€5.75 Vol 26 No 8 October 2018

WIN

Journal of the Irish **Nurses** and **Midwives** Organisation

World of Irish Nursing & Midwifery

Latest INMO CPD education programme
Page 33

SDC: 200 delegates vote to reject offer
page 8

Government proposals at a glance
page 10

Members protest nationwide
page 12

Who's who on the Executive Council
page 24

United we stand...

92% recommend rejection of government proposals

NEWS & VIEWS

FEATURES

CLINICAL

LIVING

JOBS & TRAINING

WIN – World of Irish Nursing & Midwifery is distributed by controlled circulation to **more than 35,000** members of the INMO. It is published monthly (10 issues a year) and is registered at the GPO as a periodical. Its contents in full are Copyright© of MedMedia Ltd. No articles may be reproduced either in full or in part without the prior, written permission of the publishers. The views expressed in this publication are not necessarily those of the INMO. Annual Subscription: €155 incl. postage paid. Editorial Statement: *WIN* is produced by professional medical journalists working closely with individual nurses, midwives and officers on behalf of the INMO. Acceptance of an advertisement or article does not imply endorsement by the publishers or the Organisation.

guaranteed irish™

WIN INMO Irish Nurses and Midwives Organisation
World of Irish Nursing & Midwifery

(ISSN: 2009-4264)
Volume 26 Number 8
October 2018

WIN,
MedMedia Publications,
17 Adelaide Street,
Dun Laoghaire,
Co Dublin.
Website: www.medmedia.ie

medmedia publications

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

Production & news editor Tara Horan

Editorial assistant Max Ryan

Designers Fiona Donohoe, Paula Quigley

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

Publisher Geraldine Meagan

WIN – World of Irish Nursing & Midwifery is published in conjunction with the Irish Nurses and Midwives Organisation by **MedMedia Group**, Specialists in Healthcare Publishing & Design.

INMO
Irish Nurses and Midwives Organisation

Editor-in-chief: Phil Ní Sheaghdha

INMO editorial board:
Martina Harkin-Kelly; Catherine Sheridan; Eilish Fitzgerald, Kathryn Courtney, Ann Fahey

INMO editor: Michael Pidgeon
Email: michael.pidgeon@inmo.ie
INMO editorial assistant: Freda Hughes
INMO photographer: Lisa Moyles

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

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

www.facebook.com/irishnursesandmidwivesorganisation

twitter.com/INMO_IRL

United we stand

IN THIS issue of the *World of Irish Nursing and Midwifery*, we give an overview of the Public Service Pay Commission's (PSPC) recommendations, and the outcome of later meetings with the HSE as employers.

We also outline the progress made to resolve the recruitment and retention crisis, and the remedies that we believe are needed to stem the exodus of nurses and midwives from the Irish health service.

The INMO Executive Council asked members to have their say at a special delegate conference in Croke Park on September 26. Representing every branch of the Organisation, delegates from all corners of the country attended and were briefed on the government proposals to date.

The general opinion expressed was that the government is simply not listening to nurses and midwives. The public health service is understaffed, salaries are at too low a level to attract enough nurses and midwives or, indeed, to retain them. As ever, nurses and midwives push themselves even harder to provide safe, professional care for patients, under extraordinarily difficult circumstances.

The government's studied indifference is forcing nurses and midwives to now seriously contemplate industrial action. Make no mistake, going on strike will be very tough.

The Minister for Finance and Public Expenditure and Reform, Pascal Donohue, has already stated publicly that those who step outside of the public sector pay agreement would face real and significant financial penalties. We have no doubt – and delegates at the conference in Croke Park fully understood this – that there are many who want nurses and midwives to fail in securing equal status with other healthcare grades in the Irish public health service.

An account of the delegate contributions to our Croke Park meeting is recorded on *page 8* of this issue. The debate focused on how we move forward, correcting the grossly unfair situation which nurses and midwives have faced for more than a decade.

Not afraid

No nurse and midwife I know wants to strike. Instead, we want to be able to do our job, caring for patients in the manner we were trained, for a fair wage and in safe conditions.

We know who we are. We are nurses and midwives. We are not afraid. We are proud, dedicated professionals, who give it our all and then some more, every single day. We do this in a health service that is increasingly abandoned by policy makers and the political system. We pick up the tab, and are there on the frontline apologising to patients and their families for inadequate levels of care.

It is time for nurses and midwives to now apply the very same dedication into industrial determination. That means persuading reluctant friends and colleagues to support this campaign. That means coming along to meetings, even when a shift has drained you of all your energy. That means ensuring every one of your colleagues affected by the appalling conditions at work are informed and have an opportunity to vote.

We are all now facing big decisions. The proposals the government has made are insufficient. They are designed to be divisive and split nurses and midwives in order to break our collective strength.

Ultimately, the decision to accept or reject these proposals is yours. So, attend your meetings, inform yourself, talk with your colleagues and friends, come to us with any questions and arrive at the best conclusion you can. Above all, you should vote and make your voice heard.

Whatever we decide we will stand together in determination to secure a safe future for our professions. United we stand. Divided we fall.

Phil Ní Sheaghdha
General Secretary, INMO

Your priorities with the president

Martina Harkin-Kelly, INMO president

Time for change

IRELAND is changing, and that has been all too clear in recent months. The Papal event saw very different scenes from the 1979 visit. We've witnessed an eclectic mix of candidates enter the Presidential race. The appalling leak of the Scally Report showed scant regard for the women affected, and homelessness has reached an all-time high. Nurses and midwives have seen great change, but little action in recent months. Hospitals have become more overcrowded and all services face serious understaffing. Official figures showed 714,000 on waiting lists and the INMO's trolley and ward watch analysis revealed the worst-ever August for overcrowding. Across the country, many of us protested during our lunch hour, which helped put the health crisis back on the media agenda. But little of this featured in the long-awaited Public Sector Pay Commission report, which ignored evidence of the recruitment and retention crisis and repeated the government line: "This is not a pay review nor can it be." Whatever we decide at our special delegate conference, I know that we will take any challenge we face as a united, collective profession.

OHN Section conference

THE OHN Section is one of the most vibrant in the INMO and its conference in Limerick's Strand Hotel was evidence of that. I was heartened that the conference theme, 'Creating a culture of health, safety and wellbeing in the workplace', focused on the wellbeing and health of nurses themselves. Topics included personal wellness, work-related suicide, mental health at work, mental fitness and cardiac care. I gave participants an overview of the national issues including employer agreements, the funded workforce plan, the Pay Commission and the planned special delegate conference. I would like to thank the Section officers, Una Feeney, Margaret Morrissey and Mary Forde for their incredible work *(see also page 23)*.

Shaping the future of intellectual disability nursing

A RECENT report proposes a new direction for intellectual disability nursing in Ireland. I attended the launch with Minister of State for Disability Finian McGrath, RNID members and Eilish Byrne and Bernie Stenson from the Executive Council. RNIDs are irreplaceable. Everyone deserves the proper care of a nurse; a regulated, trained professional with the requisite knowledge and a holistic approach. I am wary of a creeping over-reliance on the social-care model, which can de-professionalise care.

EFN on digital transformation

THE European Federation of Nurses Associations (EFN) is constantly working at an EU level on behalf of nurses. One such area is the digital transformation of health, as the need for patients to have access to their health data is becoming an important priority at EU level. The EFN's recent briefing note proposed involving nurses in the design of these new systems and healthcare records. We are at the coal face of the health service, so our views must be heard to make them fit-for-purpose and responsive to frontline needs. Digital healthcare featured in the Sláintecare Implementation Strategy, so this is especially timely in Ireland.

