72	28	114	147	45	145	57	64	118	206	132	114	110
Mercy University Hospital, Cork	107	71	113	90	195	185	149	134	240	142	220	215	137	300
Midland Regional Hospital, Mullingar	22	4	18	31	116	275	186	146	255	453	380	383	353	232
Midland Regional Hospital, Portlaoise	38	24	6	n/a	24	254	25	79	44	147	216	222	178	104
Midland Regional Hospital, Tullamore	n/a	2	8	4	56	113	96	13	508	302	411	445	461	286
Mid Western Regional Hospital, Ennis	43	9	17	23	10	3	12	n/a	n/a	14	16	8	24	32
Monaghan General Hospital	6	2	22	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Nenagh General Hospital	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	2	4	2	75
Our Lady of Lourdes Hospital, Drogheda	349	116	302	323	331	842	626	214	593	606	507	134	134	185
Our Lady's Hospital, Navan	40	47	72	169	7	75	8	57	26	33	49	243	57	72
Portiuncula Hospital	21	9	n/a	105	33	149	26	36	49	36	98	94	114	87
Roscommon County Hospital	50	60	80	50	113	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Sligo University Hospital	79	56	8	55	168	153	102	45	200	210	51	323	247	396
South Tipperary General Hospital	34	92	10	64	13	125	123	224	97	107	350	396	365	639
St Luke's Hospital, Kilkenny	n/a	n/a	n/a	n/a	34	47	35	209	128	278	188	229	78	406
University Hospital Galway	126	209	380	321	356	642	271	282	446	514	499	598	609	884
University Hospital Kerry	129	46	11	16	73	68	59	51	91	138	133	114	282	283
University Hospital Limerick	139	166	72	201	502	384	279	345	551	784	825	902	894	1,405
University Hospital Waterford	n/a	n/a	63	46	164	59	136	152	68	257	333	505	259	707
Wexford General Hospital	189	19	42	178	336	490	53	73	144	35	154	96	138	234
Country total	**2,177**	**1,540**	**1,634**	**2,546**	**3,727**	**4,804**	**2,647**	**2,803**	**3,981**	**4,992**	**5,406**	**6,244**	**5,794**	**8,288**
NATIONAL TOTAL	**3,724**	**3,494**	**4,443**	**5,264**	**7,004**	**7,686**	**4,400**	**4,930**	**6,511**	**7,630**	**7,551**	**8,101**	**7,824**	**10,641**
Of which were under 16	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**69**	**101**

Percentage increase/decrease:
2018 compared to 2019: 36%
2017 compared to 2019: 31%
2016 compared to 2019: 41%
2015 compared to 2019: 39%
2014 compared to 2019: 64%
2013 compared to 2019: 116%
2012 compared to 2019: 142%
2011 compared to 2019: 38%
2010 compared to 2019: 52%
2009 compared to 2019: 102%
2008 compared to 2019: 140%
2007 compared to 2019: 205%
2006 compared to 2019: 186%

Most trolleys ever in an Irish hospital

Limerick hits highest ever recorded number of patients without beds

A massive total of 82 admitted patients were without beds in University Hospital Limerick on the morning of Wednesday, October 2, 2019 – the highest figure ever recorded in any Irish hospital by the INMO trolley/ward watch.

On this day, the INMO recorded 47 patients without beds in UHL's emergency department, with 35 in wards elsewhere in the hospital. Patients without beds are typically on chairs and trolleys, often on corridors. In September, Limerick had more than 1,400 patients without beds.

The INMO has called for a direct, immediate intervention in this hospital from the Minister for Health, to include:

- Instructions to cancel non-essential elective work
- More home care packages to move patients out of the hospital
- Emergency funding for extra agency staff today
- An immediate end to the recruitment pause for nurses and midwives
- Extra support for GPs and public health nurses to allow more home/community treatment.

INMO general secretary Phil Ní Sheaghdha said: "The situation is escalating beyond crisis point and cannot be allowed to continue. We are calling on the Minister to intervene directly. He needs to cancel electives, provide emergency funding, and increase the number of home care packages today.

"Promises of future improvement will not suffice. Real action is needed today. We have been saying this on repeat for more than a decade. Ireland does not have sufficient hospital capacity. Without an increase in beds and the professionals to staff them, this problem will continue to escalate. Our members are on the frontline providing the best care they can – but the situation is intolerable for them and unsafe for patients. The INMO Executive Council is examining what real measures are needed to protect patients and frontline workers, in the absence of immediate action from the Minister and HSE management."

CUH overcrowding and understaffing

The INMO has been seeking a concrete, and funded, winter plan from the South/South West Hospital Group (SSWHG) and Cork University Hospital (CUH) over the past month.

The union pointed out that high number of staff vacancies within the service at CUH are compounding the overcrowding situation at the hospital.

The INMO has raised these concerns nationally and with all TDs across Cork.

"It is imperative that the current recruitment pause, which is delaying and hindering recruitment, is lifted for services in Cork ahead of winter. It is absolutely necessary that bed capacity is increased this winter but this can only be done with staff in place," said INMO IRO Liam Conway.

Meanwhile, the INMO has recently secured the location allowance for members across three areas in Cork University Hospital. Furthermore, a number of members who were eligible for qualification allowances due to their completion of a category 2 approved NMBI course have recently ensured this allowance is paid to them.

INMO members are encouraged to ensure once they have completed a recognised course as above, they apply directly to HR for this allowance which stands at €3,349.

The INMO is holding a monthly information clinic in CUH with a stand in the canteen. This will continue over the winter period for members seeking advice, information or with general queries. For further information contact Liam Conway, INMO IRO, Email: liam.conway@inmo.ie

Packed agenda for centenary celebration

A PACKED programme of events is planned for the INMO Centenary Celebration day on November 28, 2019, which will be held at the Richmond Education and Event Centre.

Events planned for the day include:

- Professional panel, chaired by Norah Casey, business woman, television presenter, broadcaster and a former nurse
- IR panel chaired by Eamon Dunphy, media personality, journalist and broadcaster
- 'Jury of peers' interactive IR workshop
- 'Meet Milo' and try out other attractions in the virtual reality room
- Visit the room of stories, where you can listen to the stories told by INMO members – or indeed add your own story
- Experience a 1919 ward environment
- A memory lane of artefacts and archives
- Tea and a light bite will be on offer in the Richmond's Victorian tearoom.

Invitations to attend this celebratory event have been issued through all branches and sections. Members who would like to attend are asked to contact their branch or section secretary.

The Nursing and Midwifery Awards ceremony will also be held on the evening of November 28 as a separate event. Nominees will be invited to this event directly closer to the date.

In brief

- ***Care of older person services, Cork:*** INMO reps and members in Cork highlighted concerns in late August regarding the implementation of a medication assessment tool by management across Cork older person services. Through a collective approach and with the assistance of INMO Professional, INMO reps have ensured the revision of this document in keeping with national policies and NMBI guidelines.
- ***Day care co-ordinators:*** INMO members in Cork/Kerry are seeking the regrading of their positions from CNM1 to CNM2 in line with their counterparts nationwide. As the matter was subject to a previous Labour Court hearing, the matter must be resolved nationally with a referral to the Workplace Relations Commission completed. A conciliation conference is due to take place this November.

– Liam Conway, INMO IRO

Key issues addressed on advancing RNIDs' role

A SYMPOSIUM on advancing the role of the registered nurse in intellectual disabilities (RNID) took place in Dublin last month. Organised by the Office of the Nursing and Midwifery Services Director and the National Quality Improvement Office, the symposium was opened by Siobhan O'Halloran, chief nurse at the Department of Health.

Speakers addressed a range of key subjects including:

- The development of community nurses in intellectual disabilities by Prof Owen Barr
- Acute liaison nurses role in acute hospital settings by Liam Hamill and Muireann Ní Riain
- Positive aging indicators for people with intellectual disabilities by Prof Mary McCarron.

***At the symposium on advancing the role of the RNID** (l-r): Marian Spelman, secretary of the INMO RNID Section; Ailish Byrne, chair of the INMO RNID Section; and Dr Mary Doolan NMPDU Midlands*

A lively question and answer session proved an invaluable opportunity for RNIDs to engage with the speakers.

Pressure against 'employment control framework'

THE INMO has been engaged with the Ireland East Hospital Group in relation to the 'employment control framework' which has been imposed on hospitals by the HSE.

The INMO has been meeting with the Ireland East Hospital Group, chief director of nursing and other senior managers on a weekly basis in order to expedite the filling of vacancies in hospitals, particularly the statutory hospitals.

The INMO has been successful in getting a large number of posts approved through this process and will be endeavouring to maintain pressure on the employers to ensure that all frontline positions are filled in a timely manner.

In particular in relation to Midland Regional Hospital, Mullingar, there are 60 vacancies in the hospital and approximately 40% of staff nurse positions in the emergency department were vacant in September 2019.

Progress has been made on the filling of the staff posts and graduate positions have been offered to 2019 graduates.

As a consequence of the inability of the hospital to recruit staff, management made a decision to curtail activity levels by closing ward 4 with the closure of 10 beds until the end of October 2019 (at the time of going to press).

The INMO will be monitoring progress on the filling of these vacancies on an ongoing basis.

– Albert Murphy, INMO assistant director of IR

Tullamore beds closed due to recruitment pause

The INMO and management in Midland Regional Hospital, Tullamore recently agreed on the temporary closure of 12 beds due to the ongoing effect of the recruitment pause.

The hospital has over 40 nursing vacancies and management agreed to bed closures pending the recruitment of nursing staff.

At a meeting on October 11, 2019, management confirmed the start dates for 23 nursing staff between October and the end of November. These posts will go to all services within the hospital and further recruitment initiatives were outlined to the INMO. In the interim, and pending the posts commencing, the closed beds remain closed. A further meeting is planned with management on November 7.

INMO IRO Joe Hoolan said: "Local management took the responsible decision of matching their capacity to available staffing levels. The closure of beds allowed some staff to be redeployed, temporarily, until new staff arrived. With the arrival of new staff, further meetings will occur to discuss these beds reopening."

Enhanced practice nurses and midwives are well equipped to deliver healthcare in the digital age , writes **Dave Hughes**

Enhanced practitioners set for the digital challenge

IT IS 13 years since an honours degree became a mandatory requirement for nurses and midwives to register for the professions. Even prior to that Irish trained nurses and midwives were recognised and sought after worldwide as expert and compassionate professionals.

Those values have not been lost in the transition and the combination of third level education with ethical values, enriched by the value of international recruitment, equips our caring professions for the digital challenge.

The title enhanced practice staff nurse/midwife provides recognition for the professionalism of our nurses and midwives.

The INMO policy for equal recognition with all other graduate healthcare professionals and a determination that it be recognised that caring is essential to the recovery of patients has equipped our professional nurses and midwives well for the digital age.

The future of healthcare delivery and hospital care may look very different in 10 years' time. A growing number of inpatient and ambulatory services are now being delivered at home, however acute, medically ill patients will always require acute hospital care.

Emerging features like digital centres to enable clinical decision-making and targeted treatments such as 3D printing will characterise acute hospitals. Digital and artificial intelligence can help to enhance patient interaction.

Robotic process automation and artificial intelligence can allow care givers to spend more time with their patients and less time documenting it. Digital supply chains, automation, robotics and next generation interoperability can drive efficient management and administration.

In a timely intervention the Office of the Nursing and Midwifery Services Director (ONMSD) in the HSE has now launched the Digital Roadmap for Nursing and Midwifery.

Credit must be given to Mary Wynne and Loretta Grogan for launching this important recognition of the role of nursing and midwifery leadership in meeting the challenges of the digital workplace. It demonstrates the crucial role for the enhanced nurse and midwife in making the Digital Roadmap work for patients and the staff who care for them. Mary previously sat on the INMO Executive Council and is soon to retire from her role as HSE nursing and midwifery services director. Loretta is the ONMSD national clinical information officer for nursing and midwifery.

The road map identifies how the HSE goals can only be achieved with the full endorsement of the nursing and midwifery workforce.

Ms Grogan has agreed to contribute to *WIN* in the future outlining the ideal match between the development of the professions and HSE goals.

The INMO will continue to ensure recognition of the status of nurses and midwives and secure that the safety, health and welfare concerns and dangers are addressed in the rapidly advancing revolution that is digitalisation in healthcare.

As part of the European Public Services Union, the European Federation of Nurses and the European Midwives Federation, the INMO will participate in the EU Commission research programme on the safety, health and welfare risks involved in digitalisation for health service workers. The project is designed to shape future EU Directives for the protection of nurses and midwives in the rapid deployment of digitalisation for financial imperatives.

Nurses and midwives by being part of INMO can ensure that digitalisation can work for patients, the workforce and society.

