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WIN

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Midwives Organisation

World of Irish Nursing & Midwifery

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Agreement ratified – pay and staffing remain priorities

AS YOU will see from other articles in this issue of *WIN*, the Organisation's members, following nationwide ballot, have voted to accept the new Public Service Pay Agreement, which will be known as the Public Service Stability Agreement 2018-2020 or Lansdowne Road 2 for short.

In the course of literally hundreds of information meetings and balloting sessions in early September, members repeatedly said that in voting to accept the agreement, progress on the pay/staffing issues remained their absolute priority. In that context the elaboration that the INMO obtained – in relation to the recruitment/retention section of the agreement – was the subject of much discussion with members legitimately demanding assurances that the timeframe for early progress would be adhered to.

Following the INMO's acceptance, the Public Services Committee of the ICTU met and the agreement has been formally ratified by a very large majority of public sector unions. In the final result, over 80% of all union delegations voted to accept the agreement – one of the largest majorities in favour of recent public service pay agreements.

For the INMO the priority issues as we face into the coming months will be for our pay and staffing priorities to be progressed either through the procedures laid down in the new agreement or, particularly in relation to staffing related matters, full implementation of earlier agreements in such areas as the Funded Workforce Plan for 2017, the further roll out of the Taskforce on Nurse Staffing (medical/surgical wards) and the ED Taskforce initiative.

It is quite clear, particularly about the critical issue of staffing, that we continue to receive mixed messages from the management side, especially with regard to: the filling of all vacancies; offering permanent posts to all nurses/midwives on panels and new graduates; and the filling of vacancies due to maternity leave.

Members will recall the Minister for Health, at our ADC in May and other occasions, repeatedly asserting that all 2016/17 graduates would be offered permanent, full-time posts. This explicit commitment is a central tenet of the staffing agreement reached earlier this year.

However, as I write this editorial, it is still clear that in some areas of the country, particularly along the west coast, a number of employers have failed to offer such permanent posts and continue to offer short-term contracts or, in two areas, no offer of employment whatsoever. The INMO is pursuing this matter as I write, but it is totally unacceptable that in late September new graduates have not been given the guarantee of employment in the form of permanent posts promised repeatedly earlier in the year. It is clear that the HSE, at operational level, continues to ignore national agreements, and even ministerial commitments, when it suits. This cannot continue if we are to deliver on the 1,000 additional nursing/midwifery posts committed to within the Funded Workforce Plan for 2017.

In addition to progressing the pay issues under the new agreement and delivering on the Funded Workforce Plan, in the last quarter of 2017 the Organisation will also prioritise the further roll out of the work of the Staffing Taskforce on Medical/Surgical wards. You will recall that this is a key instrument in ensuring consistent, safe and manageable workloads on all medical/surgical wards, through the use of an evidenced-based dependency tool by the ward's clinical nurse manager, and it represents a significant step towards our goal of nurse/patient ratios. On this issue, the INMO has sought to bring forward a three-year plan, which would see full implementation of the Taskforce's recommendations across the country's 250 medical/surgical wards.

You can see that the agenda is well set to progress our pay and staffing issues and the coming months will see the Organisation redouble its efforts on these areas. We have heard and understood the feedback from members and these twin objectives will be central to all of our work in the coming weeks and months.

Liam Doran
General Secretary, INMO

Your priorities with the president

Martina Harkin-Kelly, INMO president

PSSA balloting and information sessions

I ATTENDED four of the eight regional information sessions on the Public Service Stability Agreement (PSSA or LRA 2) facilitated by the INMO management team in Dublin, Tullamore, Drogheda and Donegal. The first and second vice attended Galway and Cork respectively, and Executive Council members supported meetings in their areas. The function of these meetings was to set out the rationale underpinning the Executive Council's decision to recommend acceptance of LRA2. This union operates a policy of informed decision making, therefore the meetings, in conjunction with updates, the website and social media platforms, provided YOU the member with timely and accurate information on LRA 2. These sessions along with over 300 workplace meetings also served to facilitate the balloting process that played out until September 14 and concluded with counting on September 15 in HQ. You have spoken and returned a 75% vote in favour of the Executive's recommendation. When the ICTU Public Services Committee met on September 18 a very strong majority was in favour. The teaching unions are the only large group to vote against – or will they simply accept the aggregate ballot? However, the Government side may come up with a formula of words to reassure them about the new-entry pay issue, but whether we like it or not fiscal constraints are a real issue faced by government. As your president, I am willing to see where the modular process navigates us when the Public Service Pay Commission at the end of Quarter 2, 2018, issues its review of the recruitment and retention agenda that is so critical.

National Implementation Group – union side meeting

A further meeting between Sean McHugh, chair of the National Implementation Group, and the union side was held on September 1. The issues surrounding implementation nationally are real. According to the quarterly HSE Report forwarded to the Oireachtas on September 30, the same issues are being encountered. However, central to the agreement is the funded workforce plan, which is being stalled by particular groups. It is felt that this is in a bid to save money. We require *action* on this national agreement – not retraction!

ICTU Women's Seminar

THE ICTU Women's Seminar held in Portlaoise on September 7-8 was attended by a strong delegation of INMO members. The theme this year was *'Inclusive growth – the route for achieving gender equality'*. Charlie Flanagan, Minister for Justice and Equality, was in attendance and in conjunction with Patricia King, general secretary of Congress, provided the opening address. 'Moving beyond the pay gap rhetoric' predominated Ms King's inspiring speech, which can be accessed on **www.ictu.ie**

INMO centenary book

I AM delighted to report that the INMO centenary book is progressing with draft chapters that catalogue events right up to present day now written. The centenary book editorial committee met to review the latest instalments on September 6. As you can imagine the past 20 years alone constitute a book in its own right, given the pace of change in the nursing/midwifery landscape. Nevertheless, author Mark Loughrey has managed to capture key events that have shaped this union. Await further developments before Christmas!

Capacity review submission

Following on from August's Executive Council meeting, a subcommittee was convened, comprising the two officers, the general Secretary, the librarian and myself. The submission took on board the need to emphasise a single-tiered healthcare system. Key areas highlighted were staff shortages, bed capacity and demographics.

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

Quote of the month

"Don't find fault, find a remedy"
– Henry Ford

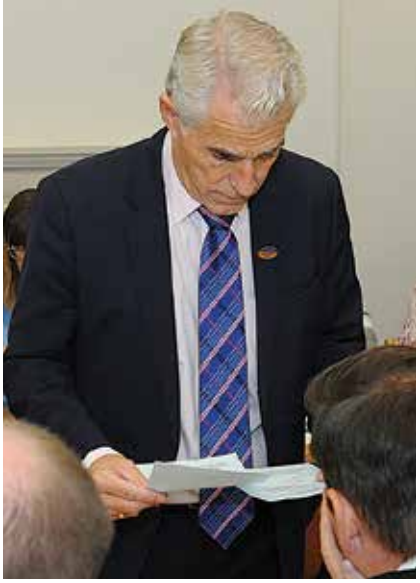
Report from the Executive Council

WHEN the National Executive met on August 28-29, the decision it faced once again was not easy. However, after deliberation and debate, the decision was taken to recommend acceptance of LRA2 on the basis of the Pay Commission modular review of the recruitment and retention process. Until that review, for any HSE management and you, the member reading this article, it is imperative that the Department of Health and the HSE implement in full the nursing and midwifery funded workforce plan ('funding' being the key word which explicitly states that ALL vacancies are to be filled with permanent full-time contracts being offered to ALL members on panels and ALL 2016/17 graduates). How difficult can this be to understand? Yet, it was obvious from the debate at Executive that directors of nursing/midwifery are being asked to complete business cases and only offer temporary contracts. All I can say is that my patience is running very thin. In the interest of patient safety (the business we're all in) being penny wise and pound-foolish compounds the utter stark conditions that you as the members are forced to work in on a daily basis. We have kept this very real, the Executive is made up of ordinary members who are all too well aware of working conditions.

Executive Council meetings: October 2-3, 2017 and November 6-7, 2017.

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



Every vote counts: *INMO members voted 75% in favour of acceptance of the Public Service Stability Agreement 2018-2020*

INMO members vote to accept LRA2

INMO members voted to accept the Public Service Stability Agreement 2018-2020 by a margin of 75% in favour, 25% against, in a nationwide ballot which took place over three weeks, concluding with the count on September 15.

This followed a recommendation from the Organisation's Executive Council to vote in favour of the proposed agreement. The INMO result emerged just ahead of a meeting of the ICTU Public Services Committee on Monday, September 18, at which the overall agreement was formally ratified.

The INMO is now seeking immediate engagement on the recruitment/retention section of the agreement. This section provides for the Public Service Pay Commission (PSPC), through the use of relevant experts, to identify all measures necessary to address the recruitment/ retention crisis facing nursing/ midwifery.

In the clarification, obtained by the INMO, it was agreed that the PSPC will issue its first modular report, involving nursing/midwifery, in the second quarter of 2018. The INMO will engage with this process, insisting that this timeline is honoured including the commitment that the management side will sit down, within four weeks of the report being issued by the PSPC, to discuss implementation of all measures (including pay) recommended.

INMO president Martina Harkin-Kelly said: "In recommending acceptance of, and voting for, this agreement it must be clearly understood the INMO will require progress on all measures necessary to address the recruitment/retention crisis which continues to haunt our health service.

"In tandem with fully implementing this agreement we will continue to insist upon the Department of Health/ HSE also implementing, in full, the nursing/midwifery funded workforce plan for this year. This explicitly stipulates that all vacancies will be filled and permanent full-time contracts be offered to all members, on panels, and all 2016/2017 graduates."

Phil Ní Sheaghdha, INMO general secretary designate, said: "In the hundreds of workplace meetings we have held with members in recent weeks, it is clear that in accepting this agreement members expect that pay related measures, to address the recruitment and retention crisis, will be brought forward and implemented over the lifetime of this agreement. We look forward to engaging with the PSPC in the coming weeks, allowing it to report in the second quarter of 2018.

"The government and health service management now have one further opportunity, under this agreement, to address our parity claim, with other degree level health professionals, and any failure, or hesitancy, to do so will not be tolerated by our members".

INMO calls for significant expansion of health service

In its recent substantial submission to the Health Service Capacity Review 2017, the INMO argues for a significant enlargement of our public health service.

The INMO submission to this review, which is being undertaken by the Department of Health, states that the capacity of the health service, both in terms of human and capital resources, must be increased significantly. The Organisation backed up this opinion with a large body of research work (see **www.inmo.ie**)

In particular the Organisation said that the increase in capacity, which is required to meet current and future demand, must involve:

- A 25% increase in the number of nursing/midwifery posts in the public health service
- A significant increase in acute bed capacity to bring us in line with the average in OECD states – currently Ireland has 2.8 beds per 1,000 population with the OECD average being 4.8 per 1,000
- An increase of up to 2,000 in the number of long-term care beds to cater, within the public health sector and in a quality assured manner, for the significant growth in the number of older people that will take place over the next 20 years
- A significant expansion of community nursing services so that it can provide seven day cover on an extended day basis
- A significant expansion of our primary care infrastructure, including enhanced access to diagnostic facilities/services on an extended day basis.

In the submission the INMO argues that the health service, in its current form, is wholly inadequate to deal with the demands being placed on it. This is manifest in the record levels of trolley overcrowding *(see page 10)* and in the record numbers of patients waiting for inpatient/elective procedures and even for outpatient department appointments.

The INMO made this submission at the beginning of September, and has indicated it is available to meet with the Department's review team to elaborate on the points made.

Overcrowding at record levels again

INMO calls for implementation of emergency measures

HOSPITAL overcrowding levels have once again reached a record high, according to the latest INMO trolley/ward watch which recorded a 27% increase in trolleys in August 2017 (7,781) compared to August 2016 (6,136).

A further serious indication of the growing crisis is the fact that in the first eight months of the year 65,455 people were admitted for care but had no bed, which represents a 7% increase on 2016 but a 90% increase on 10 years ago, 2007.

The August figures were released ahead of a meeting of the national Emergency Department Implementation Group on September 4.

The hospitals which experienced the highest levels of overcrowding, in August, were:

- University Hospital Limerick – 835 (32 in 2007)
- University Hospital, Galway – 643 (123 in 2007)
- South Tipperary General Hospital – 489 (82 in 2007)
- University Hospital Waterford – 486 (0 in 2007)
- Cork University Hospital – 457 (189 in 2007)
- Midland Regional Hospital, Tullamore – 452 (2 in 2007)
- Mater Hospital Dublin – 436 (315 in 2007).