Still Waiting and Raise the Roof campaigns

THE 'Still Waiting' campaign aims to highlight all the people suffering in Ireland's health service. At the time of going to press it was due to hold a demonstration on Saturday, October 6 in Dublin, assembling at the Garden of Remembrance at 1pm. The 'Raise the Roof' rally on October 3 will see trade unions, political parties, student unions, housing agencies and community and campaign groups join forces to demand action on the housing crisis. The wages paid to nurses and midwives mean we often face problems with affordable accommodation, so this is an issue that affects INMO members.

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

Thought for the month

"We will make no apologies for being Nurses and Midwives or seeking the respect, value and recognition that we rightfully deserve"

Report from the Executive Council

"FAIL to prepare and prepare to fail," said Benjamin Franklin. We held an extraordinary meeting of the Executive Council to discuss our response to the Public Sector Pay Commission report. The publication of the report was delayed, so we took the decision to hold a special delegate conference to hear from members directly about their views on the report. At the time of writing, that SDC was about to start, and will consider what progress we've made *(see page 8 for full coverage of SDC)*.

While I was glad to see the report eventually published, it made for disappointing reading, with much of the content contradicting itself. I look forward to discussing it further with members at the SDC.

A centenary planning meeting was held on August 27. We discussed and planned upcoming events, including a civic reception with the Lord Mayor of Dublin in the Mansion House on February 28, the date the INMO was founded. More meetings are planned.

The next INMO Executive Council meeting will take place on October 1-2.

Reminder: I would like to remind all members who are working in conditions where they cannot provide safe care, to complete a disclaimer form. This will be your only safeguard in the event of a near miss or an incident.

Get in touch

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

United we stand:
Special Delegate Conference demonstrates its united front in Croke Park

SDC rejects government proposals

A CLEAR 92% of those at the INMO special delegate conference in Croke Park voted to recommend that members reject the government's proposals on fixing the recruitment and retention crisis.

This means that all INMO members working in the public service will be balloted this month on whether to accept or reject the government's proposals, with a recommendation from the Organisation that they vote to reject it. If rejected, this would not mean automatic strike action – that would require a further ballot of members.

The government's proposals included a change in increments for some recent recruits and alterations to allowances for specific nurses and midwives. The proposals would have no impact on the majority of nurses and midwives in Ireland.

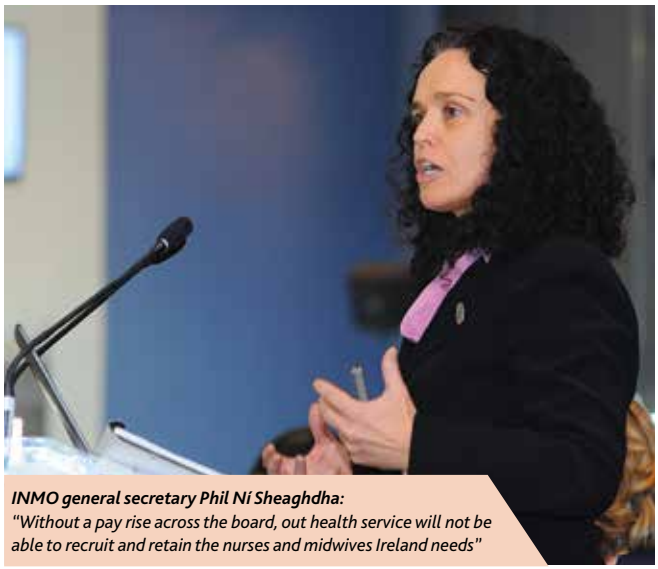
Nurses and midwives argued throughout the conference that the government proposals would not solve the recruitment and retention crisis, leaving wards and services understaffed coming into winter.

INMO general secretary Phil Ní Sheaghdha said: "The message from the conference was clear. Nurses and midwives are deeply frustrated with our health service. They are the lowest paid health professionals in Ireland, and many believe it's because they are mostly women.

"The government's proposals are simply not going to make a dent in the number of vacancies across Ireland. We are calling for members of political parties to stand with us to secure the future of our health service.

"Without a pay rise across the board, our health service will not be able to recruit and retain the nurses and midwives Ireland needs. That means more overcrowding and pressure on staff, with patients suffering as a result. As ever, we remain open to further discussion with the government."

Following the conference, INMO president Martina Harkin-Kelly said: "We are proud to be a democratic union, and now it is up to members to have their say. The special delegate conference has recommended that members reject the government's insufficient, divisive proposals."



INMO general secretary Phil Ní Sheaghdha:
"Without a pay rise across the board, out health service will not be able to recruit and retain the nurses and midwives Ireland needs"

INMO director of industrial relations Tony Fitzpatrick outlined the details of the government's proposal to delegates

Delegates united in opposition

Michael Pidgeon reports from inside Croke Park at the SDC

OVER 200 nurses and midwives met at a special delegate conference in Croke Park to discuss the government's proposals on fixing the recruitment and retention crisis.

INMO general secretary Phil Ní Sheaghdha said: "The sense of frustration in the room was palpable. We don't think the government's offer is good enough and it was heartening to see that over 90% of delegates agreed.

"The path ahead will not be easy. The government's studied indifference is driving us down the path towards a strike, which carries serious financial consequences for each and every member. But if we stand together, united in pride in our professions, I believe we can win the respect, safe conditions and fair pay that we have earned.

"For ourselves and our patients, we cannot allow the chronic understaffing and overcrowding to continue. We cannot go on like this."

Members' frustration

The conference itself heard presentations on the government's proposals and on the financial penalties for leaving the national Public Sector Stability Agreement.

But delegates were up for the challenge and clearly frustrated with the low pay. One member said: "What we get for our four hard years in college isn't the same as others, and that's just not right."

A student nurse rubbished the government's plans, saying that many of her friends and colleagues are leaving within a few months of qualifying. "A small pay rise after four years won't help them".

One INMO member, speaking about the Public Sector Pay Commission, said it "had all the hallmarks of the Department of Finance going into a room and dictating to the Commission. Classic divide and conquer tactics. 'We'll fire a few bob at some of them and split them up'."

Up for the challenge: *Roisin Lynch from Cavan General Hospital spoke passionately about the vital importance of safe staffing levels as she addressed the SDC*

Martin Ward, a CNM in Ballyshannon, was one of several delegates to express frustration at current unsafe staffing levels

Naomi Donovan, midwife at Cork University Maternity Hospital, was one of many inspiring members who addressed delegates at the conference

Speaking of their frustration, a member from Connolly Hospital said that staff "are on their knees", and that winter is coming. "I believe the nurses are ready and the time is right. The time is now, it's got to be industrial action."

However a more experienced nurse raised a note of caution, warning that the government's proposal could divide younger staff from old. She called for nurses and midwives to stay united, whatever is decided.

International members

Many members paid tribute to the work of international nurses working in the Irish health service, who "hold the service together". A member of the international section spoke of the extra pressures faced by some nurses from overseas, often assigned supervisory duties without extra pay.

One nurse spoke of her recent return from maternity leave, hoping that things had changed in the emergency department where she works. But the conditions she found were even worse: "I'm normally very moderate, but I've just had enough. It's time for every nurse and midwife to stand together and settle this for good."

First time speakers

Many of the delegates were attending their first INMO event. One said: "I don't normally like speaking in public. But I'm a long-serving nurse, so I get nothing from this plan. My daughter is a new graduate, so she gets nothing. She loves nursing, but she wants better pay and conditions, so she's leaving Ireland. Her ward is so overstretched, that she's been a patient in ED multiple times as a result. Enough is enough."

Another member spoke of the pride working with her mother in the same sector. She saw her mother fight for 30 years for fair pay and conditions. She does not want her children to have to face the same struggle, should they continue the family profession.