Dave Hughes is INMO deputy general secretary

World news

Nurses and midwives in action around the world

Australia

- Nurses plan industrial action over pay and staffing
- Nurses' union urges Labor to block free trade deals that hurt working conditions

Canada

- Super nurses: salary must climb with responsibilities, according to FIQ

India

- AIIMS nurses' strike emerges victorious

Philippines

- Government nurses must get higher basic pay, Supreme Court rules

Portugal

- Group questions government over "lost time in nurses' service"

Spain

- SATSE denounces delays in job offers for nurses
- The Balearic Islands need 3,500 nurses to reach the European ratio, according to the SATSE

UK

- Number of registered nurses on ward linked to safety of staff
- Royal College of Nursing begins strike action ballot in NI
- Bill seeking accountability for nurse staffing put before Parliament

US

- Arizona's registered nurses fight for patients in 24-hour strike
- After University of Chicago strike, nurses at affiliated hospital vote for unionisation

Healthcare communication the focus of Telephone Triage Section conference

FORTY FIVE out-of-hours nurses attended the Telephone Triage Section's conference on September 24 at the Richmond Education and Event Centre.

There was an extensive line up of speakers. The keynote address was delivered by Dr Chris Luke, an engaging speaker who is passionate about communication in healthcare.

As a former consultant in emergency medicine, Dr Luke holds more 25 years' experience in triage. He harbours a longstanding enthusiasm for public health education and initiatives aimed at alleviating or reducing the workload of hospital emergency departments and pre-hospital/triage emergency services.

The day was evaluated by all who attended and feedback was very positive.

Planning is already underway for next year's event, which will include coverage of contraception, wound care, pharmacology and diabetes management, among other topics.

The Section would like to thank the speakers at this year's conference for their participation.

The Section would also like to express its deepest thanks to Carmel Murphy, who chaired her sixth and final Telephone Triage Section conference, for her outstanding tenure as chairperson and her tireless work on behalf of all telephone triage nurses in Ireland.

The Section's next meeting will take place on Tuesday, January 23, 2020 at the Midlands Park Hotel, Portlaoise. Keep an eye out for further details on the *Diary* page in upcoming issues of *WIN* or email INMO section development officer Jean Carroll: jean.carroll@inmo.ie

Pictured at the Telephone Triage Section conference were (l-r): *Hazel James, Section vice-chairperson; Noel Treanor, IRO; Dr Tadhg Crowley, speaker; Carmel Murphy, section chairperson; Martina Harkin-Kelly, INMO president; Dr Chris Luke, speaker; Philip James, speaker; and Geraldine Byrne, Section secretary*

Outgoing Telephone Triage Section chairperson Carmel Murphy pictured at the conference with INMO section development officer Jean Carroll

International Section pays visit to the Mansion House

Pictured above are members of the INMO International Section with Lord Mayor of Dublin Paul McAuliffe on a recent visit to the Mansion House, Dublin. Lord Mayor McAuliffe welcomed a group of 15 nurses and midwives from the Section and brought them on a tour of the building. Speaking about the visit, International Section member Yemisi Jegede said: "We were warmly received by the Lord Mayor and his staff. We learned that Paul is the 350th Mayor of Dublin. The visit was pleasant and informative"

Q and A Bulletin Board

With INMO director of industrial relations Tony Fitzpatrick

Query from member

I am working in the public health service and was out sick under the Critical Illness Protocol (CIP) scheme for six months. Since my return to work I have been out sick with a non-critical illness and was advised that I have no paid sick leave remaining because I had previously been absent under the CIP. Is this correct?

Reply

Under the revised provisions for the CIP you can now continue to access the limits of the protocol within 12 months of your return to work even when you are not critically ill, provided that:

- You previously had been absent because of a critical illness/injury
- You are now absent from a non-critical illness/injury within the 12 months of your return to work.

The original 'protective year' provided that an employee could avail of the limits of the CIP within 12 months of the first date of absence so this revised protective year will enhance the support to those who return to work following a serious illness/injury who may then suffer from a routine illness/injury in the following year.

Query from member

I am currently working as a community RGN job sharing with another colleague. I have become aware that I am not benefiting from any of the public holidays that fall when I am not scheduled to work. Prior to this I had been working full time and so was receiving my public holidays. The service is usually closed on the day of the public holiday and if I work that day, I get a paid day off.

Reply

Your entitlement to public holidays is set out in the Organisation of Working Time Act 1997. To be entitled to the public holiday if you are part-time or job sharing you must have worked at least 40 hours in the five weeks before the public holiday. Job-sharing nurses/midwives who work Monday to Friday and who are not scheduled to work on the day on which the public holiday falls, are entitled to one-tenth of their normal fortnightly pay for the public holiday.

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 or
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
- Flexible working • Pregnancy-related sick leave
- Pay and pensions • Public holidays • Career breaks
- Injury at work • Agency workers • Incremental credit

RNID Section officers pictured at The Richmond: Patricia McCartney, Marian Spelman, Ailish Byrne, Jacinta Mulhere and Ann Marie O'Reilly

The RNID philosophy

As the specialty celebrates its 60th anniversary, **Michael Pigeon** heard from RNID Section officers about the highs and lows of ID nursing

"I LOVE working with the people," said Marian Spelman, an RNID in Clarenbridge, Galway. "It's not a sector where someone gets sick, they come to you, they get better and then they go home. This is about a lifelong experience where you cultivate relationships with them."

All five officers of the INMO's RNID Section agree that intellectual disability nursing is exactly where they want to be.

"You have different philosophies across professions and within nursing, but it's the philosophy here that I really love," adds Ann-Marie O'Reilly, an ADON at St Michael's House. "I love the lifelong relationships you can build with people with ID. It's so person centred and we're seeing that adopted in other areas of nursing too."

Jacinta Mulhere, RNID, agrees: "So many of the people in ID services can just value you for who you are, based on the relationship you've built up with them.

"It's not just the people you work with directly, it's the families too. You know you're able to help them, maybe relieve the pressure, and that makes such a difference to them," she said.

It wasn't always this way, though. ID services have changed hugely over the past 60 years. "It's gone from group settings or institutional care more to individual, person-centred services," said Ailish Byrne, a Laois RNID. "Many are now community based, which is brilliant. But in some ways your role is a little less clear. You're not working in the one institution the whole time. That's new for us."

"It's not new to me," laughed Ms O'Reilly. "I've been working for 34 years in the community! I think it's that the system is less clear on what our role should be. We all know what we should be doing, but sometimes it feels like the health service doesn't know or properly value what we do," she said.

Ms Byrne agreed: "The social model is being driven in the sector. You sometimes get the sense that the policy makers think we're too medical – almost a negative addition. We are the only dedicated specialist in the sector, we're very person centred. We have to be."

All five point to problems in the sector, many of which will be familiar to all nurses and midwives. Short staffing, a lack of political will to support services, and an institutional distrust of nurses looking to lead.

Patricia McCartney, a CNM/PIC in a Dublin service, spoke of her first experience with HIQA: "It was immensely stressful. You're rightly held to a high standard, but you have all this responsibility without any real autonomy."

Ms Byrne sees the impact this has on families of services users. "Parents in particular are so disenfranchised by the system and lack of services. They can't be standing outside the Dáil or lobbying – they have to be at home taking care of their son or daughter. So often it's up to us, as RNIDs, to speak up for them and fight their corner," she said.

This is why the five got involved in the INMO. "Sometimes you really have to fight to get what your service user needs and it's reassuring to know that you have the backing of the union when you need it," Ms Mulhere explained.

Ms McCartney agreed, remembering a time nearly 20 years ago: "We had some big problems in work, both for staff and service users. I got on to Dave Hughes in the INMO (deputy general secretary). He got me trained up as a union rep and management's attitude completely changed. It was so empowering for us."

"When I first joined the union, it was frowned upon a bit. You were seen as a bit of an agitator. But you have to be. That's behind the principles of being an RNID. Caring, but always fighting for the people you care for," she added.

All the officers nod. Ms Spelman replied: "That's the thing with RNID. There aren't many of us. We're small. But we're mighty."

'Care management and care planning', September 2018 at the Richmond, facilitated by Barbara Cunningham CNS/CPC Brothers of Charity

Pictured at the 2018 RNID Section conference were student RNIDs (l-r): Derek Kearon; Niamh Donohoe; Martina Canavan; Dolores Shanahan; and Neal Donohue, INMO student and new graduate officer

September 22, 2015 – 'Campaign for Excellence in RNID' protest outside the Dáil

INMO RNID Section officers Jacinta Mulhere, Anne Marie O'Reilly, Ailish Byrne, Marian Spelman and Patricia McCartney

60 years of ID nursing

Ailish Byrne, Marian Spelman, Jacinta Mulhere and **Steve Pitman** chart the evolution of the RNID role from its roots to its present-day focus on holistic, person-centred care

SINCE the Second World War, a greater awareness of the needs of individuals with intellectual disabilities (ID) has developed, arising largely from the United Nations Declaration of Human Rights in 1948.[1]

This year marks the 60th anniversary of the establishment of the Intellectual Disabilities Division of the Nursing and Midwifery Board of Ireland Register. Intellectual disability nurse education is unique to Ireland and the UK.[2]

Nurses who work with individuals with intellectual disabilities have a long history of providing care, education and mentorship in Ireland. Coincidentally, in the UK they are celebrating 100 years of learning disabilities nursing.[3] The intellectual disabilities sector has undergone philosophical, organisational and structural changes over the past two decades. The registered nurse in intellectual disability (RNID) has been pivotal in the evolution, through normalisation principles and community, from custodial-based care to care that is focused on the individual and their family.

The RNID is the registered professional best qualified to act as lead professional, educator, advocate and mentor to the individual with an intellectual disability.

The RNID is the only dedicated specialist in the ID sector; in 2016, there were 4,740 nurses listed on the intellectual disability division of the NMBI register.[4] The RNID is ideally placed to support individuals with an intellectual disability as they possess the requisite skills to fulfil this role.

The role of the RNID begins at the diagnosis stage, be it early or late in a person's life, and aids the individual's transition through each stage of life. The RNID possesses the expert knowledge and skills to support individuals with an intellectual disability, in partnership with the individuals themselves and their families, to live a full life, building on their strengths and capabilities.

RNIDs provide holistic, person-centred care and support across all environments including the family home, residential/respite homes, mainstream schools, special schools, specialist educational models and the community setting.[5]

The organisation of education for nurses working within the ID sector in Ireland began in the 1940s. One of the first training centres was founded in 1942 in Obelisk Park in Blackrock, Dublin and the first oral and practical examinations took place there in the autumn of 1944.[6] It is worth noting that parents of people with intellectual disabilities led the call for specialist training for nurses working in the field of 'mental handicap'.[7]

Discussions about establishing a new division of the Irish Nursing Council (now the NMBI) register began in 1955.[8] Fintan Sheerin provides an excellent account of the development of 'mental handicap nursing', and outlines how the training syllabus for registration as a 'mental subnormality nurse' (RNMS) was accepted in 1957.[9] The first training programmes commenced at St Louise's School of Nursing, Clonsilla, Co Dublin and St Mary's School of Nursing, Drumcar, Co Louth in 1959. Sheerin also

INMO proud to support ID nursing

As ID nursing celebrates 60 years in Ireland, the INMO is proud to back the ID sector. In 2015 there was a protest (pictured above) as part of the Campaign for Excellence in RNID which had the objective of supporting and re-affirming the content of the social policy document and the central role of the RNID and highlighting the cuts in services across the country, which have had a detrimental effect on service standards and the wellbeing of clients

highlights that in 1965, the Commission of Inquiry on Mental Handicap had a significant impact on the direction of the role of the RNMS/RNID by emphasising the need for greater focus on social and emotional issues.

The Commission on Nursing formed the basis for many of the developments that occurred within nursing and midwifery over the past two decades. Currently, the undergraduate BSc in intellectual disability nursing is offered by eight higher education institutions across the country.

The move from apprenticeship to diploma and, subsequently, an undergraduate degree programme for all pre-registration nurses, including those working in ID services, has had a profound effect on the professionalisation of nursing and midwifery. This has been achieved through the educating of nurses in a range of areas that prepare them to deliver holistic care to the individual with an intellectual disability. The importance placed on research has encouraged nurses to question, explore and reflect on their practice to ensure that it is evidence-based and meets the ongoing needs of the individual and wider society. The introduction of the centres for nurse education and the increasing importance placed on continuing education have provided opportunities for further educational support for all nurses and midwives.

CNS and ANP posts have been developed in ID services but at a comparatively lower number to other divisions of the NMBI register.[4] This is despite an overwhelming interest from RNIDs to further their education and develop these roles.

The INMO has a long tradition of supporting the RNID; the inaugural meeting of the Section for Nurses of the Mentally Handicapped Persons took place in October 1975. While the name has changed, the RNID Section has maintained its enthusiasm to represent and advocate for this role. This has become increasingly important with the significant changes that have occurred as a result of decongregation of services for people with intellectual disabilities and the emphasis of a social model of care.

Change in role

This has resulted in a change in the role of the RNID and the makeup of the team delivering ID services. RNIDs are at the forefront of debates and changes in practice relating to health, social care, capacity, consent and the global rights of the person with an intellectual disability.

The RNID is the most ideally placed professional to deliver excellence in care to people with intellectual disabilities in an interdisciplinary environment. The scope of practice of the RNID is unique as it enables nurses to offer a more expansive and holistic approach to compassion for and care of people with intellectual disabilities. These qualities embrace a biopsychosocial framework to providing care that is underpinned by the ethics and standards of a regulated profession. The nature, context and environment of care will continue to evolve to reflect the needs of individuals and society. In a health service envisaged by Sláintecare, the RNID has a role in supporting and caring for people with intellectual disabilities to ensure that they have equality of access in the hospital and across primary care settings. This role should be expanded beyond ID services to encompass the full panoply of health services including maternity services, children's services, acute care, chronic disease management, care of the older person and palliative care, thus ensuring that the RNID is available to provide optimum care. People with intellectual disabilities and their families use the full breadth of health services and should have access, where required, to the RNID, who has skills designed specifically to meet their needs, eg. behaviour support, autism and mental health.