In view of these figures the INMO, at a meeting of the national Emergency Department Implementation Group on September 4, called for all emergency measures identified in the taskforce 2015 report to be implemented, including:

- Senior clinical decision makers rostered on an extended day basis over seven days
- Nurse managers provided with full autonomy to recruit additional staff to ensure patient care standards are maintained
- Senior general managers present in the hospitals on a 24/7 basis
- Full implementation of the national directive on escalation, which was signed jointly by the Minister for Health and director general of the HSE and directs

Table. INMO trolley and ward watch analysis (August 2006 – August 2017)

Hospital	Aug 2006	Aug 2007	May 2008	Aug 2009	Aug 2010	Aug 2011	Aug 2012	Aug 2013	Aug 2014	Aug 2015	Aug 2016	Aug 2017
Beaumont Hospital	232	408	713	520	504	596	304	508	490	678	335	265
Connolly Hospital, Blanchardstown	162	259	255	152	359	354	386	464	271	364	138	187
Mater Misericordiae University Hospital	197	315	487	385	354	333	328	82	285	218	316	436
Naas General Hospital	206	68	122	199	292	221	65	40	230	273	95	304
St Colmcille's Hospital	39	42	48	145	96	126	171	47	n/a	n/a	n/a	n/a
St James' Hospital	8	41	120	174	31	77	60	104	165	101	108	117
St Vincent's University Hospital	385	545	271	354	509	587	432	74	191	335	284	134
Tallaght Hospital	227	399	319	237	457	335	47	357	188	395	121	381
Eastern	1,456	2,077	2,335	2,166	2,602	2,629	1,793	1,676	1,820	2,364	1,397	1,824
Bantry General Hospital	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	0	7	15	68
Cavan General Hospital	216	141	263	177	168	382	142	228	42	84	27	67
Cork University Hospital	319	189	329	272	453	418	151	261	115	399	473	457
Letterkenny General Hospital	330	59	24	35	36	70	32	7	152	235	128	241
Louth County Hospital	34	4	0	12	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Mayo University Hospital	131	97	28	64	126	8	109	15	10	105	175	114
Mercy University Hospital, Cork	90	108	69	38	117	44	137	122	130	98	243	256
Mid Western Regional Hospital, Ennis	94	9	17	23	26	20	24	0	n/a	5	20	0
Midland Regional Hospital, Mullingar	16	2	5	5	46	264	109	178	410	149	254	391
Midland Regional Hospital, Portlaoise	31	8	13	7	9	125	20	100	82	77	287	260
Midland Regional Hospital, Tullamore	5	2	5	7	71	89	77	22	169	267	290	452
Monaghan General Hospital	13	4	17	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	2	0	0
Our Lady of Lourdes Hospital, Drogheda	301	91	293	289	236	776	604	165	346	680	391	93
Our Lady's Hospital, Navan	77	34	90	57	50	93	13	36	33	56	35	164
Portiuncula Hospital	2	10	2	67	62	97	32	45	48	49	40	52
Roscommon County Hospital	23	9	14	25	106	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Sligo Regional Hospital	56	70	13	34	140	24	277	81	71	158	144	90
South Tipperary General Hospital	12	82	52	33	4	1	153	166	82	115	470	489
St Luke's Hospital, Kilkenny	n/a	n/a	n/a	n/a	13	52	55	139	84	255	197	432
University Hospital Galway	76	123	238	256	232	554	195	146	319	458	400	643
University Hospital Kerry	94	55	9	9	37	70	81	49	95	108	148	170
University Hospital Limerick	29	32	85	105	186	342	247	224	458	618	610	835
University Hospital Waterford	n/a	n/a	25	18	64	76	120	180	47	159	291	486
Wexford General Hospital	293	13	189	344	140	490	44 7	3	135	70	101	197
Country total	2,242	1,142	1,780	1,877	2,322	3,995	2,622	2,237	2,828	4,154	4,739	5,957
NATIONAL TOTAL	3,698	3,219	4,115	4,043	4,924	6,624	4,415	3,913	4,648	6,518	6,136	7,781

Comparison with total figure only:

Increase between 2016 and 2017: 27%
Increase between 2015 and 2017: 19%
Increase between 2014 and 2017: 67%
Increase between 2013 and 2017: 99%
Increase between 2012 and 2017: 75%
Increase between 2011 and 2017: 18%
Increase between 2010 and 2017: 58%
Increase between 2009 and 2017: 93%
Increase between 2008 and 2017: 89%
Increase between 2007 and 2017: 142%
Increase between 2006 and 2017: 110%

hospital managements to:
– implement certain measures, on a daily basis, in response to signs of overcrowding
– review capacity, for services, on a daily basis
– introduce fines for hospitals that do not implement this national directive to manage overcrowding.

The INMO welcomed the recent comments from Minister for Health Simon Harris confirming the need for a major increase in the capacity/size of the health service. What is now required is for the whole of government to provide additional resources to allow this increase in bed and service capacity, over the next three years.

INMO general secretary Liam Doran said: "There is no doubt that the level of attention required to manage trolley overcrowding has dropped in recent months. The abnormal and very harmful and detrimental effects of overcrowding are no longer viewed as requiring urgent action, as the HSE focuses on measuring and counting the problem rather than addressing it.

It is clear that setting of targets, whether they be for patients over 75 years, patients waiting to be seen or patients waiting for a decision to admit/discharge has not had any positive effect on the management of the overcrowding crisis. The monitoring and reporting of the targets has now become the priority for management rather than the actions necessary to protect patients and frontline staff.

"In the context of successive months, with record levels of overcrowding, serious concerns should be apparent to all in the ED Implementation Group, as we enter the autumn/winter period. Management, at all levels, must implement the actions detailed in the taskforce report, on a 24/7 basis and treat this crisis as a national emergency."

INMO to pursue priority issues following acceptance of stability agreement

FOLLOWING the mandate given by the workplace ballot of its members, the INMO has voted for the acceptance of the new Public Service Stability Agreement by Congress.

At a meeting of the ICTU Public Services Committee on Monday, September 18, 2017, a total of 15 unions voted to accept the agreement, which will run from 2018-2020, with three unions voting against and one ICTU affiliate still to ballot.

Full details of the pay and other measures in the agreement were included in last month's issue of *WIN* and can be accessed on the INMO website, **www.inmo.ie**

Following the formal acceptance of the agreement, the INMO is now prioritising a number of significant issues, including:

- Immediate engagement with the management side with regard to initiating the review under the recruitment/retention clause of the new agreement
- Seeking the commencement by the Public Service Pay Commission (PSPC) of this review, by independent experts, who will present their findings to the PSPC. The PSPC has indicated it will issue its report on the nursing/midwifery recruitment/retention issues in the second quarter of 2018
- An integral part of this review, by relevant experts, will be consideration of the INMO's demand for pay parity, between nurses/midwives and all other degree level health professionals, consistent with the motion adopted at the Organisation's annual delegate conference last May
- In tandem with this, the Organisation will continue to meet with the Implementation Group on the Staffing Agreement, ensuring delivery of the funded workforce plan, which involves over 1,000 additional nursing/midwifery posts by the end of this year
- A critical part of the staffing agreement is the filling of all vacant posts, permanent, full-time contracts for all nurses/midwives on panels, and all 2016/2017 new graduates – the INMO will insist on full implementation of this staffing agreement in the coming weeks
- In addition the Organisation will also be meeting with the Department of Health shortly to agree a funded workforce plan for 2018, which will see another increase in staffing levels next year as we demand full restoration of all staffing cuts imposed in recent years
- The INMO will continue to participate in phase 2 of the Medical/Surgical Staffing Taskforce, which involves the further rollout of an agreed dependency tool, managed by the CNM2, to stabilise staffing in the 246 medical/surgical wards across the country
- The INMO will also continue the work of the Taskforce on Staffing in Emergency Departments with pilot sites being finalised.

Speaking following the acceptance of the agreement and the ICTU meeting INMO general secretary Liam Doran said: "The outcome of the recent ballot is a clear instruction to the Organisation to seek the implementation of this agreement and, in particular, the section which deals with recruitment/retention issues.

INMO general secretary Liam Doran: *"The outcome of the recent ballot is clear instruction to the Organisation to seek implementation of this agreement and, in particular, the section which deals with recruitment/retention issues"*

"The Organisation has already been in contact with the Public Service Pay Commission, and the officers of the Public Services Committee of Congress, looking to initiate the processes, which emerged following the INMO's demand for elaboration on this section of the agreement. This is expected to begin within the next four weeks.

"In addition acceptance of the agreement also requires the Organisation to continue to prioritise, at national and local level, the implementation of various other agreements, ie. staffing agreement, taskforce recommendations and the ED agreement in order to ensure the management side meets all of its obligations in relation to same.

"In addition we will begin discussions, shortly, with the Department of Health on a funded workforce plan for nursing and midwifery for 2018. From an INMO perspective this plan must include another significant increase in the number of nursing/midwifery posts in the public health service in 2018."

Tony Fitzpatrick, INMO interim director of industrial relations, reports

INMO partaking in review of policy on safeguarding vulnerable adults

WHILE the Safeguarding Vulnerable Adults at Risk of Abuse – National Policy and Procedures 2014 – Review Development Group was convened at the beginning of 2017, the INMO only received an invitation on August 31, 2017 from Pat Healy, HSE national director of social care, further to a WRC agreement, to participate in the group.

The Review Development Group (RDG) was established to review the policy that has been in existence since 2014. Essentially, the group must set out a proposed review process with timelines, including a consultation process and identification of stakeholder individuals, organisations and groups to be consulted.

The review group will conduct a literature search in relation to safeguarding best practice and consult with external experts with expertise in the field of safeguarding vulnerable adults. It is planned that the RDG would make recommendations to a HSE oversight group by the end of the year, with regards to a re-drafting of the policy.

The review group has three subgroups, entitled literature review, governance and consultation. The work of the subgroups is at an advanced stage, having conducted workshops and surveys.

The RDG has written to stakeholders, seeking written submissions by September 29, 2017. The INMO is preparing a submission with the assistance of a working group. The RDG is to receive a presentation from Prof Michael Preston Shoot from the UK on October 10, 2017, with a further meeting planned for November 15, 2017.

The INMO has raised a number of issues with the review group, including the need for a definition of institutional/organisational abuse, and appropriate supports for whistleblowing. We reinforced that Trust in Care is the only procedure in place to investigate complaints against employees and some further operational concerns.

Separately we await confirmation that the addendum to the policy agreed at the Workplace Relations Commission will form part of all future training.

Issue of peer vaccination referred to WRC

THE issue of peer vaccination has been referred to the WRC for conciliation, as the INMO understands this programme was due to re-commence this autumn, despite no agreement on staffing implications.

In September 2016, the INMO raised objections to this programme due to non-consultation prior to the roll out of the Guidelines for Staff on Peer Vaccination and the staffing implications of this programme.

There is a national agreement between the HSE and the INMO and other unions, that any change to contract or any policies/procedures that would alter conditions of employment have to be negotiated with the unions representing staff involved. This did not happen in respect of the guidelines for staff on the peer vaccination programme issued in July 2016.

Nurses and midwives who are contracted to work in the HSE for a set number of hours, cannot be redeployed to peer vaccination without a collective agreement governing this redeployment.

As stipulated in the programme, nurses and midwives are asked to volunteer to undertake peer vaccinations. The INMO does not accept that the HSE can ask people to volunteer without taking into account the gap in service that this would leave, due to management insistence on no back filling/cover of the work that is created by volunteering to partake in this programme.

As there is an acute shortage of nursing and midwifery staff, this programme can only be rolled out on the basis that this is additional work, over and above the current contract between the HSE and its nursing and midwifery employees. Additional work requires additional staff. Therefore, the INMO has clearly indicated that if this work is undertaken on an overtime basis, this removes the concern of leaving the workplace short.

As Management would not agree to the above, the matter has been referred to the WRC.

The INMO stressed that, as this matter is in dispute, *members should not engage with the programme until matters have been heard and agreement reached at the WRC*. A date for this conciliation conference is due to be issued shortly.

Members with queries on this should contact their local IRO.

on current national IR issues

INMO seeking re-confirmation on issues relating to transfer of tasks in the acute sector

FOLLOWING the final verification report on the transfer of tasks – nursing/medical interface in the acute sector the INMO sought re-confirmation on several issues, including:

- That the task is undertaken by the staff member who is most appropriate to do it, at that time and in that location
- That these tasks are no longer solely the responsibility of the doctor and are being undertaken by and shared with nursing/midwifery staff
- Local implementation groups need to remain in place and should ensure that any issues that arise are dealt with swiftly, at a local level

In addition, the INMO sought sufficient and realistic access to training for nursing and midwifery.

However, it is important that nurses and midwives are not expected to do this training in their own time. Furthermore, there is a need for clinical supervision on the wards to complete the competency assessment.

The INMO sought confirmation that phlebotomy services would be fully maintained and believed that local implementation groups could examine any need for expansion of phlebotomy services. INMO officials have indicated that there are deficits with regards to phlebotomy provision on weekends.

It must be recognised that recruitment and retention challenges for nurses and midwives, short staffing on the wards, high reliance on agency and student nurses/midwives, and the dilution of skill mix at particular times may make it difficult for staff to complete the task and therefore there is a need for co-operation and task sharing.

Should members have any queries in relation to the transfer of tasks, please contact us.

Staff in the acute sector are now in receipt of time plus one sixth payments for following the transfer of tasks, as agreed under the LRA.

Meanwhile, the restoration of this premium payment to for those working in the social/primary care sector was confirmed in July.

WRC called on to assist with issues on Limerick wards

THE Workplace Relations Commission attended at the University Hospital Limerick on September 12, following a referral by the INMO and SIPTU, on conditions of employment, health and safety of nurses and staffing levels on specified inpatient wards.

The INMO highlighted to the WRC that the situation at the hospital is exacerbated by the following:

- Management breaching union agreements on staffing
- The ad hoc opening and closing of unfunded bed capacity with no additional nursing staff
- Failure to consult with unions and an unsafe hospital escalation plan to cope with demand on bed capacity
- The persistent deteriorating overcrowding, leading to risks for patients and staff
- Directives being issued to nursing staff to undertake unworkable caseloads
- Repeated requests for fire safety reports for wards has gone unattended.

At the hearing the hospital management present acknowledged to the WRC the difficulties raised by the INMO as being caused by the increasing service demands.

Management agreed at the WRC to meet with the INMO and other unions in a meaningful engagement process to address the concerns of nurses on the wards.

The ERC will review progress in the engagement process after six weeks.

– Mary Fogarty, INMO IRO

Agreed implementation of roster changes to commence in St Camillus Hospital

AGREEMENT was reached between the INMO and HSE management on a series of staffing issues at St Camillus Hospital, Limerick, at the Workplace Relations Commission in March 2016.

These issues include revised rosters and incorporating in full the role of the healthcare assistant (HCA) into the nursing team.

HSE management has now agreed an implementation timeframe for the new rosters with engagement to commence in mid-October with the revised HCA role commencing in January 2018.