A midwife spoke of the need to stand together. "We all have family. It could be our granny in the ED, our kids in the paeds, and our sister in the maternity ward. There's been so much unity here today, so we need to light some fires when we get back to work."

Patient care at risk

Other members spoke about the experiences of patients. A paediatric nurse expressed fear of what their grandchildren would face in an Irish hospital: "We're losing good staff to overseas and other sectors. I worry about the care they'll get."

Another nurse shared a story of her brother, who tragically died after spending 38 hours on a trolley beside bins in an emergency department. She received a standing ovation and thanks from all at the conference.

Closing the discussion, a proud nurse said: "I'm willing to go out with my colleagues and friends. I've got my boots ready. We demand respect and we'll get it."

Government proposals at a glance

Industrial relations director Tony Fitzpatrick explains the government's proposals and why the SDC voted to recommend their rejection

The government's proposals

What's all this about?

For many years, the INMO has been campaigning for safe staffing. We argue that without an across-the-board pay rise, it will not be possible to hire enough nurses and midwives. The government has recently made some proposals, based on a report they asked for called the Public Sector Pay Commission.

You will have a chance to vote on these proposals in October when you will be asked to either accept or reject the proposals. The INMO is recommending that you vote to reject, but the decision is totally up to you. Every INMO member in the public sector will have a vote.

What has the government proposed?

The government's proposals are in five main parts. They propose:

1. Increasing location allowances by 20%. These are special allowances paid to nurses who work in 13 specific areas, listed in the box to the right. These allowances are now worth €1,858 a year and would increase by €371 a year – the equivalent of €7 a week before tax
2. Adding maternity services to the list of areas getting the location allowances, meaning that they will get a new payment, worth €2,229 a year before tax
3. Increasing the specialist qualification allowance by 20%. This is paid to nurses and midwives who have postgraduate qualifications in relevant fields. These are now worth €2,791 per year and would increase by €558 a year – the equivalent of €11 a week before tax
4. Allowing staff nurses and midwives to become senior staff nurses/midwives after 17 years, rather than after 20 years
5. Reviewing the pay that directors and assistant directors of nursing get, based on the responsibilities they have in their specific roles. We don't have much detail at this stage, but we will meet the HSE in October to discuss.

Anything else?

Separately, they've also proposed something for the nurses and midwives who joined the public sector since January 2011. They've been on lower pay, so the government is proposing moving them up an extra increment once they hit points 4 and 8 on the scale.

In practice, this means that after four years, you'll skip an increment, so you'll be paid as if you've been working for five years. After eight years, it'll be as if you've been working for nine years.

How they'll do this is complicated, so we suggest reading more about it on **inmo.ie** or getting in touch with the INMO information office at Tel: 01 6640600.

What about an across-the-board pay rise to fix recruitment and retention?

The government rejected our demand for an overall pay rise. The government's report said that there isn't a problem recruiting and retaining nurses and midwives generally, but only in specific areas. The Department of Finance agrees with the report.

So what next?

Now it's up to you to have your say. You'll get a chance to vote to accept or reject the offer. The choice is yours to make.

By the time you receive this issue of *WIN*, balloting should have already begun. It will run for two weeks, and we're holding information meetings across the country, some of which may have already taken place.

What do you recommend?

A special delegate conference was held in Croke Park last month and was attended by nearly 300 members. It decided to recommend that you reject the offer. They didn't think the offer is good enough, and don't think it will attract enough nurses and midwives to fix the understaffing problem.

The offer won't do anything for most nurses and midwives. The proposals are designed to divide us. We think that we can get a better offer if we stand together, united and firm.

Who gets the location allowance now?

According to official salary scales, nurses get the location allowance if they work in:

- Accident and emergency departments
- Theatre/operating room
- Intensive care units
- Cancer/oncology units
- Geriatric units/long-stay hospital or units in county homes
- High dependency units
- Neo natal units (ICU)
- Endoscopy units
- Specialist ambulatory dialysis units
- Units for severe and profoundly handicapped in mental handicap services
- Acute admission units in mental health services
- Secure units in mental health services

If you're eligible for a location allowance and a qualification allowance, you only get one: whichever is higher.

Whichever way you vote, the Executive Council will examine the result and decide on the next course of action. A rejection will not necessarily mean a strike, which would require a further vote by members.

What can I do?

We recommend doing three things.

1. Inform yourself. That means going to information meetings, following the INMO on Facebook and Twitter (@INMO_IRL), and setting aside some time to read through the documents on our website. Information is power
2. Talk to your colleagues, discuss the proposals. Make sure everyone you work with is in the INMO. United we stand, divided we fall. The more nurses and midwives are together in the union, the more power we have to stand up for our professions, our patients, and for ourselves
3. Vote! When the ballots are open, be sure to cast your vote and have your say.

INMO members protesting against the ongoing staffing shortages and overcrowding in hospitals across the country

Members protest nationwide against short staffing and overcrowding

HSE fails to put plan in place for predictable winter upsurge

INMO members came out in force outside several hospitals throughout the country over the past month to highlight ongoing unsafe staffing levels and hospital-wide overcrowding and the fact that, despite appeals from the INMO, the HSE had no plan in place to deal with the predictable exacerbation of these problems throughout the winter.

In powerful shows of solidarity, nurses and midwives protested outside hospitals in Cork, Galway, Limerick, Kilkenny, Cavan and Dublin to demonstrate to the HSE, and to government, that the overcrowding and staffing shortages are leading to unsafe conditions within the hospitals.

The number of patients without hospital beds this winter is expected to reach record levels and the HSE has yet to deliver a plan to cope.

INMO general secretary Phil Ni Sheaghdha said: "This is a health service in crisis. Without a plan to improve the situation, public safety is at risk. Nurses and midwives know their patients cannot get timely and appropriate care.

"The HSE must publish a realistic winter plan and commit to ending the near-permanent crisis in Irish hospitals. This should include immediate measures to recruit and retain nurses through a pay rise. Otherwise understaffing will only get worse.

"Nurses and midwives are constantly apologising to patients for the conditions in the health service. Thousands are trapped on trolleys every week and things will only get worse as winter bites. We can't go on like this – it's time for the HSE to be honest with the public."

Protests nationwide

INMO protests began across the country with the first taking place in Galway on September 10. In the region of 150 members from University Hospital Galway were joined by a number of public health nurses and TD Catherine Connolly. Momentum was high and several INMO members did national media interviews.

Sighting the challenges they are facing in UHG, members highlighted the fact that there are still in excess of 30 posts to be filled, despite UHG managing to retain 48 new nursing graduates. INMO IRO Ann Burke commended all members who gave up their lunch breaks to come out in large numbers, despite the inclement weather on the day.

On September 11, more than 250 nurses and midwives from Cork University Hospital (CUH), Cork University Maternity Hospital (CUMH) and from other areas across Cork, protested outside CUH to highlight the ongoing staffing shortages in the hospitals.

There is real concern for patient safety going into the winter period with significant numbers of patients on trolleys in the emergency department and on wards. CUH is repeatedly among the hospitals with the highest recorded trolley figures in the country. With over 40 medical and surgical specialties on the campus, CUH is the country's only recognised Level 1 trauma centre, INMO IRO Liam Conway said that members are concerned about the effect of the predicted winter surge at the hospital.

Also on September 11 roughly 100 members protested outside University Hospital Limerick, which has seen record numbers of patients on trolleys this year and is the most overcrowded hospital in the country. The hospital is short approximately 130 beds and has 65 funded nursing vacancies. INMO IRO Mary Fogarty commended members for advocating for better and safer patient care.

In Kilkenny, around 80 nurses and midwives gathered outside St Luke's Hospital on September 17. This hospital was forced to close a 14-bed ward due to nursing staff shortages over the summer months. There was great public support for the protest and INMO IRO Liz Curran said that members are disappointed that the PSPC report didn't grasp the nettle on nursing/midwifery pay.