The opportunities for the development and expansion of the RNID role are there to be grasped. It is vital that the RNID is clear about their role, what differentiates them from other health and social care workers in ID services and, most importantly, the difference they can make to people with intellectual disabilities and their families.

The vision outlined in the HSE's *Shaping the Future* document is to set a clear direction for RNIDs, "one that is sustainable and has person-centredness, safety and inclusion at its heart". By doing this, according to the document, higher levels of excellence in the delivery of ID nursing can be achieved within the Irish health service.[10] It is vital that the RNID remains focused and engaged to ensure ongoing quality and excellence in care within the ID sector.

Ailish Byrne, Marian Spelman and Jacinta Mulhere are members of the INMO RNID Section and Steve Pitman is INMO head of education and professional development

References available on request by email to: nursing@medmedia.ie (quote Byrne WIN 2019: 27 (9): 26-27)

Navigating ID services

Trying to access the ID services in Ireland can be like trying to find your way without a map, writes **Jacinta Mulhere**

HISTORICAL events have shaped the development of intellectual disability services in Ireland as we know them today. From 1930s-1950s, people with an intellectual disability were being transferred from workhouse institutions into the care of religious orders that were paid a subvention for this service.[1]

During the 1950s families were actively setting up parents and friends associations to lobby on behalf of their relative with intellectual disability.[2] These events saw the emergence of disability empires grow, supported by funding from the Department of Health, yet families of people with intellectual disability did not have a say in the choice of service they received.[3]

Influenced by the Scandinavian principles of normalisation, the 1970s onwards saw a large number of people with intellectual disability participate in community living.[4] However, it was a policy document from the HSE in 2011, *Time to move on from congregated settings*,[5] that changed the landscape of intellectual disability service provision in Ireland completely. The focus of this change involved the transition of 4,000 people to community residences from congregated settings.

The study we discuss here was carried out at a time when €159.4 million was taken out of the disability budget between 2008 and 2015.[6] Families noticed and felt this reduction in services. The move from residential to community emphasised the changing role from community care to family care. Finch equates the role of family care to the unpaid woman in the home.[7]

This study explored how family members interacted with service providers in intellectual disability. A qualitative descriptive approach was implemented using semi-structure interviews, a topic guide and purposive sampling to collect the data. Colaizzi's framework for data analysis was adapted to analyse the data from the transcribed taped interviews.[7]Eight family members (seven females, one male) were interviewed with the average age of their relative being 40 years of age. The main themes that emerged from this study related to first encounters, signposts, moving to the community and raising issues of concern.

First encounters

All participants outlined the effects of meeting a professional at the first point of contact. If the first encounter was supportive then the families felt more positive about their child's future. Several of the participants, however, were given the 'worst case scenario' and believed that their child would not lead any sort of normal life. This gave them little or no hope for the future, but in many situations their relative defied the poor prognosis and survived to reach their potential. This participant said: "We were told she would never walk, talk and she would have no hearing as she was premature… [as she grew up] it was great, I had taught her arts and crafts and she was great with colours…"

When these participants reflected on their first encounter with the professionals, they felt that no one really knew what the outcome for their child would be. And many of the participants said that they knew there was something wrong with their child, but getting a delayed diagnosis adversely affected the input their child received and thus began the search for services.

The participants outlined the difficulties they encountered when first finding a service for their relative. Several said that if you lived in an area where there was an established disability service then it was easier to seek assistance. When some participants spoke about their attempts to access necessary services, the language they used evoked images of adversaries, as this participant says, "you were always fighting for a service".

Signposts

What frustrated participants most was the lack of signposts to direct them to the services that they required or to the services they would require in the future. Another aspect of the lack of signposts for families was the need to plan ahead while not knowing if their relative would be able to avail of the service the following year.

One participant, whose son was 18 years of age and about to leave school, outlined the difficulties she faced as she did not know what type of service her son was going to attend in September (this interview took place in May of that year). She said the following: "We don't know what's going to happen, there are no guarantees, and we are still in limbo at the moment". She expressed a deep sense of powerlessness felt by many of these families.

Another participant outlined how they accidentally found out that an additional service they required was on the campus where their relative was attending, but no one had told them about it, stating: "We were never told this service was on site. I don't know if they were afraid to tell us."

Moving from congregated settings

Some of the participants outlined how they were summoned to meetings and told

that as this was now national policy and their relative would be moving to a community service. The safety and security of residential care was now being taken away from them. The loss of the service they knew, the relationships that they had developed with the dedicated staff members and the trust that they had built over the years was suddenly going to be taken away. Just as these family members had found a service they were happy with, they were on the battle field again.

A participant whose son had complex needs said: "He is likely to dart across the road" and "he needs to be in a centre with walls around him for his own safety".

Another family member said that her relative was going to be put on a housing list, but nobody could tell her where this was going to be. The families spoke about their frustration at times when advocating on behalf of their relative or having issues addressed.

Issues of concern

Some families highlighted difficulties they encountered when they needed issues addressed. Some of the participants did not want to make a complaint as they were afraid that it would affect the service they required. One participant said the following about their concerns on reporting issues: "Number one would be, will I get people into trouble and number two, will I be looked on differently by the service. Will I get as much?"

Another participant echoed these sentiments: "And then I remember someone said, you had better watch, they could send her back to you, you know."

A second participant spoke of their fears: "You are always afraid to take on the service for fear that you are going to be penalised… that there may be a knock on from challenging the service." This participant found a way to get an issue addressed and said: "I have always gone to the top. There is no point going through this, I go straight to the [top] person here."

Conclusion

Families have to navigate the landscape of disabilities without a road map or signposts. They also have to fight for services for their relatives and yet they recognise that they are dependent on the service provider. Families need information in a timely manner and this study highlighted a clear lack of engagement with families by the services.

The depreciation of the disabilities budget since 2008 has been felt across the board by people with intellectual disabilities, their families and staff. Everyone is trying to do more with less and this has put huge strain on the care that can be offered. This study clearly highlights that there is a recognised need for improvement in communication and a greater level of engagement with families at local and national level.

Jacinta Mulhere is a member of the INMO RNID Section

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Protecting reflective time

INMO student and new graduate officer, **Neal Donohue**, discusses the critical role of reflected practice in nurse and midwife education

CLINICAL practice experience is an integral component of the undergraduate nursing and midwifery programmes. Students should be afforded varied quality learning opportunities at all levels in order to progress in becoming a competent and confident practitioner. One of the aims of the NMBI Code of Professional Conduct and Ethics is to support and guide nurses and midwives in their ethical and clinical decision making, their ongoing reflection and professional self-development.

Nurses and midwives must be proactive in identifying areas where they require improvements in their scope and quality of practice since they have a mandate to provide the highest standards of evidence-based practice under NMBI regulations and under the Nurses and Midwives Act 2011. One of the ways nurses and midwives ensure they provide the highest standards of practice is through reflecting on their day-to-day practice to consolidate theory and practice. This is also an essential component of any undergraduate programme and must be supported by Higher Education Institutions (HEIs) and Associated Healthcare Providers (AHPs).

The Nurse Education Forum 2000 recommended that within the clinical learning environment there should be agreed effective ways to maximise the opportunity for students to reflect on and learn from their clinical experience. For the purposes of consolidating theory and practice, students must develop a capacity to gain understanding of nursing and midwifery issues through observation, analysing, and critically contextualising aspects of practice. Kolb's cycle of learning demonstrates a continuum whereby a person learns through the progression of four stages. Learning commences with an experience, is supported by reflection, leading on to forming concepts and conclusions. This enhances the learner's capacity to test hypotheses in future situations and ultimately enhance practice. This process of learning is widely accepted as the basis for development of any profession and is a vehicle for innovation and change.

Effective use of protected reflective time

Many students say that protected reflective time (PRT) provides a great opportunity to enhance their knowledge on clinical skills and on medication management and pharmacology. For example, where they are supporting or shadowing a registered nurse/midwife on the medications round the task must be completed within prescribed times, and the registered nurse/midwife may, therefore, not have sufficient time to teach students.

PRT provides the student with the perfect opportunity to reflect on the experience of medications management, reflect on the knowledge they have gained, and do some background research into the desired effects, side effects, and considerations before and after the prescription and administering of medications. This enhances the student's understanding of the patient/service users' experience of an illness/condition and its treatment. It also helps them to conceptualise the plan of care for an individual.

Developing skilled reflection will enhance the student's experiential learning and lead to enhanced care practices. Students must maintain a personal portfolio of learning to support and record the development of their reflective practice and development of competence.

Management of PRT

Under the NMBI Nursing/Midwifery Registration Programmes Standards and Requirements time equivalent to a minimum of four hours per week should be allocated to supernumerary students during placement. A minimum of four hours should also be allocated to internship students in order to enhance the consolidation of theory to practice.

For internship students their contract of employment sets out the allocation of PRT as four hours per week. This is also comprehended by HSE HR Circular 030 – 2009.

In 2014 it was agreed by unions and the HSE under the auspices of the Labour Relations Commission (C-140721-13) that "four hours reflective time constitutes a predetermined and scheduled block outside of the 35 hour per week clinical roster".

It is imperative that the four hours PRT is allocated in a manner that supports the student in achieving exactly what was envisaged by the Nurse Education Forum 2000 and adheres to the standards of practice in learning for professional grades. Student learning must be supported by the opportunity to reflect on experiences that are specific to the profession or discipline and must have inherent value to the student in achieving their required level of academic progression and professional development.

Any HEI or AHP that does not support students by allocating protected time for reflective practice is in breach of the NMBI Nurse/Midwife Registration Programmes Standards and Requirements and a breach of the LRC agreement. Failure to provide internship students with PRT is also potentially a breach of their contract of employment and an unacceptable failure to adhere to HSE HR directives. Where an employer or a HEI does not support the allocation of PRT in the spirit in which it was intended, it constitutes an undermining and degrading of nursing and midwifery professional standards that cannot be accepted.

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

References and source material available on request from nursing@medmedia.ie (Quote Donohue WIN 27(9): 31)

Quality & Safety

A column by Maureen Flynn

Introduction to the quality improvement toolkit

THIS month's column focuses on methods for quality improvement (QI). The Framework for Improving Quality[1] guides thinking, planning and delivery of QI in the Irish health service. One of the six drivers is 'Use of Improvement Methods'. A new online resource is now available to assist anyone using improvement methods in undertaking a QI project. It applies tried and tested improvement methods to the process of improving quality.

Quality Improvement Toolkit

The HSE National QI Team developed the QI toolkit as a resource to support people working on QI projects using the Model for Improvement method.[2] The model tries to balance the desire and reward from taking immediate action with the wisdom of careful study. The model itself has two parts. The first has three questions:

- What are we trying to accomplish?
- What changes can we make that will result in improvement?
- How will we know that a change is an improvement?

The second part is a cycle for learning and improvement called the Plan Do Study Act Cycle. These two components together comprise a simple but powerful framework and roadmap for accomplishing processes, successful outcomes and system improvement. The tools and templates are designed to help develop a consistency in approach and a common understanding of improvement as you work together.

Using the toolkit

You can use resources at the frontline, management, board or national level. There are some tools that you will find helpful for all QI projects and some tools may be more applicable to your project than others. A project map shares the four phases of the project starting out with a 'light bulb' moment right through to the sustainability plan (*see Table*). This is where you are embedding the improvements you have achieved. The project lead is the person with ownership for the delivery of the project. It may be led by one individual or the project lead could have a team working on the project. Once you get approval to proceed with the project you may wish to identify a project sponsor (advocate of a project). For smaller projects, the sponsor can be your line manager/department head. For larger projects it may be a programme manager or a member of hospital or community healthcare organisation executive or management team.

Table: Using the QI toolkit

Phase	Steps of the QI process	QI tools & resources
Phase 1: Light bulb Idea	• Identify an improvement opportunity • Discuss with manager • Formulate improvement aim and objectives	Tool 1. Project on a page Tool 2. Stakeholder map Tool 3. Aim statement and driver diagram
Phase 2: Planning	• Discuss with stakeholders and form an improvement team and develop a QI Charter • Analyse the system to be improved mapping the pathway. Map the new pathway demonstrating improvement • Generate change ideas • Develop a measurement plan	Tool 4. Project charter Tool 5.Communications plan and actions Tool 6.Effective team meetings Tool 7.Process mapping Tool 8.Cause and effect fishbone diagram Tool 9. Five Whys - finding the root cause Tool 10. Measurement plan
Phase 3: Making it happen	• Implement PDSAs, test and monitor changes • Log and act on issues and progress report • Avail of coaching	Tool 11. Run chart Tool 12. Plan, do, study, act (PDSA) cycle Tool 13. Progress story board Tool 14. Coaching template
Phase 4: Sustain and spread	• Document QI effort and communicate results and lessons learned with all stakeholders	Tool 15. After action review (AAR) Tool 16. Project checklist
Relevant to all	• Capturing the patient and staff perspective	Tool 0. Capturing the patient and staff voice

Opportunity to get involved

You may have an idea for a change that you would like to work on. At your next team, ward or clinic meeting you might like to talk about this. The toolkit could be used as a starter kit to guide you through the process of your local improvement project. Your line manager or sponsor may help in getting started and with communicating the progress of the project with key stakeholders and senior management

Accessing the QI toolkit

The tools and templates are available to download from the website: **www.qualityimprovement.ie.**

Maureen Flynn is the director of nursing ONMSD, QI Connections Lead, HSE National Quality Improvement Team

Acknowledgements
The toolkit was developed and tested during a whole hospital QI initiative with staff of the National Rehabilitation Hospital (NRH). We would like to acknowledge and thank members of the NRH QI Committee and the NRH Community of improvers for generously sharing learning and making the toolkit available for others to use. Particular thanks to Roisin Breen, Siobhan Reynolds and members of the National QI Team for assistance in preparing this column.