– Mary Fogarty, INMO IRO

See **www.inmo.ie** for ongoing updates on all industrial relations issues

Fake news, wild cats and George Hook

It's time to stop and think before reacting, writes **Dave Hughes**

US PRESIDENT Donald Trump can be credited with giving us at least one new phrase for a phenomenon previously known as 'spin'. In his campaign and since, Trump has repeatedly referred to 'fake news' to the point where it has now become common speak among journalists, broadcasters and politicians.

Spin

Alistair Campbell, Tony Blair's 'master of spin', was adept at making good news from bad. Donald Trump, although essentially referring to the same thing, has gone a step further by suggesting that in some cases stories are entirely false and made up and yet reach vast audiences.

For example, on September 11, trolley numbers, according to the INMO's trolley/ward watch, reached 422 nationally between wards and EDs. The most overcrowded hospital was the Mid-Western Regional Hospital in Limerick, with 52 people on trolleys, many of whom had spent many hours in that position. Frustrated relatives must have been completely bewildered if they were Twitter users. That same day the very highest echelons of the HSE tweeted of their wonderful experience of the health service in Limerick, with the launch of a report by the CHO on 'integrated delivery of care'.

One could reasonably ask if the tweeters were in the same location or were they aware of the other things that were happening in the hospital that day, and if so would they have tweeted so enthusiastically? Of course there is nothing wrong with saying that a plan for integrated care is worthy of positive publicity. But in the real world there is no parallel universe in which you can ignore an overcrowded hospital in the same area while doing so.

The second occasion was probably a more deliberate attempt at spin. Those who are informed on trade unionism and the health service would have been shocked to hear that doctors were engaging in a 'wild cat strike'. This was a headline carried on the RTE1 *Nine O'Clock News* and repeated on a number of news bulletins and on *Morning Ireland* the next morning.

The reason for surprise, was that the doctors involved were not actually employees of the health service but agency medics, who were entitled to respond, or not, to a call from their agency. Whether there was a concerted plan behind the unavailability of agency medics on the day in question might be debated, but it clearly was not a strike as they were not employees.

The full story was that the HSE had changed contract arrangements for the engagement of agency staff in hospitals. In the case of nurses and midwives, the contract changed from one agency to another and new rules were brought in regarding what to do when the agency could not meet demand. There was an absence of consultation with the trade unions or the nurse/midwife managers responsible for the recruitment of agency staff, as is a requirement under the Information and Consultation Directive.

The problem, which was masked by the coverage of wild cat strikes, was that the agency nurse/midwife did not necessarily know that they had to sign up with an alternative agency in order to get work, while the agency that they were already registered with, was encouraging them to stay. The description 'wild cat strike' was disingenuous as the situation was entirely caused by the poor planning and implementation of a change by the employer.

We live in an age where news is imparted in many different ways. Newspapers are arguably the slow train now for news and even television news bulletins and 24 hour news services are often late with news compared with the speed at which Snapchat, Instagram, Twitter or Facebook can convey messages to mass audiences within seconds of an occurrence.

The access to such wide methods of publication now means that every individual connected to the internet can publish anything – true or untrue. While newspapers and other media are fairly tightly controlled because defamation law clearly applies, it is more difficult to assert one's rights due to inaccurate or damaging material published on social media.

Much of what is published on these fora is opinion and not news. One can observe an inability on the part of huge swathes of the population to read any more than a single paragraph before forming a view and making a judgement.

George Hook

However, with a station called Newstalk one would expect news and not off-the-top-of-the-head broadcasting, based on a cursory reading of a newspaper report.

One would expect that even shock-jock tactics used to generate controversy, would be properly researched and that the host would not put themselves in a position where they had to unreservedly apologise due to public reaction, or possibly reaction of the advertisers, to the outburst.

There is no doubt that in his career George Hook has been entertaining, sometimes outrageous and often self-effacing. He has sailed close to the wind before but when he reported on a UK court case of an alleged rape, he clearly went too far in what has been accurately described as victim blaming.

Is it the end of his broadcasting career and is such a *faux pas* a good reason to dismiss him from his job? Perhaps the best way to judge that is by George's own standard. A little over a week earlier he launched a scathing attack on the HSE CEO and the Health Minister.

He seized on an unfortunate description, given by the CEO, in respect of those who cast doubt on the HPV vaccination. The CEO described the campaign as emotional terrorism and George, in an over the top outburst, described the Minister in derogatory terms comparing him to a schoolboy. There is an adage that says 'if you live by the sword, you die by the sword' and that is what is facing George now.

When it comes to fake news, the only real protection we have is our own critical awareness. We should avoid rushing to hasty judgement based on scant information, and should always probe and seek the fullest possible information, before forming opinion or expressing it. We should be as careful about what we put on social media as we are about what we say to people directly. Such a simple yardstick might avoid a lot of hurt for a lot of people and lead to a new sense of etiquette and decorum in a world where we have all assumed the rights of publishers.

Homelessness now national emergency

Worst housing crisis ever experienced by the state. Freda Hughes reports

IRELAND is currently in the middle of the worst housing crisis this state has ever experienced according to a national homeless and housing agency which was addressing the Irish Congress of Trade Union's recent briefing session on homelessness in September.

Mike Allen, director of advocacy in Focus Ireland – one of Ireland's leading homeless and housing organisations, said that since 2014 the number of homeless families has increased by more than 300%.

There are currently 7,941 people dependent on emergency homeless accommodation, of who 2,895 are children. The largest demographic of homeless people is aged from birth to five years, making young children the largest single group of those homeless in Ireland.

Born homeless

Already this year, 14 babies have been born into homelessness. There is a further 90,000 people on the waiting list for social housing nationwide with many being advised that they could experience at least another five years of waiting before they begin to reach the upper end of the list. The majority of those presenting as homeless have come from the private rental sector, with the main reason for their tenancy ending being because the landlord has decided to sell the property.

Solutions

Mr Allen stressed that while Ireland's social housing policy had created the problem, it is also where we must look for solutions.

"Immediate solutions can be found by looking at the private rental sector through rent controls and adjusting rent allowance and HAP rates, however the root of the problem is in the social housing sector. Thus, this is where long-term solutions must be sought."

He went on to explain that building needs to happen on a large scale, be well funded and quickly delivered. He stressed that social mix, as opposed to mix of tenure, needs to factor in social housing policy. Mr Allen also talked about the links between poverty/lack of secure housing and poor mental health.

He told delegates that very little is spent on research into why people become homeless and into which, if any, solutions are working.

He also stated that more resources are needed for delivering targeted advice, support and information to those who need it most.

When everything is being dealt with in terms of emergency measures and stop-gap fixes, it is hard to take a strategic and long-term view of the problem and its solutions.

Stigma

Despite the fact that the housing crisis affects people from all sectors of society – be they people in negative equity, people strangled by rising rents in the private rental market, students, young workers, families doubling up and those already living in emergency accommodation or on the streets – there is still a lot of stigma attached to being homeless.

Mr Allen stated that homelessness needs to be talked about as part of the housing issue, but it is often seen as a purely social issue and further stigmatised.

Successive government's policies have created this crisis and, unfortunately, the various plans and measures the government have put in place are nowhere near adequate to tackle the full scale of the crisis we face.

ICTU

In June ICTU launched its discussion paper which calls for a local authority-led response to the housing crisis that would involve building 10,000 social housing units each year at a cost of €1.8 billion per annum. ICTU says that this could be financed by additional tax measures such as the fast-tracking of the vacant site levy and by borrowing or seeking greater flexibility as regards EU fiscal rules.

Meanwhile, existing homeless services are over-stretched and under-funded which has led to a huge rise in voluntary bodies doing what they can to support the people most affected by this crisis. Unlike charities, none of these groups are funded and none of their 'workers' get paid. Where the state has failed, people have stepped in and taken action, but this is not a sustainable solution.

Freda Hughes from the INMO Media Office is also a housing activist and attended the briefing on homelessness in Ireland on behalf of the INMO

ICTU's Friday Briefings are a series of informal talks hosted by Congress dealing with topical and workplace issues

Section roundup

Care of the older person education session in Cork

The National Care of the Older Person Section are holding an education session on Medication Management on Wednesday, October 18 in the INMO Cork Office. The cost to attend is €20. Booking is essential and can be made by logging onto **www.inmoprofessional.ie**. Alternatively you can contact Helen in the INMO at Tel: 01-6640616 to confirm your place.

International Section Conference and Culturefest

This event is scheduled to take place on Saturday, October 21 in INMO headquarters in Dublin. This year the educational component will cover topics on the dangers of social media, risk assessment, improving quality of care and motivational coaching. There will also be a financial overview including a presentation on the INMO income protection scheme from Cornmarket. Booking is essential and the cost to attend for INMO members is €30. For the afternoon of Culturefest there is no charge to attend and families are encouraged and welcome to join. Please log onto **www.inmoprofessional.ie**. to book a place, or contact the INMO at Tel: 01-6640616.

Midwives set to gather in Armagh for conference

LATER this month midwives from all over Ireland will gather in Armagh for this year's annual All Ireland Midwifery Conference, the theme of which is Actions Speak Louder than Strategies.

The conference will hear from Mary Hinds, director of nursing and allied health professionals from Northern Ireland's Public Health Agency, on implementing Northern Ireland's maternity care strategy. Kilian McGrane, director of the National Women and Infants Health Programme, HSE, will speak on the 'Republic of Ireland's maternity care strategy – creating a better future together: where are we 18 months later?'

This year's concurrent sessions, which delegates can attend two of, are on 'Vaginal birth after caesarean – exploding the myths with the OptiBIRTH study'; 'From bullying you to caring for you - Perinatal mental health'; and the final session is on 'Mindfulness – me and my health'.

The afternoon plenary sessions are being facilitated by Seana Talbot, president of the National Childbirth Trust and Kyrsia Lynch, chairperson of AIMS Ireland. They will deliver a joint presentation entitled 'Are you Listening – can you hear us?'

The final session is on the lessons learned from the *Lancet* Series on the values of midwifery – maintaining confidence in changing times. This will be delivered by Mary Renfrew, professor of mother and infant health, University of Dundee.

Bookings can be made directly on the INMOProfessional website or by contacting the INMO by phone at Tel: 01-6640641. We look forward to welcoming you to the 23rd All Ireland Midwifery Conference.

FOHNEU to form stronger links with key occupational health stakeholders

The 45th Board Meeting of the Federation of Occupational Health Nurses within the European Union (FOHNEU) took place in Stockholm in July 2017, hosted by the Swedish Association for Occupational Health Nurses. Representatives from 15 European countries attended.

The FOHNEU president Dr Henriett Éva Hirdi shared the new strategy for FOHNEU which involves forming stronger alliances with key stakeholders in the Occupational health field. Board members agreed to review and make recommendations on European Union directives and white/green papers related to occupational health. The group voted to hold the seventh FOHNEU Congress in Budapest in 2019. A sub committee was formed to co-ordinate the congress preparations. Margaret Morrissey, FOHNEU treasurer, and Una Feeney, Irish representative, will both play a key role in this committee.

FOHNEU board members gathered at the recent meeting in Stockholm

The autumn board meeting will take place in Prague. Dr Daniela Pelclova, a prominent and influential figure in occupational health in eastern Europe will give an overview of occupational health in the Czech Republic.

EU aims to simplify movement of health workers

Elizabeth Adams discusses the EU's directive aiming to ease the movement of healthcare sector professionals across member states

AS PART of the roadmap set out in the Single Market Strategy, the European Commission proposed several initiatives aiming to simplify procedures for cross-border service providers and to subject regulation in the services to European Union (EU) scrutiny. The European Commission (EC) published a 'Proposal for a Directive of the European Parliament and of the Council on a proportionality test before adoption of new regulation of professions' in early 2017.

According to the EC, more than 6,000 professions are regulated across the EU, and the health and social services sector accounts for 43% of all regulated professions. Since the variation in regulations across the EU potentially obstructs free movement of health providers, the provision of the Treaty on the Functioning of the European Union (TFEU 2012), on the freedom of establishment or freedom to provide services may apply. Given the role of health professionals in protecting human life and health, they have been singled out in the Treaty for special treatment. Therefore, Article 53 (2) of the TFEU specifies that "in the case of medical and allied pharmaceutical professions, the progressive abolition of restrictions shall be dependent upon coordination of the conditions for their exercise in the various member states".

The EU has already established a regulatory framework guaranteeing minimum qualifications to be met by health care professionals (Directive 2005/36/EC on the recognition of professional qualifications).

The draft Proportionality Directive for European professionals, such as nurses, midwives, dentists, doctors and pharmacists on proposed proportionality tests, aims to make it easier for companies and professionals to provide services across the EU. Member states must provide evidence that measures are necessary to protect a public interest objective and that they do not exceed what is necessary to attain this objective. The regulations referred to in the proposal include the following issues: continuous professional development; language knowledge; reserving specific activities for professionals with a particular professional title; rules relating to the organisation of the profession and professional ethics, registration or authorisation schemes and requirements limiting the number of authorisations to practice.

The package of measures includes a proposal for a Directive on a proportionality assessment of the rules of competent authorities. The EC has stated that regulation is often warranted for a number of professions, for example, those linked with health and safety, but that there are many cases where unnecessarily burdensome rules can make it difficult for qualified candidates to access jobs.

The EC has confirmed that it does not regulate or deregulate professions – this remains a national prerogative of member states. But unlike in EU law, a member state needs to establish whether new national professional requirements are necessary and balanced. The draft Directive would compel competent authorities to undertake a proportionality test before adopting or amending any legislation.

There is no exemption for regulators in the field of health or patient safety. Member states would then have to assess the proportionality of the proposed measure and inform relevant stakeholders before the new legislation could be adopted. The draft Directive continues to be discussed with MEPs and member states.