In Cavan, over 60 members protested outside Cavan General Hospital on September 20. In August a parliamentary question was posed on a number of vacancies in Cavan Monaghan hospital group. There are 38 overall, the majority of which are in nursing. Across the hospitals there are various agreements on staffing levels which are not being met and staff are feeling under pressure, overworked and finding it difficult to provide the best patient care. Newly appointed INMO IRO for the region, David Miskell, would like to acknowledge work of local reps in organising the protest.

On September 25, in excess of 200 members, patients and allied health professionals protested at Connolly Hospital, Blanchardstown where there are approximately 50 unfilled posts. There was an increase of 64% in patients on trolleys in the first eight months of the year compared to the same period in 2017. INMO IRO Lorraine Monaghan commended the hospital reps, members, their colleagues and their patients for coming out and protesting.


STAND WITH
NURSES
& MIDWIVES
INMO
HEALTH SE
IN
CRISIS
DO YOU CARE?!


INMO
PAY FOR
NURSES
OR IT IS
SLÁN TO
SLAINTE CARE


SAFE
STAFFING
NOW


INMO


INMO
Irish Nurses and Midwives Organisation


INMO
SAFE
NOW
INMO
BEEP
IF YOU
SUPPORT
NURSES


INMO
SAFE
STAFFING
NOW


INMO


H
INMO
SAFE
STAFFING
NOW

TDs and senators turn up in force to stand with nurses and midwives

INMO nurses, midwives and student members from across Ireland came to meet TDs, senators and government advisors to make the case for fair pay and safe staffing, on September 19 in Dublin.

Around 50 Oireachtas members heard, first hand from members, about how low pay is causing serious understaffing and harming patient care.

Student members had a thorough debate with Fianna Fáil health spokesperson Stephen Donnelly about newly qualified nurses/midwives' pay. TDs Noel Rock (Fine Gael) and John Lahart (FF) heard of the problems caused by understaffing, while Senator Grace O'Sullivan (Green Party) discussed the benefits of midwife-led care. Social Democrats health spokesperson Róisín Shortall spoke with frontline nurses about implementing Sláintecare, and Labour health spokesperson Alan Kelly indicated support for a pay rise.

Sinn Féin's health and mental health spokespeople Louise O'Reilly and Pat Buckley, also chatted with members about the challenges they face.

Members of all parties and independent TDs came to speak with us. The INMO is now seeking further meetings to ensure the case is made in the strongest possible terms.

Pictured from top (l-r): *INMO student members and student officer Neal Donohue outside the Dáil; Mattie McGrath TD with Joe Hoolan, IRO; INMO general secretary Phil Ní Sheaghdha with Michael Healy-Rae TD; student members get their points across; Lorraine Monaghan with Sean Haughey TD; INMO officers, Eilish Fitzgerald, Martina Harkin-Kelly, president, and Catherine Sheridan; Éamon Ó Cuív TD in conversation with Catherine Sheridan and Phil Ní Sheaghdha; Niamh McKeon (Executive Council), Senator Grace O'Sullivan and Bernadette Stenson (Executive Council); Donna Hyland (Executive Council) and Hildegarde Naughton TD talking to Joe Hoolan; Louise O'Reilly TD, Liz Curran IRO, and Senator Máire Devine; IRO Mary Fogarty standing with Jan O'Sullivan TD and Alan Kelly Labour Health spokesperson; Roisin Shortall (SD health spokesperson) greeting student members; Phil Ní Sheaghdha with Stephen Donnelly (FF health spokesman); and Joe Hoolan with Tom Neville TD*

Worst ever August for overcrowding

HSE admits it has no winter plan in place despite deepening crisis

AUGUST 2018 is the worst August on record for hospital overcrowding, according to INMO trolley/ward watch analysis.

The monthly analysis shows that 7,911 admitted patients were forced to wait on chairs or trolleys in August 2018 – an increase of 2% on last year. There were 30 children among those waiting without a bed.

The hospitals with the highest figures were:

- University Hospital Limerick, 969
- University Hospital Galway, 619
- Cork University Hospital, 604.

INMO general secretary Phil Ni Sheaghdha said: "Even though it was a mild month weather wise, patients and staff faced record overcrowding. Nearly 8,000 sick and injured people were forced to wait without a bed.

"The message from the frontline is clear: this all comes down to pay. The HSE simply cannot find enough nurses and midwives to work on these wages. It's no coincidence that Limerick has had such a bad month, as they have over 70 unfilled nursing vacancies.

"Unless nurses and midwives get pay equality with similarly-qualified health professionals, vacancies will remain open and things will only get worse."

Winter plan

The INMO met the HSE and the Department of Health at the Workplace Relations Commission in early September to discuss understaffing and overcrowding. At the meeting the HSE admitted it did not have a plan in place to deal with extra patients this winter.

The HSE also admitted that it had been unable to fill 169 nursing posts in emergency departments across Ireland, for which it has funding. On top of this, an additional 57 nurses would be required to provide minimum levels of safe care, according to recognised staffing ratios. Yet funding for the posts has not been granted.

(see opposite)

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

Hospital	August 2006	August 2007	August 2008	August 2009	August 2010	August 2011	August 2012	August 2013	August 2014	August 2015	August 2016	August 2017	August 2018
Beaumont Hospital	232	408	713	520	504	596	304	508	490	678	335	265	177
Connolly Hospital, Blanchardstown	162	259	255	152	359	354	386	464	271	364	138	187	260
Mater Hospital	197	315	487	385	354	333	328	82	285	218	316	436	288
Naas General Hospital	206	68	122	199	292	221	65	40	230	273	95	304	266
St Colmcille's Hospital	39	42	48	145	96	126	171	47	n/a	n/a	n/a	n/a	n/a
St James's Hospital	8	41	120	174	31	77	60	104	165	101	108	117	99
St Vincent's University Hospital	385	545	271	354	509	587	432	74	191	335	284	134	289
Tallaght Hospital	227	399	319	237	457	335	47	357	188	395	121	381	330
Eastern total	**1,456**	**2,077**	**2,335**	**2,166**	**2,602**	**2,629**	**1,793**	**1,676**	**1,820**	**2,364**	**1,397**	**1,824**	**1,709**
Bantry General Hospital	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	7	15	68	37
Cavan General Hospital	216	141	263	177	168	382	142	228	42	84	27	67	13
Cork University Hospital	319	189	329	272	453	418	151	261	115	399	473	457	604
Letterkenny General Hospital	330	59	24	35	36	70	32	7	152	235	128	241	359
Louth County Hospital	34	4	n/a	12	n/a	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	118
Mercy University Hospital, Cork	90	108	69	38	117	44	137	122	130	98	243	256	183
Mid Western Regional Hospital, Ennis	16	2	5	5	46	264	109	178	410	149	254	391	304
Midland Regional Hospital, Mullingar	31	8	13	7	9	125	20	100	82	77	287	260	215
Midland Regional Hospital, Portlaoise	5	2	5	7	71	89	77	22	169	267	290	452	431
Midland Regional Hospital, Tullamore	94	9	17	23	26	20	24	n/a	n/a	5	20	n/a	n/a
Monaghan General Hospital	13	4	17	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Nenagh General Hospital	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	2	n/a	n/a	17
Our Lady of Lourdes Hospital, Drogheda	301	91	293	289	236	776	604	165	346	680	391	93	192
Our Lady's Hospital, Navan	77	34	90	57	50	93	13	36	33	56	35	164	53
Portiuncula Hospital	2	10	2	67	62	97	32	45	48	49	40	52	162
Roscommon County Hospital	23	9	14	25	106	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Sligo University Hospital	56	70	13	34	140	24	277	81	71	158	144	90	264
South Tipperary General Hospital	12	82	52	33	4	1	153	166	82	115	470	489	342
St Luke's Hospital, Kilkenny	n/a	n/a	n/a	n/a	13	52	55	139	84	255	197	432	365
University Hospital Galway	76	123	238	256	232	554	195	146	319	458	400	643	619
University Hospital Kerry	94	55	9	9	37	70	81	49	95	108	148	170	300
University Hospital Limerick	29	32	85	105	186	342	247	224	458	618	610	835	969
University Hospital Waterford	n/a	n/a	25	18	64	76	120	180	47	159	291	486	435
Wexford General Hospital	293	13	189	344	140	490	44	73	135	70	101	197	220
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**	**6,202**
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**	**7,911**