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Spotlight on: Valerie Collins

"IT'S not just about sickness, it's about creating balance in happiness, health, education, relationships, choices and boundaries."

This is how Valerie Collins describes her approach to her role as a registered nurse in intellectual disability (RNID) in adult services with Enable Ireland. She has worked there for 22 years having previously worked for the Cope Foundation for 18 years. During her training years she worked with children, behavioural support units and people with profound and severe mental and physical disabilities. She has great all-round skills in the sector but values her role in adult services where she takes a holistic approach to working with vulnerable adults.

Three of her sisters are general nurses, but Ms Collins is very glad she works in ID services, where she can help to develop the unique potential of people who are vulnerable intellectually, physically and emotionally. This requires a broad spectrum of competencies. She feels that the RNID nurse has the capacity to be a positive influence on the service user's day and that the role requires the nurse to be empathetic, flexible, compassionate and patient. She also says it involves promoting equality and inclusion in all areas of life for the service user.

"We can make someone's day a bit better through our input and interventions. A nurse can make a unique and integral difference in helping service users realise their potential depending on where our strengths lie."

Ms Collins believes that it is important for management to be strong and not lose sight of the role of the RNID to avoid demarcation.

"We are advocates for the people in our charge. In some cases, we are their only voice. It is important that we can be assertive within our scope of practice."

Ms Collins feels that it is vital to have nurses in management roles to ensure quality, professional staffing and supervision, and to ensure best practice and

Valerie Collins: *"It's not just about sickness, it's about creating balance in happiness, health, education, relationships, choices and boundaries"*

be involved in decision making. She is concerned by some of the cost saving measures in the sector, which often result in nursing tasks being taken on by healthcare workers.

"The role is extensive, and it is important that we use nurses' strengths to maximise the potential of the individuals in our care."

She feels that the RNID has a more holistic role in that they don't just treat sick patients, but also try to bring balance to the service user's life.

As well as being a nurse, Ms Collins has studied complementary therapies for 25 years. She brings her training in reflexology and Shiatsu massage into her role as a nurse, which she says have benefited the people in her care both physically and emotionally, in particular non-verbal and profoundly intellectually challenged service users. In the future she would love to see training in some of these therapies offered to nurses and midwives as part of their continuous professional development.

Ms Collins originally joined the INMO for the further education and information services it offers, however she has since found that being part of a union provides a great feeling of professional safety in knowing that help and advice, codes of ethics and representation are all available when needed. It helps workers feel less isolated especially in facilities where there is a social model, but no nursing structure.

When asked if anything would make her day-to-day job easier or more efficient, she said: "More nurses on the ground make for a safer and more effective patient care. We simply can't be in two places at once. For example, if I am at a clinical meeting and the level of care on the floor is reduced, I must abandon what I am doing as patient care is our top priority. Having more nursing staff would allow us to do more for the patients in our care and would give us the opportunity to properly document our work.

This article is part of our series on Nursing Now, a global campaign that aims to achieve recognition of nurses' contribution to healthcare, gender equality, the economy and wider society. The campaign's aim is to improve health globally by raising the profile of nurses, influencing policymakers and supporting nurses to lead, learn and build a global movement – ***www.nursingnowireland.ie***

INMO Professional

RCM i-learn

THE ROYAL COLLEGE OF MIDWIVES

Use of epidurals in labour

It is vital that midwives stay abreast of the latest professional standards regarding pain relief in women in labour

EPIDURALS are used as a form of labour analgesia by approximately 25-30% of women during childbirth. Midwives have a responsibility to be educated on types of epidural, the advantages and disadvantages of their use, and the impact they may have on the women who choose them.

This i-learn module on epidural use for labour aims to develop midwives' knowledge and understanding of epidurals to improve their confidence in safely caring for women who choose to give birth using epidural analgesia, in line with the professional standards.

Learning outcomes

On completion of this module (study time: 60 minutes) you will understand:

- The intended and unintended effects of labour epidural
- Which types of epidural are commonly available and how they work
- When each epidural type is appropriate and the indications and contraindications for their use
- The role of the midwife in caring for the labouring woman before, during and after epidural administration, including informed consent, drug safety and monitoring of both the woman and foetus
- The range of epidural effects, from common side effects to major complications, and how to identify these and take safe, appropriate actions
- The midwife's role in the wider multidisciplinary team during epidural care.

History of pain relief for labour

Pharmacological methods to control pain and discomfort during childbirth have been used across human history and have included agents that have been inhaled, swallowed, injected and topically applied. Mention of opiate use can be found in early Chinese writing, references to wine consumption can be found in Persian literature, and the use of beer or brandy across Europe can be found in literature from throughout the Middle Ages.

During the 1930s and 40s, women in labour were often injected with high doses of morphine and scopolamine, which was sometimes supplemented with inhaled analgesia with chloroform, nitrous oxide or trichloroethylene. These doses would often cause the woman to lose consciousness, leading to maternal and neonatal complications. Women found this approach to be unacceptable and there was a demand to find a more effective method of pain control.

Today, regional analgesia has emerged as a widely used approach to pain relief in obstetrics. Epidural analgesia is very effective and is the method of choice for many women where pain relief is concerned.

What is epidural regional analgesia?

A suitably trained, competent anaesthetist is required for epidural regional analgesia. The procedure involves placing an epidural catheter into the epidural space around the spinal column of the lower back for injection of local anaesthetic such as bupivacaine, often with an opioid analgesic such as fentanyl, through a bacterial filter. The analgesia is able to cross the dura and arachnoid membrane and act on the nerve roots (local anaesthetics) or the receptors in the spinal cord (opioids). This blocks the passage of pain impulses and cuts off sensory innervations to the region, preventing transmission of pain pathways in labour.

How epidural analgesia works

- Epidural analgesia affects motor, sensory and autonomic nerves
- A needle is inserted into the lumbar spine intervertebral spaces – these are usually selected because the spine can be readily identified as lying between the highest point of the iliac crests
- The nerve fibres responsible for transmitting pain during labour include T10 to S4
- After inserting a Tuohy needle into the lumbar intervertebral space, a fine catheter is threaded through and secured in place through which the analgesia is administered
- Nerve fibres also transmit sensations such as temperature – this is why temperature sensation (eg. ice cold) changes can be used to assess the level of the epidural block.

Indications	Contraindications
• Maternal request for pain relief during labour • Intubation risk or family history of general anaesthetic problems • Cardiac/respiratory disease • Blood pressure control in hypertension • Post-operative analgesia after CS (rare)	• Declines epidural/no consent • Some neurological disorders • Thrombocytopaenia: platelet count < 100 • Bleeding disorders, eg. haemophilia • Coagulopathy • Clopidogrel (for managing stroke risk/heart disease in < seven days • 1:1 midwifery care not available • Anticoagulants/thromboprophylaxis within 12-24 hours, depending on dose • Allergy to medications used

Indications and contraindications

Women may choose epidural for labour for a number of reasons and sometimes an epidural may be advocated or indicated for medical or obstetric reasons, eg. cardiac disease or a perceived high risk labour where urgent transfer to operative delivery is envisaged. It is important for healthcare professionals and their patients to be fully informed about possible contraindications *(see Table)*. Some practices may vary between anaesthetists and trusts.

RCM i-learn access for INMO midwife members

If you are interested in completing the module, visit **www.ilearn.rcm.org.uk** Free access is available to all midwife members of the INMO.

www.inmoprofessional.ie/RCMAccess

The marriage bar

Laura Bambrick discusses the importance of recording the living memories of the marriage bar – an important part of labour history

THE marriage bar required single women to resign from their job on getting married and disqualified married women from applying for vacancies. The bar was in common use in Ireland until the 1970s, which means that there are women alive today with first-hand experience of it.

Women first became public servants on February 5, 1870, when the Post Office took over the telegraph system from private companies. Five years later, 30 women were employed as clerks in the Postal Saving Bank, where, as a rule, married women were ineligible to be hired on permanent contracts and single women on such contracts were required to resign on marriage.

In 1890 women entered the civil service, as typists, on a trial basis. Within two years they were successfully employed in seven government departments. When, in 1893, the women campaigned to be made permanent this was agreed, but also that their contract would terminate on marriage. In place of their pension and to reduce the temptation not to marry, they would be paid a 'marriage gratuity' of a month's salary for each year worked, up to a maximum of 12 months.

For the government, the marriage bar was primarily a cost saving initiative – if women were forced to retire on marriage, they would not remain in the service long enough to rise very high in the salary scale. The bar also reflected social attitudes that it was a husband's duty to support his wife and a married woman's place was in the home.

Female public servants differed in opinion on the marriage bar. Those employed in routine and low-paid work were generally in favour whereas those employed in the higher ranks, as clerks and factory inspectors, were more likely to resent it. During World War I the total number of women employed in the public service increased from 65,000, with 90% in non-clerical grades at the Post Office, to 170,000, in most departments performing every type of work. Despite this, at the end of the war the government strengthened the marriage bar by putting into legislation what had been a department regulation.

Living history – Congress wants your marriage bar story

While marriage bars were commonplace throughout Europe, the US and beyond, from the late 1800s, Ireland was one of the last countries to lift the ban. This puts us in the unusual position of having women alive today who were affected by the marriage bar. Congress is eager that these women's first-hand accounts of this important episode in labour history are documented for future generations. Together with RTÉ we would like to hear from women who had to leave a job because of the marriage bar. RTÉ will record a series of television interviews to broadcast a special programme from within its existing scheduled programmes if there is sufficient interest from women willing to share their experiences and memories of the bar. If you, or someone you know, would like to participate or would like to discuss the project, please contact Laura Bambrick by email to: laura.bambrick@ictu.ie or Tel: 01 889 7777 or Christopher McKevitt of RTÉ at: chris.mckevitt@rte.ie All correspondence will be treated with absolute confidence.

After Independence

Irish women's access to employment and equal treatment at work worsened following independence in December 1922. Within the first year, legislation removed a widow's right to return to her civil service job on the death of her husband. From 1926 the Minister for Finance was given discretionary power to hire married women to the public service, but only in exceptional circumstances and only on a temporary, non-pensionable contract. As in the UK, there was no formal marriage bar on temporary staff. In spite of this, resignation on marriage and the non-recruitment of married women was common practice in temporary posts, with the exception of office cleaners.

In 1941 the Local Government Act gave the Minister for Local Government and Public Health the power to disqualify married woman from applying for or holding permanent positions in local authority services, including state-run institutions.

Although it had been practice since independence that in order to qualify for such jobs women had to be unmarried or widowed, it was only when a loophole was found in the marriage bar that the policy was made official to prevent a recurrence.

At the time only 5% of women working in nursing were married. Once they went back to work after marriage, a married nurse or midwife was employed on a continuous temporary contract and paid at the lowest point of the pay scale, indefinitely.

In his recently published book on the history of the INMO, *A Century of Service*, Mark Loughrey gives an excellent account of the marriage bar – how it impacted on individual women, the support the ban had among many, mostly younger, nurses (who stood to gain in terms of employment opportunities and increased seniority), and the successful efforts of the INO in 1969 in winning annual increments for married members.

While private and semi-state employers were not legally obliged to apply a marriage bar, it was widespread practice to include a clause in letters of appointment to female workers that their employment ended once they married. For example, An Post, CIE, Aer Lingus, banks and, two of the largest employers, Jacob's Biscuits and the Guinness brewery all had marriage bars.

Abolishing the bar

The ban on the employment of married women in the civil service and wider public and semi-state sectors was not lifted until 1973, on foot of a recommendation of the Commission on the Status of Women and a shift in public opinion on working wives. Around 700 female civil servants had been forced to resign from their jobs on marriage in each of the preceding three years. They, along with all other former public sector workers affected by the marriage bar, now had the right to get back their previous jobs, but only if they could show they were no longer supported by their husbands by reason of desertion, separation or ill-health.

Marriage bars in the private sector were finally abolished in 1977, when European law made it illegal to discriminate in employment on the grounds of sex and marital status.

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

Breaking bad news

Adolescent patients with a terminal prognosis must be involved in decisions that concern their end of life care, writes **Tyrone Horne**

THOUGH not a marginalised group, adolescents can feel marginalised in the healthcare context as they often don't fit within existing children/adult services.[1] This feeling has been described as 'at the edge of no-man's land'.[2] When caring for an adolescent with a life-limiting condition, it can be difficult to respect both their cognitive ability and their wishes, while also providing the best care possible for them and their family.