INMO representation

The INMO is a member of the European Federation of Nurses Associations (EFN). Established in 1971, the EFN represents over three million nurses across Europe through their national nursing associations. The EFN is the independent voice of the nursing profession at European level

under the leadership of Dr Paul De Raeve, general secretary (further information is available at: **www.efnweb.eu**). The EFN is an important international organisation representing nurses and nursing concerns across wider Europe. There are a number of significant projects and policy developments that the INMO is central to due to being a member of the EFN and one of these is the draft Proportionality Directive. Issues concerning health, patient care, mobility of health professionals, education, technology and health funding continue to be central to the EU debate and the culmination of these debates result in legislation that all member states have to implement. It is therefore imperative that the EFN, in representing national nursing associations of 36 EU countries, is strengthened and empowered to influence the EU political agenda, particularly in the current economic climate.

One of the core functions of EFN is building up and improving links and relationships with the key policy makers in the EU institutions. On behalf of the INMO and other members, this establishes and maintains the EFN's credibility as a serious negotiator and influencer in the decision making process within the EU. The EFN position statements are crucial to influence and progress work with different EU institutions, officials working in the different directorate generals and other stakeholders in the European arena, while supporting members to articulate their position within their country.

The EFN policy statement on the Proportionality Directive below is only one example of the collective voice of the profession, contributing to, and influencing European Policy and shaping the strategic direction.

European Working Time Directive – interpretative communication

The EC has published an interpretative communication on the implementation of the European Working Time Directive. The communication provides guidance on how to interpret various aspects of this directive following recent case law. The aim is to help member states to implement the law correctly and avoid further infringements. It contains no proposals for future amendment/legislation.

The Interpretative Communication on Directive 2003/88/EC of the European Parliament and of the Council concerning certain aspects of the organisation of working time is available in the *Official Journal of the European Union* (available at: **http://bit.ly/workingtime).**

The EC has also published a report on the implementation of the directive across member states. The report concludes that the Directive has for the most part been transposed in both the public and private sectors. However, in some member states, categories of workers are excluded from the scope of the legislation. Compliance among member states with the requirement to treat on-call time as working time is improving, but there are still some issues (available at: **http://bit.ly/2xeUS3S**).

International visit of the Department of Nurses and Midwives, Polish Ministry and the Medical University of Lodz
Pictured (l-r back row) were: Dorota Kilańska, Department of Nursing, Medical University of Lodz. Kinga Witczak, specialist for monitoring and reporting, Department of Nurses and Midwives, Polish Ministry (front row l-r), Elizabeth Adams, INMO director of professional development and director of the Richmond; and Beata Cholewka, director of the Department of Nurses and Midwives, Polish Ministry

Elizabeth Adams is INMO director of professional development and director of the Richmond Education and Event Centre

EFN Policy Statement on Proportionality Directive

THE European Federation of Nurses Associations (EFN) represents over three million nurses and is the independent voice of the profession. With its mission to promote the interests of nurses and patients in the EU, the EFN encourages measures that facilitate the access to timely and appropriate quality care and that support health improvements of citizens.

The EFN welcomes the European Commission proposed Directive on a proportionality test before adopting new or modified regulations impacting on nurse education, service delivery and health outcomes.

Delivery of hands-on care for patients, and co-ordination of the care process to achieve better health outcomes requires a highly-qualified nursing and health workforce. The EFN, therefore, sees the proportionality test as an opportunity to ensure that patients and citizens have access to appropriately educated nurses with the competences to support them to improve their health, empower them to manage health conditions and treat illness and provide safe effective care throughout their life. The evidence is clear that highly educated nurses lead to better patient outcomes. Investing in qualified nurses also makes economic sense.

Agreed Europe wide standards for nurse education and for other health professions have been very beneficial (eg. Directive 2013/55/EU) in supporting improvements in care, strengthening the profession and facilitating mobility and EU law will continue to support the development of nursing as a profession in all the EU member states.

The EFN therefore:

- Calls on the European Institutions to ensure the adoption of legislative measures able to preserve the safety and quality of patient care, as well as the national specificities in their demographical, geographical and cultural realities
- Supports Article 5 making sure regulation is based on proper justifications by member states
- Highlights the importance of Article 6.2(i) requiring member states to take into account the effects with regard to competition in the market, quality of services, free movement of persons and services
- Emphasises the importance of cumulative effects (Article 6.4) in the field of health care professions
- Welcomes the requirement to engage the professional organisations (Article 7) in deployment of the proportionality test to reach 'fit for purpose' regulatory designs.

The EFN will continue ensuring that the level of protection of public health will not be undermined by the new provisions and that EU citizens continue to enjoy access to appropriately trained and regulated professionals. The proportionality test can play an important part in achieving this across the EU.

Q and A Bulletin Board

With INMO director of industrial relations Tony Fitzpatrick

Query from member

I have submitted an application to reduce my weekly working hours by 12 hours (one long day) per week. However, management advised that I can only apply for full time or 19.5 hours. Is this the case?

Reply

No, this is not the case. This matter is covered by the Agreement on Flexible Working in the Health Services which came into operation on February 1, 2001. This provided for the implementation of permanent and pensionable part time working arrangements in the health service. One of the principal objectives was to facilitate the retention and recruitment of staff and the maintenance of the workforce at the levels required to deliver and develop services into the future, while seeking to meet the aspirations of staff to access working hours suited to their individual circumstances. Individual members of staff may apply to work on a permanent part-time basis involving working hours, between a minimum of an average of eight hours a week and a maximum of 39 hours a week. Every application should be considered on its own merits and within the context of the employment concern. Consideration of such applications will involve:

- An assessment by the appropriate manager as to whether the applicant can be facilitated having regard to patterns of work within the organisation
- An assessment by the appropriate manager of the capacity of the unit/service to maintain required operational levels, having regard to the overall staffing requirement.

It should be noted that the agreement allows for staff to be recruited to fill vacancies on a part-time, permanent and pensionable basis in circumstances where the option of filling the position among existing staff has been fully explored. Such recruitment should have regard to any arrangement or collective agreements, to recruitment of the grade involved and should be in accordance with agreed procedures that may exist with the relevant unions, from time to time relating to the terms and conditions of employment particular to the grade involved.

In summary, it is not appropriate that management would indicate that you can only apply for full time or 19.5 hours per week. The Agreement on Flexible Working in the Health Service from 2001 is clear that you can apply for anything between eight and 39 hours work per week. The annual leave allowance for part time staff is adjusted pro rata to their contracted hours in relation to the norm for whole time staff and to the normal provisions governing the granting of annual leave. Also, public holiday entitlement will be in accordance with the Organisation of Working Time Act and any relevant collective agreement.

Query from member

I have been working as a practice nurse for a number of years. I have been asked to complete Garda Vetting forms, even though I remain a member of this practice and intend to do so for the foreseeable future. Why then, am I required to complete this process at this juncture?

Reply

Thank you for your query. The National Vetting Bureau (Children and Vulnerable Persons) Acts 2012 to 2016 provide a statutory basis for the vetting of persons carrying out relevant work with children or vulnerable persons. The Act stipulates that a relevant organisation shall not permit any person to undertake relevant work or activities on behalf of the organisation, unless the organisation receives a vetting disclosure from the National Vetting Bureau of the Garda Siochána in respect of that person. Garda vetting is conducted on behalf of registered organisations only and is not conducted for individual persons on a personal basis. The Act creates offences and penalties for organisations who fail to comply with its provisions.

This is correct and applicable to both public and private organisations. The Act defines relevant work or activities as: "any work or activity which is carried out by a person, a necessary and regular part of which consists mainly of the person having access to, or contact with, children or vulnerable adults."

Therefore, your role as a practice nurse is encompassed in the above definition. Depending on when you commenced employment with your current employer, it may not have been statutory at that time to partake in this process. However, since 2016, all sections of the National Vetting Bureau Act have come into operation and therefore it is mandatory to engage in this process. Should you have any further queries in relation to this issue, please contact our information office.

Making sense of the SPS pension scheme

Student and new graduate officer, **Liam Conway**, discusses the single public service pension scheme

AS A recent graduate nurse/midwife, there are numerous elements of public sector finances which you should become familiar with. One of the most important of these elements is your pension. Regardless of your age, knowing how your pension works and understanding the terminology involved will make saving for your future a lot easier and clearer.

The current retirement age for a recent graduate nurse/midwife in Ireland is 66 years of age. This will rise to 67 from January 1, 2021 and to 68 from January 1, 2028, in line with the state pension age.

Although reaching financial goals like purchasing your first home, buying a car or travelling may be on your list of priorities at the moment, it's also important to think longer down the road and gain an understanding of what's ahead.

The Single Public Service Pension Scheme (SPSPS) is mandatory when working in the public sector. When you commenced your 36-week internship, you would have started contributing to this pension scheme.

This is found on the right-hand side of your payslip where you will see tax deductions, PRSI and PRD. The pension contribution may be displayed as SPSPS or other initials depending on your employer. Next month in *WIN*, I will go through payslips and what all the initials mean. You can also read about managing your tax on our website in the Student/New Graduate tab at: **www.inmo.ie/Student_New_Graduates**

As a recent graduate, you will be a member of the SPSPS (Single Scheme) which was introduced for all new entrants to the public sector recruited on or after January 1, 2013. The Single Scheme also applies to members who left the public sector for more than 26 weeks and returned after the Single Scheme start date.

Unlike the traditional public sector pension schemes, where benefits are based on total years' service and a nurse/midwife's final salary, the Single Scheme is based on career average pay. This means that every year your employer will calculate how much lump sum and pension you have earned for the previous year based on what you earned in the previous calendar year. These will be 'banked' into your Single Scheme account.

These existing amounts, known as 'referable amounts', are revalued in line with inflation (Consumer Price Index [CPI]) on an annual basis. This means that your Single Scheme benefits will build up on an ongoing basis throughout your time in the public sector as you add amounts into your account and your referable amounts increase in line with CPI.

At retirement, you will receive a once off tax-free lump sum as well as your pension payments which are taxed and paid for life.

Employee contribution rates for Single Scheme members

The standard employee contribution rate for most members is 3% of pensionable remuneration plus 3.5% of net pensionable remuneration, reduced pro rata to the work pattern where the member works on a non-full-time basis (part-time, work-sharing), with definitions as per below applying:

- Pensionable remuneration = pensionable pay expressed on a full-time basis
- Pensionable pay = wages/salary (excluding overtime) *PLUS* pensionable allowances
- Net pensionable remuneration = pensionable remuneration less twice the value of the contributory state pension.

Accrual and payment of benefits to members accrue (ie. build up over time) referable amounts (ie. money amounts) for pension and lump sum for each year of work or part thereof based on pensionable remuneration at that time.

- Pension: Accrual rate of 0.58% of pensionable remuneration up to a ceiling of 3.74 x state pension contributory (SPC) (currently €45,000) *PLUS* (where applicable) 1.25% of pensionable remuneration above that level
- Lump sum: Accrual rate of 3.75% of pensionable remuneration
- Referable amounts are adjusted annually by reference to increases in CPI and aggregated referable amounts continue to be up-rated until retirement.

See case study above.

Case study

Alison started Nursing in May 2015. Her salary at the end of her first year was €30,000.

Her Single Scheme benefits (pension and lump sum) are calculated as a percentage of the salary she earned in 2015.

In 2015 she earned €30,000 so she accrued:
- €174 in pension (0.58% of salary)
- €1,125 in lump sum (3.75% of salary).

In 2016 she earned €32,000 so she accrued:
- €185.60 in pension
- €1,200 in lump sum

At the end of 2016, her 2015 benefits were reviewed to see if they should be increased in line with any rise in CPI. As there was no increase in CPI her referable amount remained unchanged.

So, as of December 31, 2016 Alison has accrued a total of:
- €359.60 in pension
- €2,325 in tax free cash

Each year you will receive a 'Benefit statement' from your employer detailing what benefits you have accrued in your Single Scheme.

You can read all about the Single Scheme including FAQs and info booklet online here: **www.per.gov.ie/en/single-scheme**

As you can see, pensions can be very complex and are dependent on many factors. If you have concerns or a specific query about your pension, a useful website is **www.pensionsauthority.ie**

As an INMO member you can avail of the financial services and expertise of Cornmarket, which has more than 40 years' experience in public sector finance. For more information Tel: 01 4200981.

Liam Conway is INMO student and new graduate officer
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Quality & Safety

A column by Maureen Flynn

Clinical leadership competency ePortfolio: how it is being used

IN OCTOBER 2015, this column provided an overview of the Clinical Leadership Competency ePortfolio (CLCeP), which now has over 7,900 users. This month we are focusing on supports available to nurses and midwives in using the resources.

CLCeP

The clinical leadership e-learning resource and ePortfolio, incorporates seven competencies which can be accessed on **www.hseland.ie**. The competencies are: (i) self- awareness; (ii) advocacy; (iii) team-work; (iv) empowerment; (v) communication; (vi) quality and safety; and (vii) decision-making.

The CLCeP was developed by the National Leadership and Innovation Centre for Nursing and Midwifery (NLIC) in partnership with key stakeholders and is available to all staff nurses, staff midwives, clinical nurse managers and clinical midwife managers 1 and 2s (or equivalent grades). Following its launch in May 2015, an awareness campaign took place. Implementation, which began in June 2016, aims to support staff to actively engage with the CLCeP.