Comparison with total figure only:

Increase between 2017 and 2018: 2%
Increase between 2016 and 2018: 29%
Increase between 2015 and 2018: 21%
Increase between 2014 and 2018: 70%

Increase between 2013 and 2018: 102%
Increase between 2012 and 2018: 79%
Increase between 2011 and 2018: 19%
Increase between 2010 and 2018: 61%

Increase between 2009 and 2018: 96%
Increase between 2008 and 2018: 92%
Increase between 2007 and 2018: 146%
Increase between 2006 and 2018: 114%

HSE fails to provide answers on key issues at ED oversight meeting

INMO contests figures supplied by HSE on number of ED posts

THE INMO sought answers from the HSE on several issues at last month's Emergency Department Agreement oversight meeting at the Workplace Relations Commission.

At the meeting on September 7, 2018, the INMO (represented by director of industrial relations Tony Fitzpatrick, ED reps and IROs) met with HSE and Department of Health's senior managers under the chairmanship of Mr John Kelly. The INMO highlighted deficiencies in the figures HSE management had supplied before the meeting, and sought answers to a number of questions from the HSE, including:

- **What is the HSE plan for winter 2018/2019 in order to alleviate the overcrowding that currently exists within EDs and hospital wards?**
- **What service curtailment plan has the HSE to ensure that services are curtailed in order to alleviate the problems within EDs?**
- **What had the HSE done differently in the previous four weeks to alleviate overcrowding on hospital wards and in EDs?**
- **What plans were in place to ensure the filling of posts that are currently vacant within the system (169 WTE) and fund the posts (57 WTE) required to care for admitted patients?**
- **What plans were in place to ensure the de-escalation of hospitals to allow extra trolleys that are being placed on wards to be taken down, and to ensure that adequate staffing is in place on these hospital wards?**

In summary, the HSE indicated that there had been a 22% increase in the number of posts within emergency departments since 2015. However, the INMO contested these figures.

The HSE outlined that it was engaged in ongoing discussions with the Department of Health and the Department of Public Expenditure and Reform (DPER) with regards to winter plans and that it was not yet in a position to outline those plans. The HSE indicated it intended for these ED plans to be formulated on time to be approved at the ED Taskforce meeting due to take place on September 27, 2018 (as *WIN* went to press).

> ***"It's impossible to think that things could get any worse. But winter is coming and there's still no plan. It will simply be impossible to provide safe care. Emergency departments were overcrowded in summer – they'll be war-zones once winter comes."***
> *– Quote from INMO ED rep following ED Agreement oversight meeting*

The INMO stressed that winter initiative plans should have been devised much earlier in the year – in April/May – to ensure hospitals had time to implement them to alleviate the predictable problems.

The Department of Health confirmed that the HSE had made submissions to the Department and DPER with regards to funding the 57 additional posts required to care for admitted patients. It stated that, while a further meeting was due to take place the following week, at that point no funding had yet been approved and there was likely to be a difficulty providing funding due to the current overspend in health.

The INMO outlined that this was an extremely serious situation for the HSE as it had conducted an exercise with the Department of Health which identified the requirement for 57 additional nurses to maintain safe care. Therefore, the HSE was knowingly allowing patients to be placed at risk.

The HSE did not present any plans with regards to filling current vacancies, except to say that it was doing everything possible to recruit additional staff. It also did not respond on whether it had plans in place to ensure the health, safety and welfare of INMO members.

However, the HSE said it was equally concerned to ensure that hospitals did not have ADONs for patient flow fulfilling an operational role within EDs as this was contrary to the central instruction of the Acute Hospitals Division. The INMO requested that the HSE pursue this matter with all hospital groups.

The INMO also sought confirmation that approval would be granted for CNM2s for admitted patients in Letterkenny, Kerry, Kilkenny, Mercy Hospital Cork and Sligo. The HSE outlined that the Acute Hospitals Division is positively pre-disposed to approving these positions, however, to date had not received any business cases from the hospital groups.

In conclusion, the meeting was most unsatisfactory, and the INMO outlined this to management. There are now 169.34 vacant posts within EDs across the country. The service has also been denied funding for the additional 57 WTE nurses to look after admitted patients. It appears that of the 123 posts that were allocated in 2017 for admitted patients, 39 remain unfilled.

Despite the high volume of vacancies within EDs, there is no discernible plan from the HSE on how it is going to fill those posts or address overcrowding.

– Tony Fitzpatrick, INMO director of industrial relations

INMO director of industrial relations Tony Fitzpatrick: *"Despite record overcrowding this summer, the HSE still doesn't have a plan to deal with winter. Community health services are being cut, so EDs will face a tsunami of desperate patients with nowhere else to go. The recruitment and retention crisis is deepening, with hundreds of nursing vacancies in hospitals across Ireland. Nurses and midwives have begun protesting at some of the worst-affected hospitals. We cannot go on like this. The HSE has to be honest with the public"*

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

Timing of 'technical adjustment' repayments

SEVERAL members have contacted the INMO recently about letters they have received from their payroll departments seeking repayment of technical adjustment.

On foot of these notifications, the INMO contacted Corporate Employee Relations Services (CERS) and National HR and a meeting was convened with HSE senior management and payroll in August 2018 to discuss the matter.

At this meeting, it was reaffirmed that the technical adjustment principles agreed in 2004-2005 continue to apply. At that time, it was agreed the technical adjustment cash value could be recouped either when the employee is leaving the service or over several pay periods, that is either of the following:

- *Technical adjustment cash value to be recouped on leaving* – the gross pay value of the technical adjustment is recouped on leaving. This does not include any provision for inflation and other increases
- *Technical adjustment to be recouped over several pay periods* – the gross pay value of the technical adjustment can be recouped over a fixed number of pay periods.

In 2005 individuals would have received correspondence indicating the amount of the technical adjustment to their pay and offering them one of the two options above. Our advice to members who receive a letter from payroll regarding the repayment of technical adjustment is to:

- Ensure that the technical adjustment amount reflects the amount that you were originally advised of in 2004-2005
- If you are not aware of/do not recall the amount from 2004-2005, contact the payroll department directly and seek proof of the 2004-2005 figure.

The HSE is to provide the INMO with clear explanations on the technical adjustments and the contact details of the various payroll departments that are dealing with this matter. There is no requirement for members to repay early *unless they so wish*. Repayment can wait until the employee leaves the service.

Framework for discussions on time and attendance changes

A DRAFT framework to allow for local engagement on the introduction of time and attendance changes was due to be drawn up by IBEC and the HSE in September, for consideration by the INMO and other nursing unions.

This follows the matter of time and attendance being raised at the National Joint Council by IBEC and the HSE, and in March 2018 the INMO, along with other unions, sought that a framework would be agreed in order to allow for local engagement on the issue.

It was agreed that a number of principles would be formulated into a framework between the unions, IBEC and the HSE on the introduction of time and attendance changes.