Unlike with younger children for whom parents make the decisions, or with older adults who have their own voice, this cohort presents a challenge to healthcare professionals when communicating,[3] especially with respect to their life-limiting condition. Although it is sometimes difficult to communicate with adolescents, they have opinions of their own and want these opinions to be acknowledged.

Adolescents with palliative care needs are a distinct group with specific physical, emotional, psychosocial and social needs. Their demands are very different to those of younger children or adults. *Beresford and Stuttard*[4] highlight the importance of recognising and respecting adolescents during this transitional stage, while still fully supporting the needs associated with their life-limiting condition. The authors discuss how even within adult care settings adolescents are in the minority as many of the other patients are older adults. The authors go on to highlight that staff from these areas often have little experience of caring for adolescents with life-limiting conditions.

Historically, adolescents with life-limiting conditions such as cystic fibrosis or Duchenne muscular dystrophy would likely not survive into adulthood. However children's nurses often say they are not equipped to care for teenagers or communicate effectively with them. With this in mind the question needs to be asked: who is suitable to care for this cohort? *Nicholl and Tracey*[5] highlight the importance of recognising the difference between children's and adults' palliative care needs and suggest that children's nurses are best suited to provide adolescent care.

The age at which adolescents move from children to adult services can differ greatly, with many adolescents and healthcare professionals believing that a specific room for adolescent patients would be hugely beneficial within children and adult services. Chronically sick teenagers struggle with the sudden change of being relocated to an adult ward where they can feel the healthcare professionals cannot meet their age-related needs.[6] Transition to adult services should always take place gradually and incorporate a parallel discharge towards end of life care and/or transfer to adult services. *Grinyer*[7] describes the need for this transition as "bridging the gap". Bridging the gap is one of many ways in which we can help adolescents through this transition.

Although it is acknowledged that the young person will die, they should not be prevented from living until that time comes. The Department of Health[8] discussed adolescence in its national policy, *Palliative Care for Children with Life-Limiting Conditions in Ireland* and described "the need for improved transition from paediatric to adult services, the need for improved facilities for adolescents when in hospital, the need for more education for carers who have to deal with adolescents, opportunities for privacy, interaction and communication with trusted adults other than parents, engagement in collaborative decision-making with parents and professionals". Work is underway within hospitals and related services to implement these recommendations.

The adolescent brain is still developing and is relatively immature. It can't yet control emotion or make decisions in a rational fashion.[4] Adolescents with life-limiting conditions will continue to talk about long-term future plans despite being aware of their terminal prognosis. However, it is sometimes said that teenagers are more realistic about their fate than their parents are. Adolescents often highlight that information is directed to their parents, who act as 'gatekeeper' to that information.

In 2000 the government produced the National Children's Strategy in which it was stated: "Children will have a voice in matters which affect them and their views will be given due weight in accordance with their age and maturity."[9] Parents and healthcare professionals can help adolescents with their ability to communicate by allowing them greater independence and thereby allowing them greater autonomy. By doing so the adolescent feels that their caregiver is supporting them more and therefore they do not feel so isolated and feel safer discussing their worries and emotions.

It is also important to remember the key place of the healthcare professional in helping parents communicate with their child. Giving the parent the information first and giving them time to absorb it allows the parent to then pass the information on to their child. It is also important to give accurate, truthful information to adolescents so as to give them a sense of

control when they are involved in discussions that concern their condition.

Effective communication is crucial to therapeutic relationships with adolescents; actively listening to the message they are trying to get across is vitally important. Parents of any adolescent, including adolescents with life-limiting conditions, can find communication difficult. It is important to keep channels of communication open and let the adolescent patient know that the parent is available when needed.[3]

In a US study by *Britto et al*[10] it was found that the majority of healthcare professionals underestimated the importance of communication to the adolescent patient. This shows that adolescents want to be given the information but still want support in making vital decisions around their end of life care. A study by *Lyon et al*[11] supports this finding and reports that 96% of adolescents with a life-limiting condition wanted to be involved in a 'shared choice' environment when it came to decisions about their care.

Legally, providing information to children is not required. Only in Germany are adolescents consulted and required to consent to clinical trials. Even in the 1970s healthcare professionals were writing about the importance of sharing information with adolescents who have a terminal prognosis. Although adolescents in Ireland are not legally recognised as being able to make choices around end of life issues, this cohort often have a deep understanding of and a realistic outlook on their medical situation. Adolescents with a long term illness are often more well-adjusted socially than their healthy counterparts.

Children's palliative care conference

The fourth International Children's Palliative Care conference will take place at NUI Galway on November 21-22, 2019. Dr Helen Kerr from Queen's University Belfast will speak about the many interventions that can be used to support the difficult transition from child to adult care, an area she and her colleagues have researched extensively.[15] The conference, entitled 'Contemporary Challenges in the Care of Children with Complex and Palliative Care Needs', will be of interest to nurses who work with such patients. For more information visit **www.cpcconf.ie**

Adolescents who are dying still undergo the same mental development and often still experience independence and relationships for the first time. Their illness and impending death can greatly interfere with this, leaving them to ask questions like 'what's the point of having a girlfriend/boyfriend?' or saying things like 'nobody is going to want to be with me'.[12] Healthcare professionals must be aware of this when making conversation and be careful not to make throwaway remarks like 'I bet you have all the girls after you', as this can cause upset.

As part of their investigation, *Jalmsell et al*[13] spoke to bereaved parents and found that parents who had spoken about death with their children felt no regret about it, while many parents who did not have the discussion regretted not doing so. *Jacobs et al*[14] found that, by and large, adolescents with a terminal prognosis want to be involved in discussions about their end of life care and would prefer to be told that they are dying.

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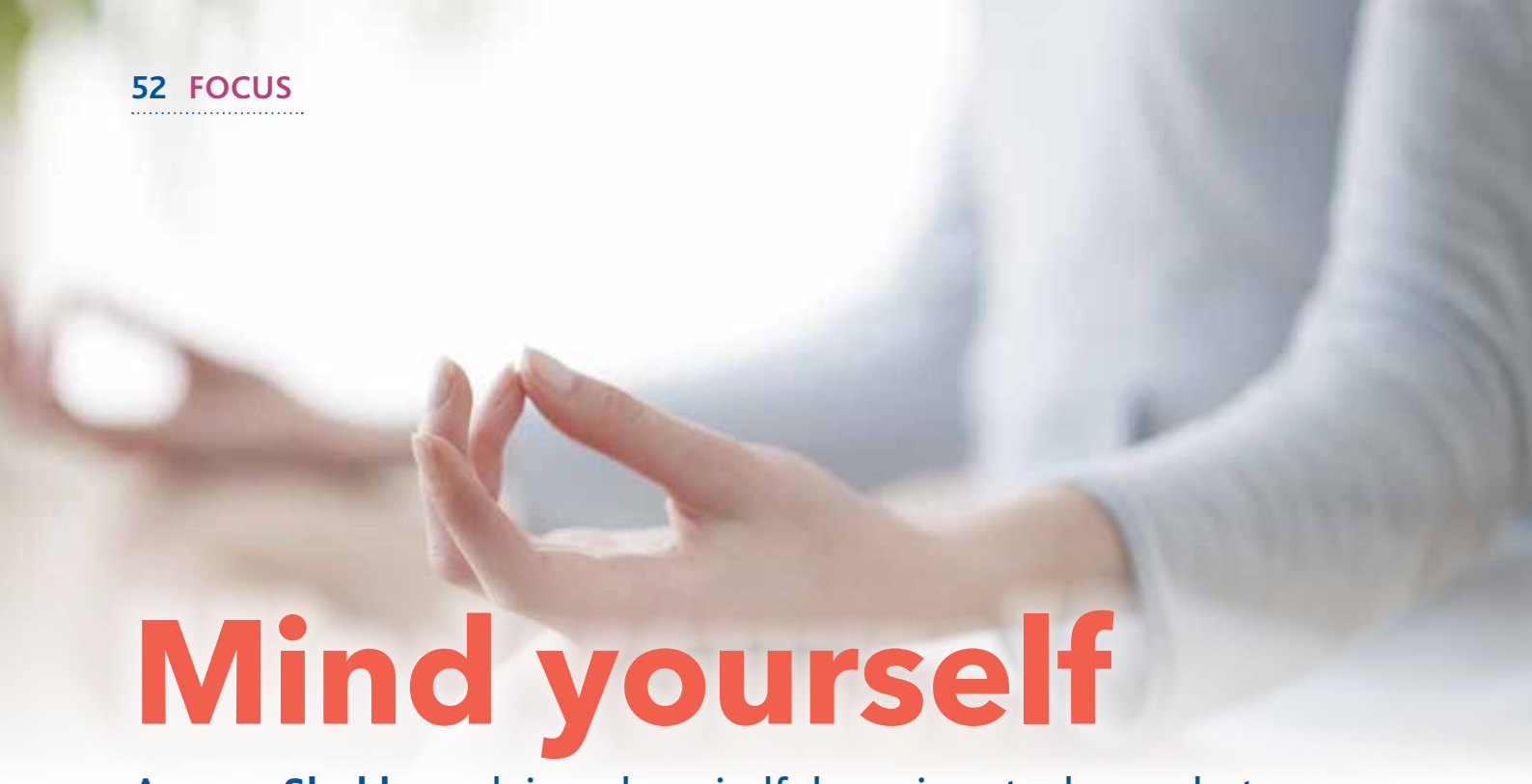
References available on request. Email nursing@medmedia.ie (quote Horne WIN 2019: 27 (9): 50-51)



Mind yourself

Aparna Shukla explains why mindfulness is not a luxury but a necessity for ever busy nurses and midwives

FOR some time we have heard complaints from patients and healthcare professionals that the system is failing to meet public expectations. The focus has often been on outward resources and facilities. There are huge industrial relations issues to be tackled but this article will examine how mindfulness can help nurses and midwives take innovative approaches to self and patient care in a stressful work environment. These approaches include what one might describe as the 'art and science' of mindfulness – an opportunity for healthcare professionals to turn their attention inward.

Many corporate companies such as Google, Apple, Nike, PWC, Fidelity Investments and Orange train their employees in mindfulness because they know that if employees are physically and mentally healthy, they will be more productive, become ill less often and the company will see improvements in staff retention.

What is mindfulness?

Mindfulness has its roots in the oriental meditation systems *'smarta'* and *'sati'*, both meaning remembrance and moment-to-moment awareness. Mindfulness was also practised by the Christian mystics or 'desert fathers' as a means of stabilising themselves for critical introspection and self-discovery.

It was not until 1979 that Dr Jon Kabat-Zinn, professor of medicine and the founder of the Stress Reduction Clinic and Centre of Mindfulness in Medicine at the University of Massachusetts, introduced this practice to the western world. According to Dr Kabat-Zinn, "mindfulness means paying attention in a particular way: on purpose, in the present moment, and non-judgementally". He further emphasises that this kind of attention nurtures greater awareness, clarity and acceptance of present reality.

There is a pervading myth that for meditation to be successful one's mind needs to be empty of thoughts. We have to accept, however, and acknowledge the fact that our mind is a thinking faculty of the body and thoughts will inevitably arise. We need to learn how to slow down the flow of thoughts and turn down the volume of this inner radio.

Mindfulness meditation cultivates concentration that gives clarity and awakens us to the fact that a lot of the time what our mind is telling us is not real and replete with fiction. Because we become the prisoner of our own likes and dislikes, we start to feel overwhelmed and stressed. Mindful breathing, for example, allows us the space and opportunity to experience peace by engaging the parasympathetic nervous system.

How mindfulness can help

The western world embraced mindfulness principles and practices due to Dr Kabat-Zinn's neuroscientific experiments and successful patient outcomes. Dr Kabat-Zinn says: "You can't stop the waves, but you can learn to surf." This seems like the best advice for nurses and midwives because in our professions, we are always dealing with people in their time of pain and suffering.

Despite our best efforts, patients are still suffering and unfortunately the healthcare workforce is now joining in the suffering, both physically and mentally.

A significant volume of work has already been carried out by our predecessors in terms of scientific and experience-based research on mindfulness. Information about mindfulness practices is more accessible now than ever before, yet our healthcare system does not seem to avail of its benefits. The NHS made the mindfulness-based stress reduction system available for its patients as far back as 2004. Ireland needs to follow suit and make this available for its healthcare institutions.

In my job as an advisor for a health insurance company, I listen to patients talk about their experiences of care in hospitals. I have been facilitating mindfulness workshops for the INMO since 2014 and I have met many wonderful nurses, PHNs and community nurses who are willing to do whatever they can to help their patients. Many of them have initiated breath work and simple yoga practices for their patients and are seeing the benefits for their recovery.

We really can't expect our exhausted and highly stressed staff to look after patients and fully offer them loving and compassionate care – we cannot give what we do not have. We need to start from the source and begin caring for our nurses and midwives.

Mindfulness awakens us to the beauty of each moment and guides us on our way

in our inner journey to peace and calm, which can be accessed whenever needed. Mindfulness practices are universal and secular, extremely practical and do not require significant time commitments. It is like building up muscle; it requires regular training and is one of the best exercises for mental awareness and clarity. Once your 'self' is awakened the world seems like a whole new place, however everything remains the same. The only difference is that you are looking at the world through a new lens, free of preconceived notions.