Supporting staff to engage with CLCeP

It is evident from the feedback at awareness sessions and collaboration with nurse and midwife leaders that staff are seeking more support to actively engage in leadership competency development. Taking this feedback into consideration, a multifaceted approach is being used:

- *Higher education institutes* – Throughout 2016 and 2017, CLCeP presentations are being delivered to both undergraduate and postgraduate nursing and midwifery students. Higher education intuitions have access to the CLCeP which can be used to underpin leadership masterclasses or as a blended learning component for their leadership modules. Feedback from students suggest they recognise the value of the CLCeP, both as a formal and informal learning opportunity and as a support to record evidence of their personal, academic and professional development
- *Clinical Leadership Competency Workshops* – there are workshops for each of the seven clinical leadership competencies. These workshops, designed by the NLIC, can be implemented independently, in combination, or as blended learning. Each individual workshop is approved for continuing education units (CEUs) by the Nursing and Midwifery Board of Ireland
- *National clinical leadership competency programme for staff nurses and staff midwives* – A 2.5-day clinical leadership competency programme based on the CLCeP has been developed for staff nurses and staff midwives. A test programme, including all seven competencies, was delivered by the NLIC with the support of the CNME in UHG to a cohort of staff nurses and staff midwives (n=26) from the Saolta Hospital Group, in July 2017. The feedback from participants was excellent and the NLIC is now preparing the programme for national roll out
- *Bespoke clinical leadership competency programme* – Designed and delivered by NLIC, the bespoke eight-day clinical leadership development programme for clinical and social care managers from intellectual disability services is underpinned by the CLCeP. Evaluations demonstrate that participants experience personal and professional leadership development while undertaking the programme and engaging with the CLCeP
- *Promoting ongoing awareness of the CLCeP* – The NLIC continues to raise awareness of the CLCeP by using marketing material, presenting at conferences and to specialist nursing and midwifery groups
- *Nursing and Midwifery ErasmusPlus project: School of Nursing and Midwifery, Trinity College Dublin* – Ireland is one of four countries supporting undergraduate nursing and midwifery students to enhance and develop their leadership potential. The ErasmusPlus project, funded by the EU, will see students participate in a European junior leadership academy. Following collaboration with the NLIC, the CLCeP has been chosen as the online resource that the 45 students who are participating in this project will complete at different time points of the academy to determine the learning and self development that has occurred as a result of participating in the project. This is a wonderful opportunity to share the CLCeP with nurses and midwives both nationally and internationally.

Get involved

At your next ward, team or department meeting you might include a discussion on the CLCeP and how it might be helpful for members of your multidisciplinary team. Other healthcare professionals in addition to nurses and midwives have engaged with the CLCeP (n=2,533), which demonstrates the potential for the CLCeP to be used as a multidisciplinary eLearning resource and ePortfolio.

More information

Information on the CLCeP can be obtained by viewing a short video using the following link: http://bit.ly/CLCePvideo

For further information on the CLCeP, please contact Marie Kilduff, leadership and innovation advisor, NLIC by email at: marie.kilduff@hse.ie

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Nausea and vomiting in pregnancy

In the latest clinical update in this series, **Rebecca Elliot, Nina Thirlway** and **Gerry Morrow** examine the complications of nausea and vomiting in pregnancy, including hyperemesis gravidarum

MOST women feel nauseated or vomit in early pregnancy. These symptoms are commonly referred to as 'morning sickness', but symptoms can occur at any time during the day.[1] It is thought that nausea and vomiting affects up to 80% of pregnant women and that about 35% of these women have significant problems.[2]

Hyperemesis gravidarum is prolonged and severe nausea and vomiting with associated dehydration, electrolyte imbalance, ketonuria, and body weight loss of more than 5% of pre-pregnancy weight.[1,3] The incidence of hyperemesis gravidarum is around 0.3-3.6% of pregnancies.[3] Figures vary because of different diagnostic criteria and ethnic variation in study populations.

The cause of nausea and vomiting in pregnancy is uncertain. Several associated factors may influence its development. Suggested causes include:[1,2,3,4]

- Human chorionic gonadotrophin (hCG) – there is general agreement that the stimulus for nausea and vomiting in pregnancy originates from the placenta. Increased hCG levels are thought to increase nausea and vomiting. This is supported by a tendency for women with multiple pregnancies, who generally experience increased levels of nausea and vomiting
- Oestrogen – nausea and vomiting in pregnancy are more common when estradiol levels are increased. When levels are decreased, nausea and vomiting are less common
- Evolutionary adaptation – it has been suggested that nausea and vomiting are a mechanism to prevent the woman eating potentially harmful foods
- Gastric dysfunction – in pregnant women, oesophageal, gastric, and small-bowel motility are impaired because of smooth-muscle relaxation due to increased levels of progesterone. Delayed gastric emptying in pregnancy may also contribute to nausea and vomiting
- Psychological influences – Less favoured is the theory that nausea and vomiting in pregnancy are an abnormal response to stress or are associated with negative feelings about the pregnancy, but this is not supported by good quality evidence. It has been suggested that psychological symptoms may be a result, rather than a cause, of nausea and vomiting in pregnancy.

Several other factors are associated with the development of nausea and vomiting in pregnancy, most which are not modifiable. These include:[1,3,4]

- History of hyperemesis gravidarum in previous pregnancies
- History of motion sickness
- History of migraines
- Family history (first-degree relatives) of nausea and vomiting in pregnancy
- History of nausea with oestrogen-containing oral contraceptives
- First pregnancy
- Obesity
- Stress
- Being seropositive for *Helicobacter pylori*. This is associated with an increased risk of hyperemesis gravidarum.

Complications

Maternal complications

Most women with nausea and vomiting in pregnancy do not experience severe complications. However, the symptoms can significantly affect their lives and have a negative effect on parenting and family relationships. Women with nausea and vomiting may also experience low mood or depression.[1,3,4]

Medical complications are more likely to occur in women with severe vomiting or hyperemesis gravidarum and include metabolic complications, weight loss, dehydration, hyponatraemia or hypokalaemia, abnormal liver function test results, vitamin deficiencies.[1,3,4]

The combination of immobility and dehydration associated with hyperemesis gravidarum may increase a woman's risk of venous thromboembolism.[5] Today, maternal death from nausea and vomiting is very rare.[3]

Foetal complications

Mild or moderate nausea and vomiting have little effect on pregnancy outcome. It is thought that nausea and vomiting may even be predictors of successful pregnancy outcome. A lower miscarriage rate has been recorded in women with nausea and vomiting during pregnancy compared with controls. This is thought to be related to robust placental synthesis in a healthy pregnancy. In women with hyperemesis gravidarum, an increased risk of malformations is unlikely. However, a higher incidence of low birth weight babies has been documented. Foetal death is very rare and is usually limited to extreme cases of hyperemesis.[3,4]

Diagnosis

Nausea and vomiting in pregnancy are usually diagnosed because of symptoms alone when other causes of nausea and vomiting have been excluded. Women may report nausea, vomiting, or both. Other symptoms include odour and food aversion. Nausea and vomiting in pregnancy usually begins between the fourth and seventh weeks of gestation, peaks between the ninth and 16th weeks, and resolves by around the 20th week of pregnancy. Laboratory investigations are not required in uncomplicated cases. A minority of women, for whom symptoms are more severe, will require further assessment. This group includes women with hyperemesis gravidarum, which commonly presents with persistent vomiting not related to other causes, weight loss (usually at least 5% of pre-pregnancy body weight), dehydration and electrolyte imbalance and ketonuria.[1,2,3]

If nausea and vomiting starts at 11 weeks of gestation or later, this is usually not

caused by pregnancy and another cause should be sought. Findings which may suggest an alternative diagnosis include abdominal pain or tenderness (more than mild epigastric tenderness after retching), fever, headache or abnormal neurological examination and goitre.[1,3]

Other conditions that may cause nausea and vomiting in pregnancy include:

- Genito-urinary conditions such as urinary tract infection, uraemia, pyelonephritis, ovarian torsion, and renal stones
- Metabolic disorders and endocrine conditions including hypercalcaemia, thyrotoxicosis, diabetic ketoacidosis, and Addison's disease
- Gastrointestinal conditions such as gastritis, gastroenteritis, peptic ulcer, pancreatitis, cholecystitis, bowel obstruction, hepatitis, gallstones, and appendicitis
- Neurological disorders including vestibular disease, migraine, and central nervous system tumours
- Other pregnancy-related conditions such as acute fatty liver of pregnancy, and pre-eclampsia. Drug-induced vomiting, for example iron or opioids, and psychological disorders for example eating disorders. [1,3]

Assessment

Ask about the onset, duration, and frequency of nausea and vomiting, whether food and drinks are being tolerated, if there are any associated symptoms, for example weight loss, abdominal pain, or co-existing conditions, such as diabetes, which may be adversely affected by nausea and vomiting. Ask about the effect on the woman's life – at work, home situation and support, ability to care for her family – and the effect on her mood. A validated questionnaire may be used to assess the severity of nausea and vomiting in pregnancy (eg. Pregnancy-Unique Quantification of Emesis [PUQE] score, see **www.rcog.org.uk**).[1,3]

If a woman has nausea or vomiting of sufficient severity to affect fluid and food intake her weight should be monitored. Examine the woman for signs of dehydration, eg. dry mucous membranes, tachycardia, postural hypotension. Look for signs of muscle wasting and test the urine for ketones. Consider referring for ultrasonography to identify predisposing factors, eg. multiple or molar pregnancy. Measurement of serum human chorionic gonadotrophin is not recommended.

Further blood tests, such as full blood count, urea and electrolytes, liver function tests, calcium and phosphate levels, and thyroid function tests, are not routinely recommended in primary care; if they are thought to be necessary, admission to hospital may be more appropriate.

Advice

Reassure the woman that nausea and vomiting are a normal part of pregnancy that usually resolve by 16 to 20 weeks of gestation, and pregnancy outcomes are generally better for women who have nausea and vomiting in early pregnancy. Advise the woman to rest, avoid any foods or smells that trigger symptoms, eg. spicy or fatty foods. Eating plain biscuits or crackers in the morning before getting up may help reduce symptoms, as well as eating bland, small, frequent meals low in carbohydrate and fat but high in protein. Cold meals may be more easily tolerated if nausea is smell-related. Drinking little and often rather than large amounts may help to prevent vomiting. Those affected may wish to try taking ginger or using acupressure to relieve symptoms.[1,4]

Consider advising avoidance of iron-containing preparations, if they make symptoms worse.

Advise all women with nausea and vomiting in pregnancy to seek urgent medical advice if they experience very dark urine, or no urination for more than eight hours, abdominal pain or fever, severe weakness or feeling faint, vomiting blood, repeated, unstoppable vomiting, inability to keep down food or fluids for 24 hours, severe headache, visual problems, severe pain below the ribs, sudden swelling of the face, hands, or feet (symptoms of pre-eclampsia). [1,4]

Consider drug treatment with an anti-emetic if initial treatments such as dietary advice or rest have failed and the woman has persistent symptoms. Note that all anti-emetics are unlicensed for treatment of nausea and vomiting in pregnancy. If an anti-emetic is required in pregnancy, an antihistamine (oral cyclizine or oral promethazine), or a phenothiazine (oral prochlorperazine) should be prescribed. The woman should be reassessed after 24 hours. If the response to the treatment is good treatment with the chosen anti-emetic can continue and the woman should be reviewed once a week thereafter. [1,3,4]

If the response to treatment is inadequate, the woman is not dehydrated and there is no ketonuria, treatment should be switched to another anti-emetic from a different class. Oral metoclopramide or oral ondansetron are second-line options, but should not be prescribed for longer than five days. The woman should be reassessed after 24 hours and reviewed once a week thereafter.[1]

Deciding when to stop medication should be pragmatic, eg. it may be possible to stop anti-emetic medication at around 12-16 weeks, by which time symptoms have usually improved, in conjunction with clinical judgement, eg. severity of symptoms, response to treatment in previous pregnancies, preference of the woman.

The woman should be considered for admission to hospital if she has continued nausea and vomiting and is unable to keep down liquids or oral anti-emetics, or if she has continued nausea and vomiting with ketonuria and/or weight loss (greater than 5% of body weight), despite treatment with oral anti-emetics. [1,3]

If they have a confirmed or suspected comorbidity, eg. she is unable to tolerate oral antibiotics for a urinary tract infection, she may require hospital admission and there should be a lower threshold for admitting to hospital or seeking specialist advice if the co-existing condition may be adversely affected by nausea and vomiting, such as diabetes.

Admission or specialist advice may also be required if there is suspicion of an alternative diagnosis or complication requiring specialist management.