This framework was to simply set out how engagement and consultation should take place regarding time and attendance timeframes, implementation phases and review periods, in order to ensure compliance with all information and consultation requirements.

Once a framework was agreed, this would allow for local engagement to take place, with detailed proposals being provided to the unions collectively and individually.

IBEC and HSE agreed to draft a framework document and issue it to the unions by September 11, 2018. At time of going to press, the unions were considering the proposal and will revert to IBEC and HSE shortly.

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

National review of the role of the healthcare assistant

The INMO has been involved in the national review of the role of the healthcare assistant (HCA), which is under the chairmanship of Sean McHugh. The final draft report and literature review has now issued and was due to be discussed by the INMO Executive Council at its September meeting. The INMO would then feedback to the chairperson, before publication of the final report. See **www.inmo.ie** and INMO social media platforms for updates on publication of this report.

Governance of home helps

Discussions have been ongoing this year on the issue of home help governance and the single assessment tool. Following a meeting in July between the INMO and the HSE, with an independent chairman, documentation was forwarded by the HSE for review. A subgroup was due to meet in September and October to review and agree on the documentation to be presented to a further meeting.

Occupational health nursing strategy

The INMO has secured a number of amendments to the draft report on an occupational health nursing strategy, to ensure an appropriate line management and executive nurse management structure for OHNs. A final draft had recently been issued. The INMO has written to management expressing dissatisfaction at unilateral amendments and seeking a meeting. The launch of this strategy has been delayed to allow for further negotiation on its contents.

Global Nurses United:
At the GNU annual meeting in Sydney were (l-r): Rita Martin, New South Wales Nurses and Midwives Association; INMO first vice president Catherine Sheridan; Judith Kiejda, NSWNMA; and INMO IRO Mary Fogarty

INMO presentation to GNU:
INMO first vice president Catherine Sheridan addressing the GNU annual meeting in Sydney

Global fight to secure safe ratios

Mary Fogarty reports from the GNU conference in Sydney

THE struggle to secure safe nurse/midwife to patient ratios was a common theme running throughout the annual meeting of Global Nurses United (GNU), which took place in Sydney, Australia in July.

The INMO, as a founding and active member of GNU, was represented at this meeting by myself and Catherine Sheridan, first vice president.

GNU is a forum that brings together 17 national nursing and midwifery unions, which all share the common goal of defending and improving members' working conditions and ensuring recognition of the central role undertaken by nurses and midwives in our health services.

The GNU conference heard the union leaders from nursing and midwifery in 15 of the 17 member countries discuss a range of issues of common interest and concern.

A common theme from all the attending countries was the struggle to secure safe nurse/midwife to patient ratios. Significant campaigns on ratios have taken place in Quebec, South Korea, New South Wales, Victoria and New Zealand with the unity of union members being a key strength in achieving the campaign goals.

As part of her presentation, Catherine Sheridan gave the Irish perspective on this, outlining the Framework on Safe Staffing and Skill Mix on Medical and Surgical Wards, which provided overwhelming evidence on the measurable benefits from ensuring the correct nurse staffing levels are constantly protected and supported.

Ms Sheridan also gave the conference a comprehensive overview of other current issues in Ireland, including:

- The claim for pay parity and the Public Services Pay Commission's report, which was then imminent
- Hospital overcrowding
- The two-tier healthcare system, detailing the proposals within the Sláintecare report
- The ongoing scandal of the cervical screening programme was explained in the context of providers seeking out lower cost options without full overview of the service clinical requirements.

The topic of violence against healthcare workers was addressed by Christopher Cliffe, chief executive officer of CRANAplus, which is the peak professional body in Australia for remote and isolated healthcare workers. He told the conference of the murder of remote nurse Gayle Woodford in South Australia who was lured out to her death when on call in November 2017. CRANAplus developed a comprehensive guidance booklet for the safety and security of remote workers. Mr Cliffe also spoke on indigenous health in remote locations.

Jason Ward, adjunct senior researcher in the Institute for Study of Social Change at the University of Tasmania, spoke on profit shifting from public funds through tax avoidance mechanisms. This presentation highlighted how in aged care in Australia the public funds accessed by private, for-profit healthcare providers are used to increase profits to the detriment of nurse to patient staffing ratios. The Global UK-based company Bupa was identified as being under investigation as it is the largest for-profit aged care company in Australia.

The conference heard from officers of the New Zealand Nurses Organisation (NZNO) on its recent fight for improvements in nurses' pay and nurse to patient ratios. A fifth government proposal was being considered by the union at the time of the conference, which has since been accepted.

The GNU ratified a proposal during the conference in support of Spanish nurses via their union SATSE, which is campaigning for the establishment of minimum nurse ratios related to the needs of patients. This campaign is moving to get political support for legislation that guarantees minimum numbers of nurses per patient.

Fernando Losada, National Nurses United (NNU) in the US, spoke on the effects of the climate crisis on public health, with eight million deaths annually from air pollution alone. We also heard from Ken Zinn, political director at the NNU, of the struggle for nurses in the world renowned Johns Hopkins Hospital to organise in a union.

Following the GNU conference, Catherine Sheridan and I attended two days of the New South Wales Nurses and Midwives Association (NSWNMA) annual conference in Sydney, which we noted had many similarities to the INMO ADC.

Day one of this conference focused on professional issues with enlightening presentations from Dr Jordan Nguyen on the intersection between technology and humanity; Donovan Jones and Shanna Fealy on applying innovative technology to midwifery education; and from Prof Lisa Nissen on quality use of medicines – the future for nursing and midwifery in medicines.

Prof Nissen's view is that patient engagement is the drug of the future.

Hannah Dahlen, midwife and researcher, presented on midwives reclaiming their heritage. Tracey Spicer of the Tedx Talk 'The Lady Stripped Bare' urged delegates to stand up and speak out for the good of our profession, community and society.

While in Sydney we visited Liverpool Hospital, an 877-bed hospital situated 50 minutes outside central Sydney. It is a principal referral and teaching hospital of the University of NSW and University of Western Sydney. It is a major emergency and trauma centre and has 23 operating theatres, maternity and paediatric, and medical and surgical services from birth to aged care. The range of educational and training facilities at the hospital for all healthcare professionals was simply amazing.

On day two of the NSWNMA conference we heard from nursing and midwifery representatives at the frontline who are union leaders in their workplaces on how they stood united to secure improvements in staffing levels. The NSW health minister attended the conference and was faced with dozens of union members queuing to question him on his commitment to fund the agreed nurse to patient staffing ratios.

Being part of the global family of nursing and midwifery is important for the INMO as we obtain beneficial insights into how our fellow professionals are mobilising.

We learn from the valuable work of others, contribute to that work, and build on the global solidarity which assists us to both defend our members and assist others to defend theirs. It was a great privilege for me to attend this year's conference.

Mary Fogarty is an INMO industrial relations officer

Payment of allowances at Bon Secours, Limerick

THE INMO secured the correct payment of annual specialist and location allowances for all nurses at Bon Secours Hospital, Limerick, as the hospital was not paying this for nurses on maternity leave, annual leave or paid sick leave.

Management proposes to backdate the underpayments to January 2018, however the INMO is seeking further retrospection.

The Organisation is also in negotiations on new HR policies at the hospital. A new policy on maternity pay top up when a nurse is on maternity leave has not been agreed as it proposes to pay higher earners a higher percentage of basic pay than those on lower salaries. Management is reviewing same ahead of the next scheduled meeting.

– Mary Fogarty, INMO IRO

ADON post secured at Mount Alvernia, Mallow

THE INMO secured the protection of the assistant director of nursing grade at Mount Alvernia Hospital, Mallow at the Workplace Relations Commission last month.