Neuroscientific studies are constantly reminding us about neuroplasticity – the ability of the brain to change continuously throughout an individual's life – through regular mindfulness practices. This is an opportunity for nursing and midwifery leaders to support nurses and midwives in becoming insightful and intuitive. It is a win-win situation for everyone. Happy and peaceful nurses and midwives are likely to be more productive and less stressed. Mindfulness helps us wear a natural smile and embrace each moment as an opportunity to do our best for our patients. Although hospitals are becoming increasingly high-tech, there is no replacement for a human smile and welcoming eyes.

Upcoming mindfulness programme

The next 'Mindfulness and Meditation in Holistic Nursing and Midwifery Care' programme will take place at the Richmond Education and Event Centre on Tuesday, November 19, 2019. To book a place, contact INMO Professional at Tel: 01 6640618 or visit **www.inmoprofessional.ie** Fee:€90 members; €145 non-members. See *page 33* for further details.

Training opportunities

Let us give every nurse and midwife the opportunity to change without the burden of expectation and judgement.

The good news is that stressed-out nurses and midwives don't have to travel to the Himalayas or to a monastery to experience peace and joy. Instead they can do so during their normal workday. INMO Professional is eager to support nurses and midwives and help to improve their mental wellbeing. INMO Professional is planning to introduce wellness courses designed specifically for healthcare professionals, including mindfulness and yoga. These will be available at an affordable rate so that members can easily avail of them after a hectic day at work.

Conclusion

Compassion is a core skill for all healthcare professionals and should be part of the day-to-day practice of caring for nurses and midwives. However, nurses and midwives have never been taught how to cultivate this compassion and caring.

Mindfulness is not a magic solution to all the problems we face in our healthcare system. If nurse and midwife managers experience the benefits first hand, then they may feel confident enough to offer this service to their staff and patients. Let us take our hospital and community care towards a more holistic approach by embracing mindfulness.

Aparna Shukla is a qualified nurse, midwife and yoga and mindfulness teacher with a master's degree in nursing from Delhi University

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Mothers need better breastfeeding support

Healthcare providers need to be more proactive from the outset to help more women to breastfeed successfully. **Alison Moore** reports

IN WESTERN society we know that for myriad reasons women often cannot achieve optimal breastfeeding, which leads to giving up, topping up with formula and early weaning. With this in mind, Prof Diane Spatz, professor of perinatal nursing at the University of Pennsylvania in Philadelphia and a nurse researcher and director of the lactation programme at Children's Hospital Philadelphia, believes that healthcare professionals must ask how they can proactively mitigate this to help mothers achieve full milk production so that they can meet their breastfeeding goals.

Prof Spatz, who was speaking at Medela's Breastfeeding and Lactation Symposium held in London earlier this year, said that there is a critical window of opportunity to establish milk supply.

"What we know from a research standpoint is that the first hour after birth is crucial. We know that the first day, the first two days, the first three to five days, really set the stage for long-term milk production.

"Unfortunately, with current birth hospital practices, the way in which women give birth, with very interventional deliveries and what occurs during the hospital stay, the quote, 'normal lactation experience' doesn't usually occur for most mother-baby dyads," she said.

Given the evidence, Prof Spatz said that it is clear that healthcare professionals need to change the current practice paradigm to ensure that women and their families, firstly, are able to make an informed feeding decision and, secondly, are able to effectively establish and maintain a robust milk supply.

She believes that this must start with antenatal education in order to create a sense of empowerment about breastfeeding and a sense of urgency about milk supply. She said that during antenatal care, women and their families need to be educated that all pregnant women, no matter at what gestational age they deliver, will be producing milk (lactogenesis). They should

Prof Diane Spatz

be educated on the physiology of milk production and the critical window after birth that sets the stage for the mother to come to full volume.

Risk factors

Prof Spatz emphasised that it was critical during pregnancy to identify any potential risk factors that could impact the mother's ability to reach full milk volume. Such risks included glandular hypoplasia or breast surgery. Further, she said it was also crucial to identify potential risk factors that could delay lactogenesis II (secretory activation) such as, primigravida, obesity, hypertension, diabetes and maternal age over 30 – all prevalent in the Irish setting – to name a few.

"If the mother has risk factors, she should be informed prior to delivery. Strategies should be presented to optimise her breastfeeding journey; these include antenatal expression of colostrum, using pasteurised donor breastmilk as a bridge until milk supply comes to volume, and to pump early and pump often after delivery.

Prof Spatz says that these steps are not taken often enough to help those mothers at risk. She said that in hospital following the birth many health professionals do not have a sense of urgency about ensuring the mother effectively converts from lactogenesis I to lactogenesis II and that many routine hospital practices negatively affected the mother's ability "to come to volume". These practices, she said, included inductions, the lack of rooming in, lack of skin to skin, concerns about infant weight loss and formula supplementation from birth.

"If a baby is healthy and can breastfeed, that baby should be breastfed within the first hour, We know that this doesn't happen globally. If the baby is unable to feed before a good rest, then we need that mother to be expressing with a pump with initiation technology within that first hour. What we want families to understand is that there's a critical window of opportunity. This is time sensitive. There's a set period of time, where we have to really focus on milk supply," she said.

Prof Spatz argued that if this critical window to establish milk supply postpartum was understood and observed more widely, the beneficial effect would be widespead.

"Mom's only job when her baby is home with her is that she eats, sleeps and breastfeeds. If we really protected that critical window of opportunity for mothers and focused on the supply, we would probably solve a lot of the world's breastfeeding problems," she said.

Prof Spatz said that research shows that globally the number one concern of mothers is milk supply and that it was common for infants in hospitals around the world to be supplemented with formula. This means that they are not going to wake on cue to feed, so the breasts aren't stimulated and milk supply will spiral downward.

She said she would love to see mothers with risk factors adding expression sessions with a hospital-grade pump.

"My message is if you're going to say the word 'supplement', then you need to say the 'P word' which is pump. We must change the practice paradigm, so that all women have the opportunity to reach their personal breastfeeding goals," she said.

Diabetes research

We look at some of the research presented at the annual meeting of the European Association for the Study of Diabetes

OBESITY is linked to a nearly six-fold increased risk of developing type 2 diabetes, with high genetic risk and unfavourable lifestyle also increasing risk but to a much lesser extent. These are the conclusions of new research presented at this year's Annual Meeting of the European Association for the Study of Diabetes (EASD) held recently in Barcelona. The findings were presented by Hermina Jakupović from the University of Copenhagen, Novo Nordisk Foundation Center for Basic Metabolic Research, Copenhagen, and colleagues.

Genetic predisposition, obesity and unfavourable lifestyle have an important role in the development of type 2 diabetes, an increasingly common disorder that contributes significantly to the global burden of disease. According to the International Diabetes Federation, approximately 425 million adults (20-79 years) were living with diabetes in 2017; by 2045 this is expected rise above 600 million.

The current strategy to prevent type 2 diabetes is underlined by the maintenance of normal body weight and the promotion of a healthy lifestyle. Lifestyle interventions designed for weight loss have been shown to delay the onset of type 2 diabetes among high-risk subjects. However, the effects of lifestyle factors and obesity on type 2 diabetes risk may vary between individuals depending on genetic variation. Thus, it is important to understand the interplay between genetic predisposition, obesity and unfavourable lifestyle in the development of type 2 diabetes.

In this new research, the authors aimed to study whether the genetic risk for type 2 diabetes is accentuated by obesity and unfavourable lifestyle. They applied statistical modelling to a case-cohort sample of 9,556 men and women from the Danish prospective Diet, Cancer and Health cohort (49.6% women, 50.4% men, mean age 56.1 (range 50-65)). Almost half (49.5%) of the participants developed type 2 diabetes during an average 14.7 years of follow-up.

A favourable lifestyle was defined as having at least three of the following healthy lifestyle factors: no current smoking, moderate alcohol consumption, regular physical activity and a healthy diet. An unfavourable lifestyle was defined as zero or only one healthy lifestyle factor, while the remaining participants were defined as having an intermediate lifestyle. Genetic risk was assessed by a genetic risk score (GRS) comprising 193 genetic variants known to be strongly associated with type 2 diabetes. The GRS was stratified into low (lowest 20%), intermediate (middle 60%) and high risk (top 20%) groups.

The researchers found that having an unfavourable lifestyle and obesity are associated with a greater risk of developing type 2 diabetes regardless of their genetic risk. Obesity (defined as a body mass index of 30kg/m^2 or higher) increased type 2 diabetes-risk by 5.8-fold compared to individuals with normal weight. The independent effects of high (versus low) genetic risk and unfavourable (versus favourable) lifestyle were relatively modest by comparison, with the highest genetic risk group having a two-fold increased risk of developing type 2 diabetes compared with the lowest group; and unfavourable lifestyle was associated with a 20% increased risk of developing type 2 diabetes compared with favourable lifestyle.

The authors concluded that the effect of obesity on type 2 diabetes risk was dominant over other risk factors, highlighting the importance of weight management in type 2 diabetes prevention.

Puberty, menopause and the pill

Later puberty and later menopause associated with lower risk of type 2 diabetes in women, while use of contraceptive pill and longer time between periods associated with higher risk. The study by Dr Sopio Tatulashvili, Avicenne Hospital in Bobigny, France, also presented at EASD, suggests that in general longer exposure to sex hormones, but later in life, could reduce the risk of diabetes, and that women at high-risk of type 2 diabetes taking the contraceptive pill may require personalised advice.

Early screening to detect poor blood sugar control could lower the risk of further complications. For this reason, it is important to identify the risk factors of type 2 diabetes. The aim of this study was to determine the association between various hormonal factors and the risk of developing type 2 diabetes in the large prospective female cohort study (Etude Epidémiologique auprès de femmes de la Mutuelle Générale de l'Education Nationale).

The authors observed that higher age at puberty (over 14 versus under 12 years) reduced type 2 diabetes risk by 12%, and increased age at menopause (52 years and over, compared to under 47 years) reduced risk by 30%. Breastfeeding (ever breastfed versus never breastfed) was also associated with a 10% reduced risk of developing type 2 diabetes. Furthermore, an increased total lifetime number of menstrual cycles (over 470 in a woman's lifetime versus under 390) was associated with a 25% reduced risk and longer duration of exposure to sex hormones (meaning the time between puberty and menopause) (over 38 years compared with under 31 years) was associated with a 34% decreased risk of developing type 2 diabetes.

By contrast, the use of contraceptive pills (at least once during a woman's lifetime compared with no use at all) was associated with a 33% increased risk. Longer time between periods (menstrual cycle length) (32 days and over versus 24 days and under) was associated with a 23% increased risk.

Focus on: ulcerative colitis

Helen O'Donovan and Valerie Byrnes discuss the case study of a patient with ulcerative colitis who presented at the ED

A 67-YEAR-OLD woman presented to the emergency department with a recurrence of rectal bleeding of three-months duration after 10 years of well-controlled ulcerative colitis.

The woman was initially diagnosed with ulcerative colitis (UC) in 2002. She was treated with oral therapy in the form of mesalazine 800mg once daily. Her disease was well controlled on this treatment for 10 years. During this time, her disease was monitored by assessing symptoms at regular clinic visits and follow-up with colonoscopy or sigmoidoscopy as needed.

In 2012, she presented to clinic with a recurrence of *per rectum (PR)* bleeding, which had been ongoing for approximately three months. She denied any increase in frequency of bowel motions but did report some crampy abdominal pain. Colonoscopy revealed severe diverticular disease and biopsies of the sigmoid colon showed mild chronic active inflammation with evidence of cryptitis.

Next step and management plan

The dose of mesalazine was increased to 2.4g per day and the patient responded well to this. Monitoring of this patient's disease included regular clinic visits, repeat colonoscopy and monitoring of faecal calprotectin levels. She was reviewed regularly at clinic. The dose of her medical treatment was titrated in relation to symptoms.

On review in late 2018, she was taking mesalazine 800mg daily. At this time, her bowel motion frequency was stable, and she did not have bleeding *PR*. She did report intermittent abdominal pain. Of note, at this time, her faecal calprotectin level was elevated at 320µg/g. As a result, her medication was again increased to 1.6g daily. She was booked for review in six months where a decision regarding need for colonoscopy would be made.

Elevated faecal calprotectin

Faecal calprotectin is a useful monitoring tool in inflammatory bowel disease and in identifying those who have developed or are about to suffer an acute flare in their disease.[1]

If normal in asymptomatic patients, it can be reassuring. If elevated, treatment can be adjusted prior to colonoscopic investigation.

Faecal calprotectin is a cytosolic protein released by neutrophils in response to inflammation. Faecal calprotectin levels have shown a good correlation with the degree of inflammation in inflammatory bowel disease.[2,3,4] Although there is no validated upper limit of normal, a faecal calprotectin level > 200-250µg/g in UC has been found to have good accuracy in predicting endoscopic activity.[5]

Regular monitoring

Regular disease monitoring is important in patients such as this with longstanding UC. It is also important to consider routine health maintenance and monitoring for other diseases for which patients with inflammatory bowel disease are at a higher risk. Patients with UC are at increased risk of infections due to their underlying disease, medications and the fact that they may be malnourished due to poor absorption. Routine vaccination is recommended.[6]

Patients with inflammatory bowel disease are at increased risk of colorectal cancer and should undergo screening based on the extent and duration of disease.[7]

Those admitted to hospital for any reason, but especially during a disease flare, should receive prophylactic anticoagulation unless contraindicated. These patients should also be monitored regularly for signs of malabsorption and side effects of treatment.