Offer additional support and self-help information, such as Hyperemesis Ireland **www.hyperemesis.ie/** and HSE information on morning sickness **www.hse.ie/eng/health/az/M/Morning-sickness/Complications-of-morning-sickness.html.**

Dr Rebecca Elliot is clinical author at Clarity Informatics, Nina Thirlway is style editor at Clarity Informatics and Dr Gerry Morrow is editor and medical director at Clarity Informatics. Clarity Informatics is contracted by the National Institute for Health and Care Excellence (NICE) to provide clinical content for the Clinical Knowledge Summaries service available through the Clarity Informatics Prodigy website at: www.clarity.co.uk/prodigy

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CPD Quiz

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

1. Causes of nausea and vomiting in pregnancy are thought to include:

A) Increased levels of human chorionic gonadotrophin (hCG)
B) Low levels of oestrogen
C) High levels of oestrogen
D) Low levels of human chorionic gonadotrophin (hCG)

2. Factors that increase the risk of nausea and vomiting in pregnancy include:

A) Family history of nausea and vomiting in pregnancy
B) History of migraines
C) History of nausea with oestrogen-containing oral contraceptives.
D) First pregnancy

3. Complications of nausea and vomiting in pregnancy include:

A) Depression
B) Dehydration
C) Vitamin deficiency
D) Obesity

4. All anti-emetics are:

A) Unlicensed for treatment of nausea and vomiting in pregnancy
B) Licensed for treatment of nausea and vomiting in pregnancy

5. Nausea and vomiting in pregnancy may be caused by other factors including:

A) Urinary tract infection
B) Medication
C) Migraine
D) Eating disorders

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

Clarity informatics

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

Answers: Question 1 = A, C; Question 2 = A, B, C, D; Question 3 = A, B, C; Question 4 = A; Question 5 = A, B, C, D

The parent perspective

Lessons can be learned from listening to the parents of children who are living with rare diseases such as MPS, writes **Suja Somanadhan**

MUCOPOLYSACCHARIDOSIS (MPS) is a group of lysosomal storage disorders (LSDs), which comprise a range of rare inborn errors of metabolism.[1-4] Each MPS disorder is caused by the body's inability to produce specific lysosomal enzymes involved in the degradation of glycosaminoglycans (GAGs).[1-3]

This specific enzyme deficiency results in an accumulation of large amounts of GAGs, or complex sugar molecules in harmful amounts in the body's cells and tissues.[1-4] This results in progressive cellular damage, which in turn leads to an array of manifestations that worsen with age, and can affect multiple organ systems, leading to cognitive impairment and eventually resulting in severe morbidity and premature death.[1-4] Clinical features may not be visible at birth and children can appear to have normal development in the first years of life but deteriorate as storage of GAGs affects organs and tissues.[1-3,5]

Except for MPS II, MPS disorders are genetic disorders inherited in an autosomal recessive pattern affecting both males and females.[1-3] Within MPS, the wide-ranging clinical spectrum and varying degree of severity mean that diagnosis can often be delayed.[1-3] It has been reported that early diagnosis and treatment can improve outcomes in MPS.[6-7] In MPS I, haematopoietic stem cell transplantation (HSCT) may be successful. In other types of MPS (I, II and VI), enzyme replacement therapy (ERT) in the form of supportive treatments has shown benefits in terms of GAGs reduction and increased distance walked as part of the six-minute walk test.[1-3,8-10] Children with MPS and their families anticipate an unknown lifespan since it is a progressive condition and falls under category three of life-limiting conditions in which there is a lack of curative treatment options, where treatment is exclusively palliative and may commonly extend over many years.[11]

Developments in advanced supportive treatment options have made dramatic changes in the quality of life (QoL) for individuals with certain forms of MPS. Despite these developments, in most cases symptoms associated with the disease can affect multiple areas of daily life and significantly impair the individual's lifespan.[2-4] Recent studies recommend further research into the experience of caring for children with rare life-limiting conditions, investigating the needs of families for the long-term care of their child through adolescence to adulthood, and the specific services required.[13-14,20]

The European Commission on Public Health defines rare disease as a life-threatening or chronically debilitating disease, mostly inherited. In EU countries, any disease affecting fewer than five people in 10,000 is considered rare. There are over 30 million people living in Europe with one of the 6,000+ rare diseases, ie. up to 6% of the total EU population.[21,22] The UK Strategy for Rare Diseases[21] and the National Rare Disease Plan for Ireland[22] and many more rare diseases national strategies[23,32] across European member states highlight the importance of engaging and involving patients and their families in research and incorporating the patient and carers' voices into the policies and services that affect them.

These strategy documents have also highlighted the importance of establishing a variety of research approaches to rare diseases. Qualitative healthcare research, which can be tailored to explore the experience of living with a rare condition and the challenges patients and their caregivers face in their daily life, is becoming increasingly important. Given the lack of current evidence, there is a need to make an explicit plan in developing and promoting best practice in care for the families of children with MPS.

Facts about rare diseases in children

- More than 6,000 rare diseases
- One in 17 people will be affected by a rare disease at some point in their lives
- 50-75% of all rare diseases affect children
- 30% of children with a rare disease die before their fifth birthday
- Most importantly, rare diseases affect not only those diagnosed but also their families, friends, carers and society as a whole

Role of parents of children with MPS in this research

- MPS is a group of rare inherited metabolic disorders
- Category 3 of life limiting conditions
- The highest world recorded incidence of MPS-type 1 (Hurler Syndrome) in Ireland[48]
- To provide an opportunity for the parents of children with MPS to share their

Figure: Themes and corresponding sub themes of the lived experience of parents of children with MPS

Lived existential themes		Thematic area		Sub-themes (parents' expressions)
Lived other (relationality)	→	Living with MPS	→	I have always remained positive We are proactive in MPS It is a battle You are on a rollercoaster
		Living with a rare genetic disease		World came crashing down You feel guilty You feel sorry for the child that they are missing out
Lived body (corporeality)	→	The stigma of rare condition	→	Features stand out We don't want him to be treated any differently
	→	It is all MPS but different diseases	→	Light at the end of the tunnel It was a double-edged sword
Lived space (spaciality)	→	Future is unknown	→	It's no man's land You feel like you are in a box and you can't get out of it
	→	Hospital versus home	→	Hospitals bring you back to reality You are in your own home and you do your own thing Healthcare system is a revolving door
Lived time (temporality)	→	Experience of waiting	→	You are left waiting, waiting and waiting It is like watching a time bomb
	→	A tough road ahead	→	Frequent flyer Live day by day
Lived Things (materiality)	→	Things in their day-to-day life with MPS	→	Over the phone diagnosis The internet can be a wonderful tool

experiences of living as a family with this condition

Research question: 'What is the experience of a parent living and caring for a child, adolescent, or young adult with MPS?'

Research aim: To explore and interpret parents' experiences of living and caring for their child, adolescent, or young adult with MPS.

Research objectives:

- To understand and interpret parents' experience of living and caring for a child with MPS
- To examine the knowledge and understanding of MPS from parents' perspective
- To explore the impact of regular hospitalisation of children living with MPS on family life.

Research methods:

A hermeneutic phenomenological approach, informed by the philosophical constructs of Heidegger,[25] Gadamer,[26-27] and Van Manen[28-30] was undertaken to study the complexities of a challenging life world.[31] As such, this specific methodology enables a deeper understanding situated within parents' day-to-day lives, managing and living with this condition in a family context, and the factors that both enhance and inhibit that experience.[32] Utilising hermeneutic phenomenology enabled access to parents' reflection in a moment of time on their lived experience and enabled a deeper understanding of the day-to-day challenges of living with a child, adolescent and young adult with an MPS disease.

A total of eight parents (n=8) participated in this study over a 17-month period. Data was collected through three-time point serial interviews, a total of 19 in-depth, digitally-recorded interviews were completed, and each interview lasted for 60-120 minutes. At the time of interview, these parents had children aged between six months to 22 years, diagnosed with the following range of MPS disorders: MPS I syndromes (Hurler syndrome, Scheie syndrome), MPS II (Hunter syndrome), MPS III (Sanfilipo syndrome) and MPSVI (Maroteaux-Lamy syndrome).

The serial interview approach provided an opportunity for the researcher and the parents to return to and reflect on the themes raised at the previous interview, thus enabling a process of interpretive insight.[28-30] Van Manen's five existential themes emerged as a reflective data analysis framework following thematic analysis of interview transcripts.[28-30] These five fundamental life world themes described the way humans experience the world, and these are "Lived relation, Lived body, Lived space, Lived time, and Lived things"[29-30] underpinned the data analysis and meaningful expression of the parents day to day experience of living with MPS.

Findings

Nine themes and 22 corresponding sub themes (parents' expressions) were identified during data analysis. The main themes identified during data analysis were described as living with MPS, living with a genetic rare disease, the stigma of a rare condition, MPS as encompassing multiple diseases, unknown future, hospital versus home, experience of waiting, a tough road ahead, and things in their day-to-day life with MPS.

The following sections will discuss these themes in the context of Van Manen's five lived existential themes[29,30] utilising selected interview extracts to illuminate that experience in the parental voice. *Figure 1* summarises the themes and sub-themes of the lived experience of parents of children, adolescents and young adults with MPS.

This study's findings reflect the wider literature looking at the impact of other types of life-limiting illness, which have also indicated that caring for someone with MPS has a wide impact across all dimensions of the family's life.[13-14,33-36] These findings are again consistent with the literature on parents of children with other life limiting conditions and life-threatening conditions.[36-38] Equally consistent with the literature that emerged of parents adapting and fitting in around their child's increasing needs, as their illness progressed.[13-14,39]

Families described their evolving role of a parent to a main care provider, with mothers acting as the principal care providers among those interviewed. Only one father was interviewed, although the invitation to participate was open to both parents, either together or separately. Fathers clearly play an important role in these children's lives, and take on roles of protecting and providing care for their family. However, the study findings are consistent with literature which shows that women continue to primarily take on the role of caregiver when a child has a life-limiting illness.[40-41] The notable concern on the part of parents for their healthy children's welfare is expressed in this study and is mirrored in other literature.[42-44]

Studies have consistently shown that having a rare disorder gives rise to family problems, strain on marital relationships, feelings of isolation and additional financial pressures, as well as having a negative impact on healthy siblings.[12-14,20] This study also highlights the inadequacy of communication skills among healthcare professionals, especially during the initial diagnostic disclosure.

The study findings are consistent with other published studies on challenges in the way in which terminal illness diagnoses are disclosed to families.[20,45,46] Most of the families in this study did not receive their child's diagnosis of a rare life-limiting condition face to face in the clinic and were dissatisfied with how healthcare professionals disclosed their child's diagnosis, particularly in instances where diagnosis was given over the phone. Of note, many of the families were not referred to, or attending, the national centre that provides specialist care for MPS at the time of diagnostic disclosure. There is the need for clear national clinical pathway or guideline to manage the assessment of diagnosis and breaking of bad news.

This study also reported that the healthcare professionals' lack of specialist knowledge of the rare diseases and genetics raised challenges with diagnosis and appropriate specialist referral. To avoid any unnecessary delay in referral, diagnosis and disease management or treatment, it is recommended professional awareness and competency in the area rare genetic diseases.[22] This study highlighted the need for greater and more diverse initiatives that could serve as indicators for the future understanding and development of policy and practice related to paediatric rare life-limiting conditions. Even though parents reported some positive aspects of current services, eg. their relationships with primary healthcare professionals and the quality of services they currently receive, the overall findings of the study highlighted difficulties in accessing health and social care services at the regional level. Parents described inconsistent and inequitable services often characterised by bureaucracy and delay. Despite findings from across studies[20,38,39,45] there is a consistent shortfall in social, emotional and respite support for families of children with MPS.

The study findings highlight the need for more responsive physiotherapy, occupational therapy, psychology and social support services at the regional centres. The findings also reflect other studies that suggest that family needs are subject to change over time and highlight the importance of frequent and planned re-assessment of the social, emotional, and economic challenges experienced by children and their families.[13,14,20,33,39,45,47]

The research also pointed to unmet mental healthcare needs among parents. If these unmet needs are not addressed, there is a risk that these families will experience negative consequences additional to the already high burden and cost of their child's condition. There is also a needing to set out a process framework on six monthly to annual review to assess and advise family's needs and psychosocial support services in the care of children with rare progressive diseases. One of the key recommendations is having a designated key worker overseeing the care and management of children with MPS and related diseases. This position would help to enhance parents trust in the health system and overall coordination to minimise waste of time and resources.

Conclusion

This research study is the first of its kind to act as an initial enquiry and to generate knowledge through researching the lived experience of Irish parents of children, adolescents and young adults with MPS. This study provided a voice to the Irish parents of children with MPS, and in doing so will make their lives more understandable to the wider audience. It brings to light the uncertainty, sorrows, and everyday challenges faced by these families, and hopefully will improve the care and support for them through the many months and years of their child's illness.

Recommendations

The findings of this study highlight the need for greater and more diverse initiatives that could serve as indicators for the future understanding and development of policy and practice related to paediatric rare life-limiting conditions. This study reported on MPS and its impact on parents and healthy siblings, and how they felt equally stigmatised and isolated in society, expressed as living in a no man's land.

This study therefore recommends the following points:

- There is a need for greater attention to the psychosocial support for the families of children with MPS
- There is a need for a targeted Centre of Excellence for Rare Diseases, where the families or individuals can receive clear information at the time of diagnosis (as far as possible), psychosocial support throughout the life course of the illness, and around critical transition times, such as death and bereavement through the provision of counselling, respite care, peer and sibling support
- Improved communication training is necessary for professional staff, including how to communicate sensitive information and support needs of parents at the time of diagnosis of MPS and other rare diseases
- Consideration should be given to having a designated key worker to work with the parents of children with rare, life-limiting illnesses on a continuing basis
- There is a need to develop a competency framework for rare disease support and management, with a combination of training, skills, experience and knowledge, including a person's ability to apply them to perform a task safely.

Suja Somanadhan is an assistant professor of children's nursing at the College of Health Sciences at UCD. *This PhD research project was the winner of the CJ Coleman 2017 INMO Research Award; this article will give you a short summary of the project. A full research report is available to read via open access https://ojrd.biomedcentral.com/articles/10.1186/s13023-016-0521-0 article reference as follows: Somanadhan, S. & Larkin, P. (2016) Parents' experiences of living with, and caring for children, adolescents and young adults with Mucopolysaccharidosis (MPS), Orphanet Journal of Rare Diseases. 11: 138, doi:10.1186/s13023-016-0521-0*

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References available on request by emailing: nursing@medmedia.ie (Quote: Somanadhan S. WIN 2017; 25 (8): 43-45)

Finding the right path

In the second of a two-part series, **Ruth Morrow** discusses overcoming the many barriers to optimal asthma management

THE focus of this article is on barriers to asthma management and measures that health professionals can implement to improve outcomes for patients with asthma.

Barriers to asthma management can be classified as follows:

- Health professional barriers such as time restraints, lack of interest in or motivation about the condition, lack of knowledge in asthma
- Medications – resistance to inhaled corticosteroid treatment by parents and patients
- Cost of medications and costs for attending asthma clinics
- Patients' beliefs and attitudes.

Health professionals

It is well documented that 95% of asthma care should be delivered in primary care. Resources in primary care and time restraints remain a significant problem for health professionals when providing services for patients with asthma and have yet to be addressed.

The GINA 2017 guidelines[1] recommend the implementation of a process of a 'Model of Care' within the health system. In Ireland, the National Clinical Programme for Asthma linking primary care to specialist care with multidisciplinary effort involving many stakeholders has been developed. However, implementation has been problematic.[2] In primary care, the Asthma Cycle of Care for children under six was introduced but as yet there have been no further developments for older children, adolescents or adults with asthma.