This brought to an end a longstanding dispute in which the HSE sought to reconfigure the governance structures within the hospital, ultimately losing the post of ADON for Mount Alvernia. However, after a number of conciliation conferences members and reps were successful in retaining the post at Mount Alvernia.

On the same day, Mount Alvernia members landed another collective victory by putting forward a new rostering proposal that would result in an early start and early finish in the afternoon. The rostering proposal was accepted by the HSE.

The above issues are seen by members as significant to improving their work life balance and have a significant positive outcome for the delivery of the service within Mount Alvernia.

– Liam Conway, INMO IRO

Limerick rep training course:
At the very successful rep training course that took place in Limerick recently were (standing, l-r):Sinead Skinnader, Aine Quirke, Slyvia O'Brien, Maria Abollah, Dave Hughes (INMO deputy general secretary) and Mary Fogarty (INMO IRO in the Limerick region) and (seated, l-r) Patricia Malone, Claire Burke, Marie Flood, Catherine Selley, Colleen Moyles, Angela Mulcair and Fiona Deasy

World news

Nurses and midwives in action around the world

Australia
- Government agrees to develop nurse ratios framework
- New figures show a marked increase in ED presentations

Canada
- Quebec election: CAQ vows to abolish mandatory overtime for nurses
- Nova Scotia appoints panel on long-term care: 'It's been ignored for far too long'
- Toronto hospitals can't force unvaccinated nurses to wear masks, ruling says

Guatemala
- Health worker union accepts salary increase proposal

Kenya
- Hospitals remain closed due to shortage of personnel

New Zealand
- Nurse strangled at hospital; staff issued with camera vests
- 50 patients, one nurse: Coroner's findings show high caseload for Waikato mental health nurse

Philippines
- Why Filipino nurses pursue greener pastures in the United States

United Kingdom
- One in four nurses drop out before graduating, new research reveals
- London mayor backs campaign to tackle nursing shortages

United States
- Nurses at many HCA hospitals say they are willing to strike over pay, staffing, security
- Nurse's union claims St. Joe's staffing shortage risks patient lives, hospital responds

Public servants are paying more than their fair share of taxes, says **Dave Hughes**, who backs shifting some of the burden back to VAT

PAYE workers pay the bulk of tax collected

THE Revenue Commissioners annual report 2017 records that the total amount collected in taxes on behalf of the state came to almost €71 billion, which is probably the largest tax collection ever on behalf of the Irish Republic.

In its report, Revenue indicates that the increased revenue collection is a reflection of a recovered economy with growing employment. The shift however in the sources of tax from value added tax (VAT) to income tax is notable.

In the boom years up to 2008, the amount of money collected from VAT exceeded that collected from income taxes. The two have always been the highest yielding tax heads for Irish governments. In the recessionary years the amount collected in income tax has consistently been the higher of the two and in 2017 with the declared recovered economy, the amount collected between income tax, levies and USC has stretched well ahead of VAT, with €22 billion being collected in income tax as against €17.9 billion from VAT. Probably the most reported tax head in 2017 was corporation tax but by comparison to the two big tax head, this produced €9.3 billion.

Income tax comes from two sources – the self employed and the PAYE taxpayer, or those who work for others. In net terms the PAYE taxpayer paid €16 billion of taxes, including the USC, while the self-assessment tax on self-employed yielded €2.4 billion. But for nurses, midwives and all other public servants, PAYE and USC were not the only taxes collected with the public service employment levy yielding, yet again, another €700 million to the exchequer.

In Revenue's breakdown of net receipts by employment sector, the PAYE collected from public servants in administration, defence, education, health and social services was over €4 billion. That represents more than 25% of the total net PAYE take from a sector employing only 18% of the workforce. Public servants are paying more than their fair share of taxes.

It is galling, therefore, to hear the loud voices calling for tax concessions and the hospitality industry demanding the retention of temporary reduction in VAT it gained seven years ago in 2011 based on arguments relating to the depth of the financial crisis and its impact on our hospitality sector and the April 2010 Icelandic volcanic eruption.

The rate of tax on the hospitality sector in Ireland was 13.5% in 2011 and it was reduced to 9%. Even at its previous level it was among the lowest in Europe and the reduction measure was only announced as being intended to last until 2013. Seven years later the Irish Congress of Trade Unions is calling for the relief to be abolished.

The Department of Finance estimates that this temporary measure cost €2.2 billion in foregone taxes between the years 2011 and 2016. When one looks at the figures above it is clear that the shortfall was then made up in monies collected from the PAYE worker, including those who work in the hospitality sector.

Congress in its pre-budget submission has advanced reasons why the temporary reduction should be withdrawn. Among these are the fact that visitor numbers are up by two million from their previous high point in 2008, and so are profits in the hospitality sector.

Arguments about the impact on small seasonal business with low annual turnover mask the fact that the sector is dominated by 30 large firms with over 12% of the sector's annual turnover between them.

Sustaining the lower rate of VAT is less likely to help small enterprises in the tourist business than raising the threshold for VAT registration from its current level of circa €32,000 per annum. That threshold could realistically be more than doubled without impacting on the revenue collected if the lower rate was removed.

As most customers will agree the lower VAT rate has not resulted in cheaper hotel rooms or meals in restaurant, and there is ample evidence that the sector is one of low pay and insecurity.

So, as the Minister for Finance prepares for this year's budget, it is time to look at investment in public services and, particularly, our health service. Sláintecare needs funding as do adequate salaries for the recruitment of nurses and midwives. A significant contribution to the ability to do both would be the abolition of the temporary concession to the hospitality industry.

In 1980 we witnessed mass demonstration by PAYE workers against the excessive burden they carried at that time while others were tax free. While subsequent reforms brought around by those protests have seen tax taken from those who previously did not pay, or paid very little, gradually we are seeing the erosion of the taxes coming from other sectors and more and more the PAYE worker is carrying the burden.

The Congress pre-budget submission is available at **www.ictu.ie**

The Revenue Commissioners tables of revenue collected are available from the Revenue Annual Report 2017, which is available at **www.revenue.ie**

Packed agenda at OHN Section's annual conference in Limerick

MORE than 70 occupational health professionals met in Limerick last month to attend the OHN Section's annual conference.

INMO president Martina Harkin-Kelly briefed members with a national industrial relations update as well as the issues of overcrowding, short staffing and the ongoing issues of recruitment and retention.

Ms Harkin-Kelly complimented the planning committee on putting together such a relevant programme, which touched on all four key components of workplace health management; occupational health and safety, workplace health promotion, social and lifestyle determinants of health, and environmental health management.

Left: At the OHN Section's annual conference were (l-r): Una Feeney, chairperson; Margaret Morrissey, FOHNEU rep; Jonny Holland, speaker; Martina Harkin-Kelly, INMO president; Mary Forde, planning committee; Michelle Russell, speaker. Right: Neil O'Brien, mental fitness coach, speaking at the OHN's annual conference

Michelle Russell delivered a presentation on safety in practice, a topic requested in the feedback from last year's conference. This subject is always relevant and brings into focus the importance of policies, procedures, guidelines and keeping the patient central to the process. Following the evaluation of the feedback, the Section will be running a three hour OHN-specific workshop in the Richmond Education and Event Centre in November. Full details on this workshop, which will be free for members to attend, will be issued to the Section.

Former Munster rugby player Jonny Holland addressed members on the topic of personal wellness. Mr Holland now devotes his time to public speaking, health promotion and nutrition. He detailed the benefits of exercise, recommended guidelines and stressed the importance of finding an exercise that you enjoy.

The mid-morning session focused on work-related suicide and self harm. Facilitated by Birgit Greiner, the session promoted practical support around mental health in the workplace. Ms Greiner, a senior lecturer in public health in UCC, has done extensive research on the investigation of work stress factors as determinants of physical and mental health. She is currently working with the National Suicide Research foundation on a case-control study on psychosocial, psychiatric and work-related factors for suicide to respond to the increasing demands of evidence-based guidance for the prevention and management of mental health issues in the workplace.