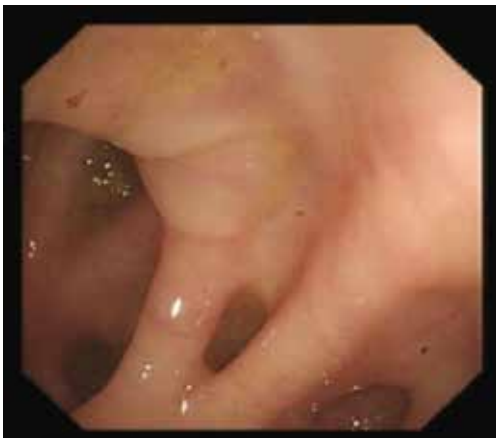

Figure 1. Colonoscopy revealed severe diverticular disease and biopsies of the sigmoid colon showed mild chronic active inflammation with evidence of cryptitis

Helen O'Donovan is a gastroenterology senior house officer and Valerie Byrnes is a consultant gastroenterologist at University Hospital Galway

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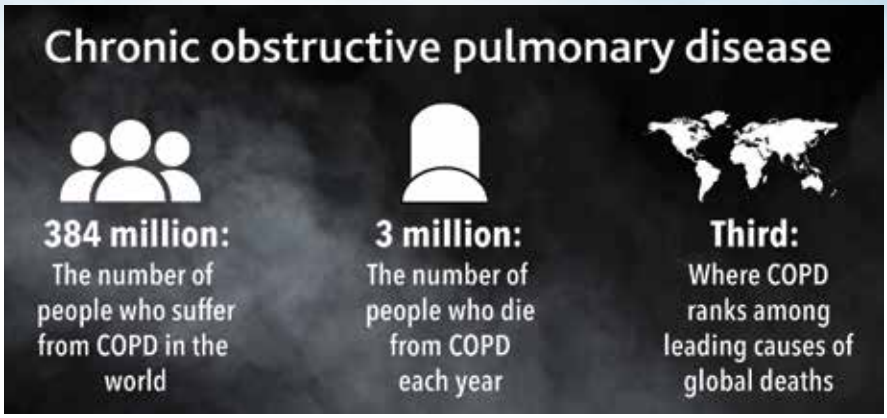
Fighting for breath

In recognition of World COPD Day, *WIN* looks at the impact of this and other respiratory diseases on global health

THREE million people die from chronic obstructive pulmonary disease (COPD) every year, making it the third leading cause of death worldwide, according to the Global Initiative for Chronic Obstructive Lung Disease (GOLD). To raise awareness and improve the care of the 384 million people currently living with the condition, GOLD has themed this year's World COPD Day – which takes place on November 20 – 'All Together to End COPD'. The day's activities are organised in each participating country by healthcare providers, educators and members of the public.[1]



Adapted from Forum of International Respiratory Societies infographic for World Lung Day. See ***www.firsnet.org***

The definition of COPD was amended in the 11th revision of the World Health Oganization's (WHO) International Classification of Diseases (ICD-11)[2] to recognise the importance of precipitating factors. According to ICD-11, COPD is a preventable, treatable respiratory condition characterised by airflow limitation and persistent respiratory symptoms including:

- Shortness of breath
- A repetitive cough
- Increased phlegm or mucus production
- Feeling tired
- More frequent chest infections from which it takes the patient longer to recover.

Significant COPD risk factors include smoking and exposure to indoor and outdoor chemicals, as well as occupational dust particles.

In Ireland

While there is currently no data available at a national level on the prevalence or incidence of COPD in Ireland, it is estimated that nearly 500,000 people aged 40 years and over could have COPD, approximately half of whom are likely to be undiagnosed,[3] and COPD as a primary diagnosis accounts for approximately 15,000 inpatient hospitalisations, according to the Irish National Healthcare Quality Recording System. Ireland also has one of the highest age-standardised death rates from COPD in Europe.[4]

A number of public health initiatives are underway, backed by health support groups, aimed at easing the burden of COPD and other respiratory diseases in Ireland. The Asthma Society recently called on the government to publish its clean air strategy to improve the health of people with COPD, asthma, lung cancer and heart disease. It is urging TDs to press for the introduction of a national ban on smoky coal, first announced two years ago but blocked by threats of legal action by suppliers.

According to the society, people with chronic respiratory diseases are particularly vulnerable to high particulate levels in the air caused by burning solid fuel and nitrogen dioxide from vehicle emissions.

Though Ireland's air quality is within EU legislative limits, the Environmental Protection Agency has found that it exceeds the stricter WHO guidelines for fine particulates, ozone and nitrogen dioxide.

The Irish Heart Foundation and the Irish Cancer Society also recently called on the government to do more to help smokers to quit as part of World No Tobacco Day on May 31.

Global impact

A recent study published in the *New England Journal of Medicine*[5] analysed health and environmental data from 652 urban areas across 24 countries and found significant associations between short term exposure to toxins contained in particulate matter and increased respiratory mortality risk. Of the 59.6 million deaths recorded in this large population-based study, nearly 10% occurred as a result of respiratory illness.

Commenting on the findings of the study, Forum of International Respiratory Societies environmental committee member Dr Teresa To from the University of Toronto said: "The study shows extremely compelling data that suggest inhalable and fine particulate matter does not just represent a common annoyance but is associated with human mortality most affecting our most vulnerable populations who suffer from underlying cardiac and respiratory illness. It should prompt not only medical providers, but also policymakers to take notice."

Further information

The first World COPD Day was held in 2002. Now every year, GOLD chooses a theme and uses the day to raise awareness of the disease and coordinate the distribution of related materials and resources such as its annual strategy report, the latest iteration of which is available on the GOLD website – **www.goldcopd.org**

Healthcare professionals can also share details of World COPD Day activities taking place in their workplace via the same website.

– Max Ryan

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Beating health cover increases

There is money to be saved by shopping around before renewing health cover, writes **Ivan Ahern**

HEALTH insurance in Ireland used to be about hospital cover and hospital cover only. Today it has grown substantially in terms of benefits that can be used every day with regular plan developments by the three providers in the market Laya, VHI and Irish Life Health. Up to 2016, providers would have regularly introduced price increases, on occasion up to 20%. Customers usually become aware of the increase when it's time to renew their policy.

The normal pricing cycle changed during 2017 when all three providers began to apply price freezes, with some plans even enjoying price reductions. This cancelled out an immediate need for customers to shop around to get the best value when renewing their cover. As of June 2019 the freeze ended and prices are rising again. VHI increased prices by an average of 6% (some up to 10%), in August 2019. This followed Irish Life Health increasing prices by an average of 3% in June, while Laya Healthcare applied increases of a similar percentage in July.

The main reason cited for the increases relate to a recent spike in claims received by providers during the back end of 2018 and throughout 2019. The cost of claims has also increased, meaning the providers are paying out more each month for claims.

It's important to remember if you're looking to take out health insurance for the first time, or looking to renew your policy, that there is an abundance of benefits and options for customers in 2019 in comparison to previous years. Your plan should be built around your lifestyle needs and the needs of your family. If you're worried about your current plan, don't be. You can change to a plan which better suits your needs in terms of benefits and price.

When you receive your renewal notice from your provider, the message is simple: don't renew your cover until you review it. You could be missing out on significant savings by failing to shop around every year. There is only a short window to review your cover before you are tied into a new 12-month contract with significant financial penalties for cancelling early. Save some money for something else this year and review your health insurance cover.

Table 1: Premium comparison January to November 2019

	Jan 2019	August 2019	Premium increase	% increase	Alternative	Alt price	Saving
VHI Healthcare One Plan Family	€1,130	€1,227	€97	8.6	PMI 3713	€1,148	€79
Irish Life Health Nurture Plus ILH	€1,206	€1,271	€65	5.4	4D Health 1	€1,089	€182
Laya Healthcare Fex 175 Explore	€1,125	€1,247	€122	10.8	Signify Plus	€1,050	€196

Table 2: Total savings generated by switching to alternative cover

	Adult	Child	Total cost	Alternative plan	Adult	Child	Total	Total saving
VHI Healthcare One Plan Family	€1,130	€239	€97	PMI3713 & One Plan 150	€1148	€198	€2,692	€241
Irish Life Health Nurture Plus ILH	€1,206	€236	€65	5.4	4D Health 1	€1,089	€169	€498
Laya Healthcare Fex 175 Explore	€1,125	€393	€122	10.8	Signify Plus	€1,050	€249	€682

Table 1 shows current plans with alternative plan options that offer similar cover at a cheaper price. If you compare the premium from January to today's prices, some plans have increased by over 10% during that time. Avoid a premium increase and switch your plan to the alternative option.

The alternative plans listed above are 'corporate plans' and all three providers offer a range of these plans. Customers are often unaware that these corporate plans are available to them and often provide a stronger level of cover at a lower premium to the consumer alternative. What's more, if you have your whole family insured on the same plan and opt to insure adults and children on different plans at your renewal, the savings multiply *(see Table 2)*.

Don't forget

- Take on an excess: This is the initial amount of the claim you pay and options range from €75-€500. The higher the excess, the lower your premium will be
- Split your cover: All family members do not have to be on the same plan. Shop for the best plan per individual
- Young adult (18-25) discounts may be available. These are not available on all plans so ask about them
- Watch out for special offers: if they coincide with your renewal, then you can avail of them, these are usually quite well advertised, eg. half price kids etc
- Check out the corporate plan equivalent of your own plan – corporate plans don't suit everyone but the benefits and pricing tend to be attractive
- Review your plan annually to ensure your cover is up to date and competitive.

Don't overpay for your cover, call Cornmarket to review the market for you. Tel:01 4160230.

Ivan Ahern is a director at Cornmarket Group Financial Services Ltd

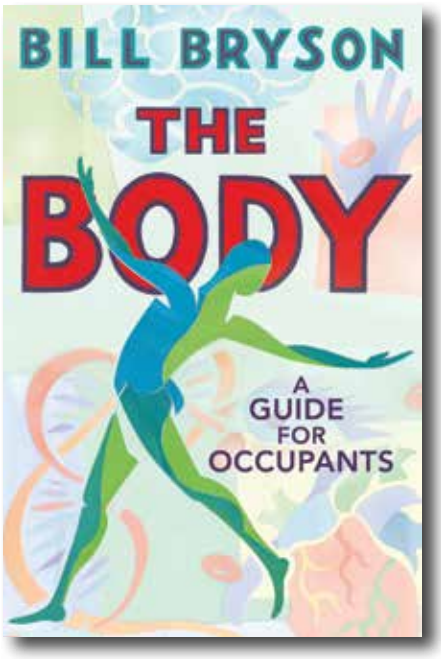
The amazing story of us

A SET of human lungs, if smoothed out, would cover a tennis court and the airways within them would stretch from London to Moscow. There is a metre of DNA packed into every cell in the human body and if all of this was formed into a single fine strand, it would stretch 10 billion miles. These are just a few of the mindboggling nuggets of information offered by Bill Bryson in his latest book, *The Body: A Guide for Occupants*.

Bryson approaches the subject of biology in the same no-nonsense, relatable, observational style as he employs in his other writing, but you cannot escape the fact that a huge amount of research has gone into this book.

The human brain, he observes, while having the consistency of a "slightly overcooked blancmange" churns through more information in 30 seconds, while you sit doing nothing, than the Hubble Space Telescope has processed in 30 years!

In a chapter entitled 'Food, Glorious Food' Bryson takes the reader through the history of our understanding of nutrition



including the pre-human use of cooking to make more foods more accessible to humans as fuel. The research suggests that our ancestors were cooking food as much as 1.8 million years ago, "long before we were properly human" as Bryson puts it.

The book is comprehensive and has chapters covering every part and system of the body. It also covers sleep, conception, birth, nerves and pain, disease, medical progression and, of course, death, the chapter on which is aptly entitled 'The End'.

Of the book, Bryson himself said the following: "We spend our whole lives in one body and yet most of us have practically no idea how it works and what goes on inside it. The idea of the book is simply to try to understand the extraordinary contraption that is us. What I learned is that we are infinitely more complex and wondrous, and often more mysterious, than I had ever suspected. There really is no story more amazing than the story of us."

Full of extraordinary facts and amazing stories *The Body: A Guide for Occupants* is a clever, amusing and entertaining endeavour to explain the miracle of the physical side of being human.