Medications

Inhaled medications are essential for treating asthma and COPD as well as other respiratory conditions such as fibrosis. The big advantage of using inhaled medication is that the drug reaches the lungs directly where it is needed with little systemic absorption, thereby lowering the risk of side effects when compared with oral or intravenous administration. On the other hand, inhaled medication is not suitable for everyone, particularly those with poor inspiratory effort, poor dexterity, learning difficulties or cognitive impairment.

A recent systematic review of inhaler technique involving 54,354 adults and children with either asthma or COPD investigated the extent and prevalence of inhaler use.[3] The review assessed the most common errors made by patients, the percentage demonstrating correct, acceptable or poor technique, and thirdly the change in outcomes over time. The overall results demonstrated a prevalence of correct inhaler technique in 31% of adults and children, acceptable technique in 41% and poor technique in 31%. The most frequent errors reported were incorrect preparation of the device, errors in co-ordination, incorrect speed or depth of inspiration, and not holding the breath after inhalation.[3] In the same study, there were difficulties reported in firing the meter dose inhaler (MDI) and breathing from the chamber.

Poor inhaler technique is associated with poor asthma control, frequent emergency department and GP visits, increased admission to hospital, increase in the levels of morbidity and mortality, increased costs, and inappropriate escalation of treatment.[4] In a study by Rogliani et al, it was demonstrated that each device has its pros and cons with age, cognitive status, visual acuity, manual dexterity, manual strength and ability to co-ordinate the inhaler all having an influence on whether the patient can use the inhaler.[5]

The choice of the most appropriate inhaler devices is of extreme importance and patients should be actively involved in this decision. Evidence indicates that patients who express a preference for a particular device are more likely to use their inhaler correctly and are easier to teach correct inhaler technique.[6]

Costs

Inhaled medications remain expensive despite the recent introduction of generic medications, and cost needs to be taken into account when prescribing medications. In its pre-budget submission in 2016, the Asthma Society of Ireland stated that 40% of respondents it surveyed did not take their medication because of cost, along with 18% of respondents losing their medical card in the previous year.[7]

Patient beliefs and attitudes

Cultural barriers also exist with inhaler use. In some populations, the use of an inhaler is seen as improper or impolite, and oral medications may be preferred.[8] Previous experiences, negative or positive, with family members or friends can have a significant impact on how parents and patients deal and cope with their asthma. It is worth spending time exploring these and allaying any misconceptions and fears the patient may have.

One of the most frequently asked questions is the effect of inhaled corticosteroids on children's growth. Poorly controlled asthma can affect growth[9] and growth velocity in the first one to two years of inhaled corticosteroid treatment.[10] The effects of inhaled corticosteroids on growth are seen in pre-pubertal children in the first one to two years of treatment which are not progressive or cumulative.[10,11] A study that examined the long-term outcome on growth showed a difference of only 0.7% in adult height.[10,11] It is recommended to check children's height at least annually. Consideration should also be given if the child's asthma is poorly controlled with frequent use of oral steroids and poor nutrition. In children under five years, decisions about controller treatment should be discussed with parents/guardians with the relative benefits and risks of treatment explored.

In conclusion, this article has explored barriers associated with asthma management and has provided health professionals with some strategies which can assist with improving outcomes and quality of life for patients with asthma and their families.

Ruth Morrow is an ANP in primary care and a registered nurse prescriber in practice in Leitrim

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Long-acting reversible contraceptives

Women should be made aware of the range of long-acting reversible contraceptives, including the newest offering Kyleena, when making a decision on contraceptive methods, writes **Deirdre Lundy**

THE latest intrauterine contraceptive system (IUS) was launched in Ireland in recent months offering women an added choice. Similar to Mirena and Jaydess, Kyleena is a T-shaped intrauterine device that has a levonorgestrel hormone reservoir on its vertical shaft.

Kyleena has a smaller frame (like the three-year Jaydess device) but with the 19.5 LNG payload, it has been granted a licence for effective contraception for five years. It acts primarily to block fertilisation in creating a progestin rich hormonal environment which is highly disruptive to sperm motility in the cervical canal, uterus and tubes. There is also a back-up protection afforded by the anti-implantatory effects caused by the foreign body response in the endometrium to the device.

Benefits

As Kyleena is small and uses an 'evo inserter', insertion is easy as it is for Jaydess. With the extra levonorgestrel loading dose of 19.5mg, the device is licensed for five years. However, it is not powerful enough to significantly improve menorrhagia in afflicted women and cannot be used as an alternative to systemic progestogen when HRT is prescribed (only Mirena is licensed for those purposes).

Kyleena's efficacy in preventing pregnancy was established by a clinical trial involving 1,452 women aged 18 to 35 years who had the IUS fitted.[1] This study excluded some women including: those who were less than six weeks postpartum, those with a history of ectopic pregnancy, women with clinically significant ovarian cysts or HIV, or those at high risk for sexually transmitted infections.

Table: The intra-uterine hormonal systems

	Mirena	Kyleena	Jaydess
Dimensions	32mm X 32mm No ring, black strings	28mm x 32mm Silver ring, blue strings	28mm x 32mm Silver ring, black strings
Insertion tube	4.4mm	3.8mm	3.8mm
Duration of contraception	5 years	5 years	3 years
Indications	Contraception, menorrhagia, HRT	Contraception	Contraception
Loading dose	52mg LNG	19.5mg LNG	13.5mg LNG
Release rates			
>24 days	20µg	17.5µg	14µg
>60 days	20µg	15.3µg	10µg
>1 year	20µg	9.8µg	6µg
>3 years	12µg	7.9µg	5µg
>5 years	10µg	7.4µg	-

Efficacy

In the first year of the trial, there were two pregnancies in over 16,000 menstrual cycles. Over the trial's five-year run, there were 13 pregnancies in more than 57,000 cycles.

The absolute risk of pregnancy was low but where pregnancies did occur, ectopic rates were high (>50%). This was significantly lower than the background rate of ectopic pregnancy in the fertile population, but still something to counsel about and for which healthcare professionals should be vigilant.

Fertility return was good, with about 71% of the women who wanted to become pregnant after the study conceiving by 12 months after removal which compares well to the conception rates of 80% in year one after the removal of a Mirena IUS.

LARC methods and Irish women

Irish women need to be fully informed about all contraceptive options including LARCs. Data from a 2010 survey showed 62% of couples use condoms with 43% using the combined oral contraceptive pill (COCP) or a progesterone only pill (POP). Only 12% used Nuvaring, Evra patch, Depo or the ImplanonNXT and only 11% use an IUS.

As the COCP and POP have failure rates as much as 20 times higher than the 'fit and forget' LARC methods the risk of unintended pregnancy to the sexually active population is also much higher. The question must be asked, are we as healthcare

professionals doing enough to inform and facilitate LARC uptake?

Healthcare professionals should take the opportunity to discuss all the options available, including the range of LARCs, to reduce unintended pregnancy risk. There are many information leaflets available from the HSE and family planning clinics to help with this education.

Obstacles

In relation to LARC, there can be obstacles that may discourage women from considering intra-uterine methods. For private patients, a hormone IUS can be expensive. However, in the event of an initial problem with a device, a second one can be obtained free of charge in the same month. The cost of fitting has to be taken into account. An option to consider is referral to a hospital-based training clinic. GMS patients can be treated in a GP-led hospital-based IUCD insertion clinic.

Knowledge

Counselling is achievable, even in time-limited situations, when patient information leaflets and online resources are made available.

Costs

A hormone IUS will cost a non-GMS patient €144 in addition to the fee for fitting. Once an expensive IUS is purchased that patient and her family will be exempt from further prescription medication charges for the remainder of that month should the need arise. If the device is lost or expelled or accidentally contaminated, a second device can be obtained from the same pharmacy free of charge as long as the original prescription was written in the same calendar month. Cost of fitting can be very high and, as a result, off-putting for some women. One way to overcome this cost to the patient is to consider referral to a hospital based training clinic. GMS patients can also be referred to a GP-led hospital based IUCD insertion clinic.

Embarrassment

Embarrassment can also be an obstacle to LARC use. Some woman can find the fact that such an intimate procedure is required for insertion to be a deterrent. The health professional's manner and confidence go a long way in defusing a patient's anxiety.

Pain

Fear of pain is also an issue. It can be uncomfortable to have an interuterine contraceptive device (IUCD) placed. Some women find it hard to tolerate even a pelvic examination. Some have discomfort when you pass a speculum, or use a vulsellum, and passing the sound through the internal cervical os can be more uncomfortable for some than others. Touching the fundus can cause a deep, visceral pain in some women.

However, in my experience, severe pain is rare even among nulliparous or teenage patients. Pre-placement counselling about pain should be realistic and the choice as to when to abandon the procedure should always be left to the patient.

Pain can be minimised by: good candidate selection (or exclusion), pre-Rx pelvic exam and assessment of the cervix for excitation or sensitivity, pre-placement analgesia with anti-prostaglandin medication like mefenamic acid, possible benefit from prostaglandin PO or PV – there are data both for and against – and a gentle technique while employing distraction techniques during placement, eg. 'vocal local'.

Sexually active women should at least be made aware of LARC options as well as other contraceptive options. This includes younger and nulliparous women.

Deirdre Lundy is co-ordinator of the ICGP's sexual and reproductive health courses

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Dissecting a relationship

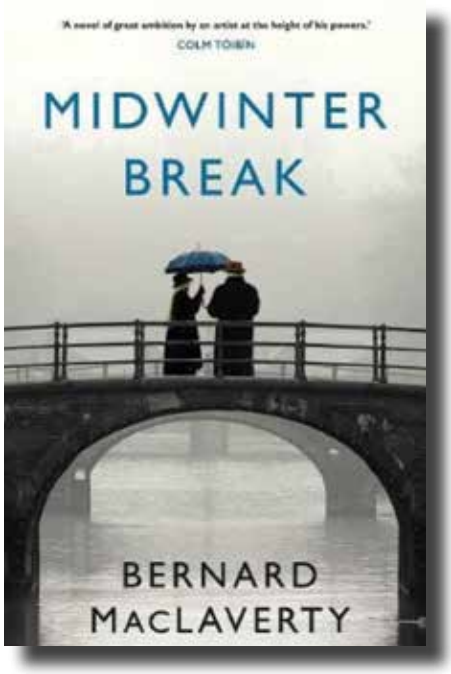
BERNARD MacLaverty is one of Ireland's most accomplished authors, known for his mastery of storytelling. His works include novels, short stories, and screenplays.

Like the protagonists in his latest novel *Midwinter Break*, MacLaverty is from Northern Ireland and lived there until the mid-1970s before moving to Scotland.

Gerry and Stella moved from the North to escape the Troubles, and the shadow of that sorry period hangs over *Midwinter Break*. However, the novel is about much more than that, dissecting as it does in a forensic but ultimately humane way the sometimes grim and occasionally comedic vicissitudes of a longstanding relationship.

Readers may recognise excerpts from their own lives in *Midwinter Break*'s narrative – a brief holiday abroad to get away from it all, banish the cobwebs and revitalise oneself, but in which excited expectations turn a little grim. What? No? Maybe I just don't go to the right places.

Anyway, it's a theme effectively explored by many writers including Richard Ford, who it must be said probably



does Trips of Reckoning better than any other modern writer, eg. *Occidentals/ Independence Day*.

These trips can, as we know, be enjoyable, but also have the potential for 'gruesome twosomeing' as it's called in the travel trade, and there is much of this in MacLaverty's story. Unsurprisingly, Gerry and Stella's Amsterdam stay becomes a tableau of the faultlines in their relationship – his burgeoning alcoholism, her desire to get more out of life, her frustration with his charming but frustrating ways, his mocking of her deeply felt religious faith.

The story is compelling, told sparsely, humorously and compassionately as the relationship journeys to some kind of reckoning. The only minor caveat is the use, towards the end, of that Irish literary occasion of sin – the Big Long List of Stuff. *Par exemple,* amid a litany of facts and details Stella knows, a recitation of bus route numbers in Glasgow. One is tempted, but is ultimately too polite, to scream 'desist', and curse that influential James Joyce fella.

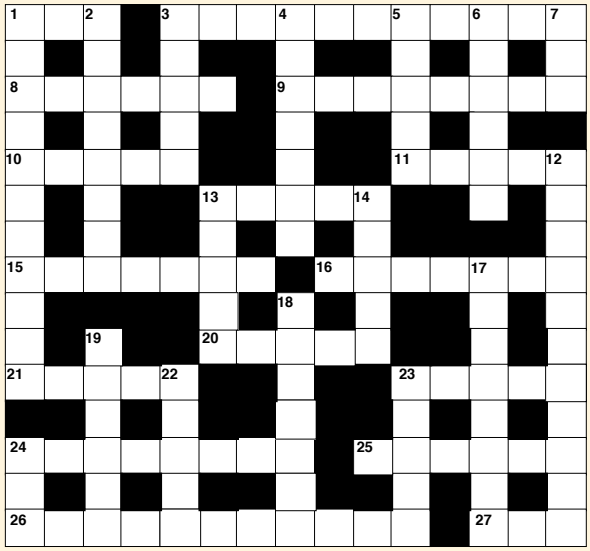
That apart, *Midwinter Break* is a very satisfying read.