– Alison Moore

The Body: A Guide for Occupants by Bill Bryson is published by Penguin. ISBN: 978-087522405. RRP STG £25

CROSSWORD Competition

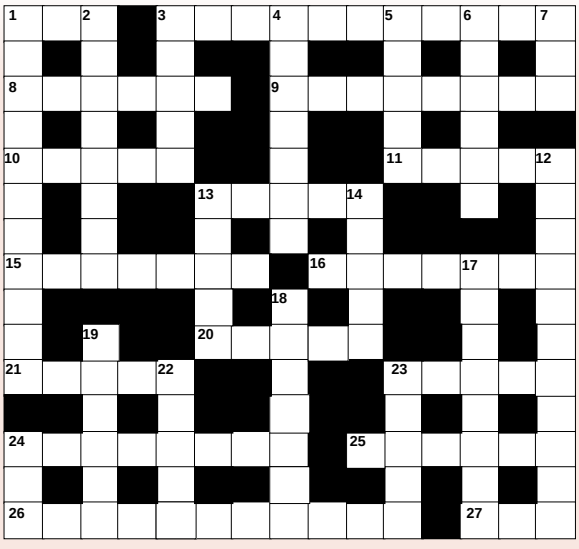
WIN a €50 gift voucher

Across

1 Type of rowboat, or a concert (3)
3 Was this relation Adam's second grandchild? (5,6)
8 Pattern associated with the family of Sailor Brown (6)
9 Mac (8)
10 Melodies (5)
11 Perish in water (5)
13 In the Bible, he had a whale of a tale to tell! (5)
15 Insists on having (7)
16 Some urinals are cut off by water (7)
20 Lacy table mat (5)
21 Head-case! (5)
23 Piece of shamrock, perhaps (5)
24 Piece of furniture in which to hang clothes (8)
25 Expert - on a TV panel, for example (6)
26 The 'R' of DNR (11)
27 Angling stick (3)

Down

1 Enjoy greyhound racing, but lose one's sensibility? (2,2,3,4)
2 Popular garden and house plant (8)
3 Tricolours, perhaps (5)
4 Maid found in strange taverns (7)
5 Possessed (5)
6 One's offspring has swallowed marijuana? That's exactly right! (4,2)
7 Mesh (3)
12 The grenade hits like that? One must be myopic! (11)
13 Worn out (5)
14 Sweetness from bees (5)
17 Breed of dog named for part of Canada (8)
18 Type of hazelnut (7)
19 Protects, keeps watch over (6)
22 Entices into breaking the rules (5)
23 Ketchup (5)
24 Conflict occurs when one opens 24 across! (3)



October crossword solution

Across: 1 Double vision 7 Opt 9 Ante 10 Fodder 11 Flax 14 Lacks 15 Kayak 16 Taco 18 Uncut 21 Dosed 22 Renal 23 Suede 24 Espy 25 Toxic 26 Shock 29 Puff 33 Evaded 34 Ewer 36 Emu 37 Red letter day

Down: 1 Don 2 Used 3 Loft 4 Vodka 5&9 Steak and kidney pie 6 Noel 8 Tax collector 12 Hyssop 13 Skids 14 Louse 17 Annexe 19 Creek 20 Trite 27 Hovel 28 Cadet 30 Four 31 Adze 32 Dead 35 Ely

The winner of the October crossword is: Zoe McHale Killarney, Co Kerry

You can now email your entry to us at nursing@medmedia.ie by taking a photo of the completed crossword with your details included.
Closing date: Thursday, November 28, 2019
If preferred you can post your entry to: Crossword Competition, WIN, MedMedia Publications, 17 Adelaide Street, Dun Laoghaire, Co Dublin, A96E096

Name:
Address:

Hospital-based service offers timely support to patients with sight loss

EARLIER this year, the National Council for the Blind of Ireland (NCBI) began its Eye Clinic Liaison Officer (ECLO) service aimed at providing support to patients at the point of diagnosis.

The service was rolled out at the Mater University Hospital, Children's Health Ireland (CHI) at Temple Street, St Vincent's University Hospital and the Royal Victoria Eye and Ear Hospital.

The service receives referrals from hospital outpatient clinics, inpatients and day surgery patients. ECLOs represent all VISPA partners – NCBI, ChildVision, Irish Guide Dogs and Fighting Blindness. Each organisation has its own unique service offering that the ECLO can highlight, matching the needs of each patient. The purpose of the ECLO role is to listen and signpost patients to appropriate services. Patients have often not had the opportunity to speak with someone in the clinic about their diagnosis and prognosis, and they may not have enough information about their eye condition or treatment. The patient may have experienced sudden traumatic sight loss or a slow gradual loss of sight.

The ECLO also has a key role in advocating on behalf of the patient and provides information and training to hospital staff, eg. sighted-guide training.

To date, the ECLO service has received 310 patient referrals, with over 140 onward referrals being made to community-based service providers including NCBI's lifecycle teams. In addition, 56 staff training sessions have been provided across the three hospital locations.

Feedback on the impact of the ECLO service has been positive. In total, 84% of surveyed patients felt their emotional wellbeing has increased having had contact with the ECLO. One patient described the fear she used to feel: "I used to be afraid to sleep in case I woke up totally blind. Now I feel more reassured."

Another wrote about the impact the ECLO has had on his career prospects: "The ECLO encouraged me to go back to work. I didn't think I could do it."

To celebrate the 100th referral from the ECLO service to NCBI on July 29, 2019, presentations were made at both CHI at Temple Street and the Royal Victoria Eye and Ear Hospital. The presentations highlighted the success of the role and recognised two 'champions' in both hospitals who have been particularly proactive in referring and advocating on behalf of the service. For further information about the service visit **www.ncbi.ie**

Pictured are members of the CHI at Temple Street ophthalmic department (l-r): *Claire McAntee; Aidan Quinn; Stephen Farrell; Hilary Devlin, NCBI; Tara Rose Devine; Sabrina Shanahan; Elaine Fitzgerald; Nora Mohd; Noree Jordan; and Paddy Murtagh*

Pictured are staff from the outpatient department at the Royal Victoria Eye and Ear Hospital (l-r): *Bríd O' Sullivan, Raluca Anghel, Monica Angues, Rhona Gallagher, Elaine Crossan (NCBI), Ann Lehane, Michelle Walsh, Jean Reeves, Niamh Ní Cheallaigh*

Cornmarket continues support of INMO Professional

Cornmarket Group Financial Services Ltd presented a cheque for €20,000 to INMO Professional last month in the Richmond Education and Event Centre. The INMO has a longstanding relationship with Cornmarket and appreciates its ongoing support. INMO Professional is committed to supporting the continuing education of nurses and midwives and delivers high quality, relevant and up-to-date programmes and courses. For further information visit: ***www.inmoprofessional.ie***

Pictured at the presentation were (front, l-r): Martina Harkin-Kelly, INMO president; Derek Delany, market manager, Cornmarket; (middle, l-r) Steve Pitman, INMO head of education and professional development; Edward Mathews, director of professional and regulatory services; back (l-r): Ivan Ahern, director at Cornmarket; and Phil Ní Sheaghdha, INMO general secretary

MAMMI study launches online resource

New repository will help women, mothers and health professionals

A SUITE of free on-line resources for motherhood aimed at women, mothers and healthcare professionals has been launched by the School of Nursing and Midwifery at Trinity College Dublin. The resources will provide evidence-based information aimed at addressing women's knowledge gaps, breaking the silence around embarrassing or sensitive health issues, and enabling women to self-assess and take action for their health.

The resources have been developed from the findings of the Maternal Health and Maternal Morbidity in Ireland (MAMMI) study, an Irish longitudinal study which examined the health and health problems experienced by over 3,000 first-time mothers around Ireland, and is based on what women said they wished they had known before they became mothers.

The findings suggest that although women experience a range of health issues in the postpartum period, the health of mothers is frequently overlooked or secondary to their baby's health, because the main focus of care is on child-health issues. These health issues, which are often preventable and curable if recognised and treated early, negatively impact on women's physical and mental health, preventing them from fully enjoying life and motherhood.

Following birth, postpartum healthcare and information becomes almost exclusively child focused; women say that they struggle to access reliable resources and trustworthy information regarding their own health and the health problems they might be experiencing.

The new on-line resources are divided into three areas:

- Women's Health After Motherhood (WHAM)
- Motherhood, Empowerment, Sustainable Self-help: Addressing Gaps in Education with Science (MESSAGES)
- Towards Recovery After Childbirth, through Knowledge (ON-TRACK).

The WHAM course, hosted on the FutureLearn platform, presents a diverse range of online resources, designed and developed by women who recently became mothers and maternal health experts. The educational materials aim to bring care home to women by offering them and professionals evidence-based content on postnatal maternal health in the form of videos, articles, interactive activities, downloadable infographics, self-assessments and coached tasks.

The new online resource was launched last month. The course offers advice and strategies on how to prioritise postpartum care and help women to support one another during the postpartum period. It addresses common physical and mental health challenges after birth, and teaches women how to help themselves and when to seek professional healthcare

The MESSAGES project contains self-help and educational videos and materials to help women understand the causes of, and conservative treatments for, urinary incontinence. The resources include material to help women self-assess and track their progress. The MESSAGES project is funded by Science Foundation Ireland.

ON TRACK is a series of education videos on pelvic girdle pain, postpartum sexual health and postpartum anxiety funded by the Health Research Board Knowledge Exchange Dissemination Scheme (KEDS).

Dr Deirdre Daly, assistant professor in midwifery and principal investigator of the MAMMI study, said:

"The MAMMI study was set up as a study with and for women. From the very start, and especially after we shared the findings with women at various events and seminars, women kept telling us to 'do something about these findings', 'you have to break the silence' and 'you have to do something to make it better for future mothers'.

"Working in partnership with MAMMI study participants, healthcare professionals including women's health physiotherapists, a perinatal psychiatrist, and other experts in mental health, sexual health and domestic violence, we spent the last year designing these wonderful, reliable and trustworthy resources for women, and for healthcare professionals to use to complement their practice. The fact that these resources are co-designed with women means they are highly relevant to women as they become mothers. They cover, in the words of so many women, 'what I wish I had known'."

Naomi Donaldson, from Dublin, a participant in the MAMMI study who assisted in the development of the new resources, said: "Every question I had as a new mother felt like a stupid question to me. I felt I was the only one experiencing motherhood as I did. I realised through the MAMMI study that for the most part, everyone is going through the same thing. Those 'stupid questions' aren't stupid at all and they are all answered within the new on-line resources that are being launched today. If the resources had been available when I had my baby, they would have allowed me to prepare myself for the loneliness, isolation and guilt you feel as a new mum."

Margie McCarthy, head of education and public engagement at Science Foundation Ireland, said:"Science Foundation Ireland is delighted to support the MESSAGES project, which highlights how clearly written, easy-to-access evidence based literature can significantly improve people's everyday lives. By working directly with mothers who have experienced issues after childbirth to co-create these important resources, they are more effective, more relevant and accessible to all."

To find out more about the suite of online resources, visit: **www.futurelearn.com/courses/womens-health-after-motherhood**

November

Tuesday 12
Care of the Older Person Section meeting. INMO Cork office. 10.30am

Thursday 21
OHN Section conference. The Richmond Education and Event Centre. See *page 41* for full details and how to book

Wednesday 27
CPC Section meeting. The Richmond Education and Event Centre

Saturday 30
ODN Section conference. The Richmond Education and Event Centre. See *page 46* for full details and how to book

Saturday 30
PHN Section meeting. INMO HQ

Saturday 30
Community RGN Section meeting. INMO HQ

January

Thursday 9
Retired Section Christmas lunch. Wynns Hotel, Dublin. Contact Anne Igoe at Tel: 087 7735735

Saturday 18
PHN Section AGM and meeting. The Richmond. 11am

Saturday 18
Community RGN Section
AGM and meeting. The Richmond Education and Event Centre. 11am

Tuesday 21
Telephone Triage Section AGM and meeting. Midlands Park Hotel, Portlaoise

Clarification

- The article *Access all areas* published in the October issue of *WIN* was written by Ciara Conlon, Kieran Harkin and Sheila Fitzgerald. Originally it was stated that the article was written by Ciara Conlon "with the help of Kieran Harkin and Sheila Fitzgerald"

Thursday 23
Retired Section AGM and meeting. The Richmond Education and Event Centre. 11am

Saturday 25
School Nurses Section
AGM and meeting. The Richmond Education and Event Centre. 10.30am

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

Retirement

- The INMO and colleagues and staff of the Mater Misericordiae University Hospital extend their gratitude to **Dolores Coughlin** on the occasion of her retirement and to express their best wishes for a long and healthy retirement.
  – Albert Murphy, assistant director of industrial relations, Dublin North/North East

Conferences

- The 21st National Conference and AGM of the Irish Nephrology Nurses Association will take place on April 24, 2020 at the Maldron Hotel, Tallaght, Dublin 24. Visit **www.inna-ireland.com** for further details of cost and registration details
- March 31, 2020. Children's Nursing Research Conference, Centre for Learning and Development, Tallaght University Hospital. For further details, please visit **www.cuh.ie/research-education/annual-nursing-research-conference/**

INMO Membership Fees 2019

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

Condolences

- The INMO and all in the Sligo Branch would like to extend their deepest condolences to Ann Judge on the death of her mother Mary in August. May her soul rest in peace
- The INMO management team and Executive Council wish to extend our deepest sympathies to John Delamere and his family on the death of his sister Breda in September after a long illness. *Ar Dheis Dé go raibh a h-Anam*
- INMO staff, Executive and members would like to wish former president Kay Craughwell and her family our deepest sympathies on the recent passing of her nephew Daniel (Danny) Craughwell. May he rest in peace