– Niall Hunter

Midwinter Break by Bernard MacLaverty is published by Jonathan Cape (2017). Price £12.99 Sterling. ISBN: 978-1911214212

Crossword Competition

WIN A €30 BOOK TOKEN



Across

1 Jump on one foot (3)
3 Spicy Ms Halliwell takes the money for the cake (11)
8 Ogled (6)
9 Undo what connects one of the French with a pair (8)
10 Scottish golf course that has hosted the British Open on 8 occasions (5)
11 American elk (5)
13 See 14 down
15 Recipe whose ingredients are fur and loam (7)
16 Cure-all (7)
20 Give the doctor one remote control weapon (5)
21 Check out the street for a rendezvous (5)
23 Doglike scavenger (5)
24 Descriptive of water with no current (8)
25 Excellent abilities (6)
26 Charades get strange when one has joined a party uninvited (11)
27 Married (3)

Down

1 Keep things going temporarily in the absence of another (4,3,4)
2 Might a moral rep provide such a tooth? (8)
3 Inexperienced environmentalist? (5)
4 Type of Swiss cheese (7)
5 As grows in a witch's garden? (5)
6 Use, give a job to (6)
7 Owing (3)
12 Mortified to be poorly armed (with broken sabres) (11)
13 Stacked (5)
14 & 13a The result of car dismantling, or roles for thin actors? (5,5)
17 Salad accompaniment made with white cabbage (8)
18 A way to solicit that's a pain in the backside! (7)
19 Despot (6)
22 Uniform jacket (5)
23 Walked cross-country (5)
24 Droop (3)

Solutions to September crossword:

Across: 1 Misconduct 6 Talc 10 Crumb 11 Vandalism 12 Upstart 15 Atone 17 Hewn 18 Auks 19 Cakes 21 Alchemy 23 Karen 24 Scut 25 Tall 26 Teeth 28 Youghal 33 Overlooks 34 Above 35 Edam 36 Ventilator

Down: 1 Mice 2 Stud poker 3 Orbit 4 Dover 5 Cone 6 Amigo 8 Compensate 9 Vacancy 13 Axel 14 The Holy Grail 16 Backstroke 20 Kickabout 21 Anthill 22 Menu 27 Enema 29 Onset 31 Bone 32 Deer

Name: .....
Address: .....
.....
.....

The prize will go to the first all correct entry opened
Closing date: Friday, October 20, 2017
Post your entry to: Crossword Competition, WIN, MedMedia Publications, 17 Adelaide Street, Dun Laoghaire, Co Dublin

The winner of the September crossword is: Sinead Burke Mountbellew, Co Galway

MONEY MATTERS

Finding the right health cover

Dermot Wells offers some tips on getting the health insurance that best suits your needs

HEALTH insurance price increases are continuing to make the headlines this year, with many of the health insurers applying multiple rate increases. Currently, there are over 350 health plans available which makes it difficult to choose between plans. We've put together some top tips to help you when next shopping for your health insurance.

Review your cover each year

Every year insurers release new health plans onto the market. In some instances, the health insurers will review their existing plans and launch new plans, which provide very similar benefits but at a lower cost. That's why it is so important to shop around each year in advance of your renewal date. This will help to ensure that you are always getting the right level of cover to suit your current circumstances.

Switch health plans or insurers

Did you know that there are no waiting periods applied for switching between health insurers at renewal? Each of the three insurers will give you credit for time served on previous cover. The only time you will need to re-serve initial waiting periods is if you are re-joining health insurance after a gap of more than 13 weeks. However, it is also important to remember that if you are upgrading your health insurance cover with new benefits there is a two-year upgrade rule that comes into effect, meaning you will not be covered at the higher rate of benefits in respect of any pre-existing conditions you may have for the first two years of being on that plan.

Be wary of lower cost plans

If you are trying to cut your health insurance costs by switching to a cheaper plan, then you need to be careful that you are not significantly reducing the level of benefits available to you under your plan. Ask your broker to explain the key differences between plans, as downgrading cover and subsequently upgrading again in the future will mean serving the two-year upgrade rule for any pre-existing conditions.

Avail of young adult rates

Since the introduction of lifetime community rating on May 1, 2015, the health insurers have offered 'young adult rates' on certain plans. These rates mean that if you are aged between 18 and 25 you can avail of a discounted rate rather than paying the full adult rate (previously this was only available for 18 to 20 year olds). The discount available is age banded so the younger the dependent, the less you pay. If your dependent is aged 25, a discount of between 0-9% will apply, if aged 24 a discount of 10-19% will apply and so on. However, this is not a rule and not all plans offer young adult discounts.

Splitting cover

Splitting cover can help you save money. If your partner and children (including adult dependants) are all on the same level of cover, then you could be overpaying for your policy. Each member should be insured on a plan specific to their needs. For example, children under 16 may not need to have access to hi-tech hospitals, but this benefit could be important for older children as these hospitals are centres of excellence for cardiac procedures. By splitting cover (placing members/dependants on different plans), you could save significantly at your next renewal.

Taking on an excess

If you're in good health, you could take on an excess for private hospitals to reduce your costs further. An excess is the first part of the claim you are liable for. Health insurance plans generally offer excesses that range from €0 to €600 per admission to a private hospital, with most clients opting for an excess of up to €125/€150 per admission. Remember that if you do take on an excess now and want to move to a different plan in the future to bring down your excess, then the two-year upgrade rule will apply.

Corporate plans

Did you know that all health insurers have corporate plans, which are available to everyone? These corporate plans may come in at a cheaper premium than other health plans, and still allow members to claim money back on everyday medical expenses such as GP, ED and physio visits. Ask your broker about corporate plans before your next renewal.

When shopping for health insurance, think of it like your car insurance – shop around for the best deal and get all the facts. If you're happy, change cover or switch insurer. It is often useful to get advice from a health insurance expert.

Dermot Wells is general manager, Health Insurance Division, Cornmarket Group Financial Services Ltd

Irish nurse wins international 'hero' award

Theatre nurse Audrey Al Kaisy recognised by Ansell

ONE of 10 Ansell Hero awards was presented to Audrey Al Kaisy of the INMO's Theatre Section last month. The presentation took place in St Michael's Hospital in Dun Laoghaire in Dublin. INMO president Martina Harkin-Kelly was in attendance to present Audrey with the award on behalf of Ansell.

Audrey has been a perioperative nurse for the past 25 years. She was recognised with the award as she has demonstrated leadership throughout her career by setting the standard for nursing care. She has further educated herself and has led the INMO Theatre Nurses Section for three years.

The 2017 Ansell Cares Hero Nurse Service Award for European operating room nurses is an important way to recognise theatre nurses who have made a lasting impression on their colleagues, their patients, their profession and in their community. According to award sponsor Ansell, theatre nurses are the key to making things happen in an increasingly demanding and technical environment, and that in order to continue to deliver excellent care, they have to focus on continued education. Despite these challenges, much of the great work they do is behind the scenes and does not get the recognition it deserves. So, to address this, Ansell launched the Hero award which now encompasses the US, Australia, New Zealand and Europe

Martina Harkin-Kelly, INMO president, pictured presenting the Ansell Hero award to Audrey Al-Kaisy in St Michael's Hospital, Dun Laoghaire, last month

The number of votes Audrey received has been matched in euros that will be donated to her charity of choice.

Speaking on the award, Ms Harkin-Kelly said that Audrey has certainly lived up to the embodiment of her name which means 'noble strength'.

"She is to be congratulated on her achievement ranked in the top 10 out of a strong field of 150 nominees at this year's EORNA conference in May. Well done from us all as you fly the Irish flag in the field of theatre nursing."

Clonmel Healthcare opens €2m storage and distribution facility

CLONMEL Healthcare, the consumer health company, has announced the completion of the construction of a brand new €2 million warehouse facility in Clonmel.

The 1,800 square metre build, which officially opened its doors last month, will see the consolidation of storage and distribution of pharmaceutical and specialised medical products supplied to pharmacists and medical professionals across Ireland.

The construction involved an extensive renovation and extension of Clonmel Healthcare's existing facility. Previously, the warehouse capacity was a mere 300 pallets, yet was responsible for moving out 10 million packs of prescription drugs and over the counter products annually – one of the largest distribution of pharmaceutical products in Ireland.

With the opening of the new, larger facility, which is located on Waterford Road, Clonmel Healthcare expect to store 2,400 pallets of products at any one time which is ; a huge increase on last year, ensuring a much more efficient storage and distribution process.

Pictured at Clonmel Healthcare's new facility in Clonmel were: Barry Fitzpatrick, director of sales; Amy Phillips, product manager; and Tom Farrell, national sales manager

Jim Hanlon, CEO Clonmel Healthcare, said of the new warehouse: "The consumer demand for Clonmel Healthcare products has been steadily increasing year on year, so it was time we invested in the re-sizing of our facility, in addition to our sales office in Dublin, in order to meet increased customer demand."

Dementia patients face nutrition issues

More than half of those with dementia forget to eat or eat twice

THE majority of people living with dementia in Ireland are struggling to eat properly, according to new research on the relationship between diet and nutrition and the condition.

The research has shown that these difficulties include the person forgetting to eat (58%), forgetting they have eaten and eating again (54%), finding it difficult to finish meals (51%) and being too tired to eat (36%).

Research carried out by Ipsos MRBI, commissioned by Nutricia Advanced Medical Nutrition and The Alzheimer Society of Ireland (ASI), also found that a majority of survey respondents reported a change in their sense of taste (59%), smell (56%) and thirst (52%). More than half (56%) reported greater difficulties chewing and 44% in swallowing food.

Further findings revealed that 70% experience weight changes and 60% report changes in appetite, following diagnosis with dementia. More than one-third (37%) of respondents had a weight increase and 34% a decrease. 32% reported a decrease in appetite and 28% an increase.

The research also highlighted challenges with shopping and cooking. Some 82% reported that it could be difficult to get to the shops for food, 88% that shopping can be confusing and 70% that family and friends may manage shopping on their behalf.

The research reported that very few (6%) retained a role in meal preparation following diagnosis and stated that more than half (54%) had not actively searched for information on managing diet and nutrition following diagnosis.

Launching a new patient, family and carers information booklet on Eating Well with Dementia were: Tina Leonard, Alzheimer Society of Ireland, head of advocacy and public affairs; Jim Daly, Minister of State at the Department of Health with special responsibility for Mental Health and Older People; and Fiona Rafferty, Nutricia Advanced Medical Nutrition, head of public and strategic affairs

This research has been used to formulate a new booklet for families and carers called *Eating well with Dementia* which has been published by Nutricia Medical and the ASI.

The booklet offers practical tips and helps families and carers to understand how dementia can affect a person's appetite and experience with food; how to meet nutritional needs of someone with dementia; how people with dementia can enjoy and be involved in meal preparation and mealtimes; and how to deal with weight loss, weight gain and other nutritional issues.

Basic tips, included in the booklet, include keeping the table setting simple, establishing a routine, allowing sufficient time to eat, being flexible around food choices and not worrying about neatness, will be of huge assistance to family members and carers across Ireland.

Nutricia's head of public and strategic affairs, Fiona Rafferty said: "The objective of this research was to better understand the effect that dementia can have on an individual's relationship with food and nutrition. It clearly shows a need for more information. Many are looking for specific advice as to how dementia can affect their nutritional intake."

The ASI's head of advocacy and public affairs, Tina Leonard said that family and friends can play a key role. "Some of the tips contained in this booklet include making sure that people with dementia have some company at mealtimes and that mealtimes are sociable and enjoyable events for all of the family. Other simple tips include encouraging people to eat finger food, should using cutlery be an issue."

The booklet is now available from the ASI by ringing the helpline at Tel: 1800341341, emailing helpline@alzheimer.ie, at **www.alzheimer.ie** or in primary healthcare facilities.

October

Saturday 7
ODN Section meeting. Mayo General Hospital. 11.30am. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Saturday 7
Radiology Nurses Section meeting. Venue TBC. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Thursday 12
All Ireland Midwifery Conference Armagh City Hotel. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Monday 16
Retired Nurses and Midwives Section autumn break to Tower Hotel, Co Waterford. Cost: Three-night stay, dinner bed and breakfast per person sharing €159. Single rate €219. Tel: 051 862300. For further information email: magnordell@gmail.com

Wednesday 18
Care of the Older Person Section meeting. Medication Management seminar from 10am, INMO Cork Office . Tel: 01 6640648 for further details

Saturday 21
International Nurses Section Culturefest. INMO HQ. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details. *See page 50 for full details*

November

Saturday 11
PHN Section meeting. INMO HQ. 11am-1pm. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Saturday 18
CNM/CMM Section meeting. INMO HQ. 11am-1pm. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Wednesday 22
ED Section meeting. INMO HQ. 12.30pm. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Thursday 23 November
ADON Section meeting. INMO Head office. 11am – 1pm. Teleconferencing facilities available for this meeting. Contact jean.carroll@inmo.ie for further details.

Wednesday 29
CPC Section meeting. INMO HQ. 10.30am-12.30pm. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

December

Thursday 7
Retired Section bi-annual conference, Thursday, December 7 at INMO HQ. 10.30am-2.30pm. See box below for more information

Thursday 7
The INMO has reserved tickets in the Tivoli theatre for the Sleeping Beauty Pantomime on Thursday, December 7. Tickets can be purchased by INMO members at the discounted price of €16.50. Tel: 01 454 4472 to book your ticket or for more information log onto www.tivoli.ie

January

Wednesday 3
International Nurses Section AGM. INMO HQ. Time TBC. Contact jean.carroll@inmo.ie for further details

Saturday 20
ODN Section AGM. Naas General Hospital. 11.30am. Contact jean.carroll@inmo.ie for further details

Wednesday 24
Telephone Triage Section AGM. 11am. Portlaoise. Contact jean.carroll@inmo.ie for further details

INMO Membership Fees 2017

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

Condolences

❖ The RNID section wishes to express their deepest sympathies to Patricia McCartney, St Vincent's Centre Navan Road, and her extended family, on the recent passing of her brother Martin Hansberry. May he rest in peace.

Retired Nurses and Midwives Section biannual conference

The Retired Nurses and Midwives Biannual Conference will be held on Thursday, December 7 in INMO HQ from 10.30am to 2.30pm.

Topics for discussion include legal issues and CPR for children. There will also be a Christmas fair and lunch.

Cost to attend is €20 for members and €100 for non members.

Book online at: **inmoprofessional.ie** or contact Helen at Tel: 01 6640616