Dr Sarah O'Neill, chartered counselling psychologist and medical director at Spectrum Mental Health, spoke on practical support around mental health in the workplace. Prof Carl Vaughan from the Mercy Hospital presented on advances in cardiac care and the impact on employees' return to work. Neil O'Brien, gave a talk on 'mental fitness in times like these.' Neil is one of Ireland's most requested speakers and coaches in the area of mental health and fitness, along with career and work success.

Busy meeting for RNID Section

At the RNID Section education meeting, facilitated by Barbara Cunningham CNS/CPC Brothers of Charity, were the officers of the Section Marian Spellman, Anne Marie O'Reilly and Ailish Brennan

The RNID Section held a well-attended workshop and meeting in September in the Richmond Education and Event Centre.

A national update on issues was provided to an audience of more than 65 members, and delegates were nominated to attend the special delegate conference on the organisation's pay claims.

The Section will next meet on December 12 at the INMO.

Retired Section autumn break

The Retired Section is having its next autumn break on October 22-24, 2018 in the Castlecourt Hotel, Westport, Co Mayo. The cost for three nights B&B and two dinners is €195 per person.

To ensure your place, contact Grace O'Malley at the hotel at Tel: 098 55088. Any further queries can be directed to Teresa Connolly from the Retired Section Social Committee at Tel: 087 6402962.

International Nurses and Midwives Section CultureFest

The International Nurses and Midwives Section recently held its CultureFest. A full report, including photos of the event, will be included in the next issue of WIN.

See Diary on *page 68* for details of upcoming section meetings and conferences

Introducing Executive Council 2018/2020

The INMO Executive Council for 2018/20. *Back Row (l-r): Ailish Byrne, Niamh McKeon, Clare Hoban, Kathryn Courtney, Sean Shaughnessy, Ann Noonan, Bernadette Stenson, Donna Hyland, Karen Eccles, Maeve Gaynor, Frances Cullen, Marie O'Brien, Grainne Walsh, Helen Butler.Front Row (l-r): Tony Fitzpatrick, director of industrial relations; Catherine Sheridan, first vice-president; Dave Hughes, deputy general secretary; Phil Ní Sheaghdha, general secretary; Martina Harkin-Kelly, president; Eilish Fitzgerald, second vice-president; and Edward Mathews, director of regulation and social policy. (Executive Council members not in photo: Breege Creaven, Ann Fahey, Margaret Frahill, Karen McGowan and Ethan O'Regan)*

All photos by Lisa Moyles

Officers

President

Martina Harkin-Kelly is a specialist co-ordinator and nurse educator, CNME Sligo/Leitrim and West Cavan, HSE Cregg House Campus. This is her second term as president having served on the Executive Council since 2012. Martina qualified as an RGN in 1986 and worked at Moorfield Eye Hospital in London for four years before returning to Ireland to take up a position in Sligo General Hospital. She holds a BA in economics and sociology and an MA in humanities. She has worked in the specialities of ophthalmics, coronary care, orthopaedic theatre and nursing administration. She is also a dual qualified BLS instructor and community first responder. Martina is the INMO representative for the centre for nurse education.

First-vice president

Catherine Sheridan is the paediatric early warning system (PEWS) coordinator for Galway University Hospitals. She is qualified as a RGN. She is a qualified basic life support/cardiac first responder and paediatric advanced life support instructor working part-time as the training site coordinator for Croí, the West of Ireland Cardiac Foundation and is a provincial faculty member of the Irish Heart Foundation. She was awarded an honorary clinical fellowship in 2011. She completed a PGDip in health sciences at NUIG in 2016 and is currently undertaking a masters degree in clinical education. Catherine has served two consecutive terms on Executive Council and is an active member of the Galway Branch of the INMO.

Second-vice president

Eilish Fitzgerald is a PHN at South Lee, Cork/Kerry Community Healthcare. She is a RGN, RM, and holds a higher diploma in public health nursing from UCC and a diploma in nursing management from the RCSI, as well as CPD modules from UCC in physical nursing assessment, obesity management and prevention for healthcare professionals. Eilish has been actively involved in the INMO since 1997. At branch level she has been chairperson, education officer and is currently vice-chairperson of the Cork HSE Branch. She has also been chairperson and vice-chairperson of the PHN Section and sat on the standing orders committee for ADC for two terms. Eilish served on the previous INMO Executive Council.

Clinical

Ailish Byrne is a senior staff nurse at the Muirosa Foundation, Laois Family Support Services. Ailish trained as an RNID in Moore Abbey, Monasterevin before completing her training in general nursing at University Hospital, Kerry. She has worked in surgical areas at University Hospital Waterford and St Luke's, Carlow/Kilkenny and has been a local representative for Laois Disability Community Services for the past 16 years. Ailish is the chairperson of RNID Section.

Kathryn Courtney is a CNS in palliative care at Marymount Hospice in Cork. She did her general training in Mercy University Hospital before studying for a diploma in health services management at the College of Commerce. Kathryn also holds a BSc in nursing from UCC and a PGDip in nursing (palliative care) from UL. She worked in Australia and also in Dublin for some time and returned to Cork to work at Marymount University Hospital and Hospice, where she has been since 2005.

Breege Creaven works as a staff nurse on the surgical urology ward at Galway University Hospital. Breege trained at UCD and St Michael's Hospital, Dun Laoghaire (2008-2012) and worked on a respiratory medical ward for two and a half years at Beaumont Hospital. Breege received a PGDip in respiratory nursing care from the RCSI in 2015 and completed her MSc in general nursing at University of Limerick in 2018. She joined the INMO in 2008 as a student.

Clinical

Frances Cullen is a senior staff nurse at St. Joseph's District Hospital, Ballina, Co Mayo. She holds a postgraduate honours degree in gerontology from NUIG. She also holds a 998 teaching and assessing certificate from the ENB in London. Frances did her general training in London and worked in teaching hospitals with high dependency nursing, intensive care and neurology patients. She is vice-chairperson of the Ballina/Belmullet Branch.

Karen Eccles is a staff nurse in theatre at Cavan General Hospital. She qualified as an RGN in Kent and completed the ENB183 theatre and anaesthetic course at St Thomas's Hospital, London. Karen then worked in the Blackrock Clinic and later as a CNM2 in theatre at St Vincent's University Hospital, Dublin. She is chairperson of the Cavan Branch, and vice-chairperson of the Theatre Section. She has represented members at joint reviews, Labour Court and WRC hearings, and attended ED negotiations.

Ann Fahey is a staff nurse at Our Lady's Hospice, Harold's Cross. Ann began her nurse training at 18 but, due to the marriage bar, was forced to discontinue. For years she worked as an auxiliary nurse at the Adelaide Hospital and then entered the diploma course in 1996 through Trinity College, finally becoming a nurse. She qualified as a CNS and, in 2013, completed a teaching and learning certificate at UCD. She is a representative for Our Lady's Hospice and chairperson of the Dublin Southwest Branch.

Maeve Gaynor is a staff midwife on the labour ward at Our Lady of Lourdes Hospital, Drogheda. She qualified as a registered midwife (BSc) in 2012 from Dundalk Institute of Technology and completed a nurse/midwife prescribing certificate at the RCSI in 2016. She also holds a BSc in science from UCD and a diploma in network and satellite communications from Letterkenny RTC. Maeve has worked for five years as a registered midwife. She has been a member of the INMO for over nine years.

Clare Hoban is a staff nurse at Temple Street. She trained as a RGN from 2002 to 2005 at the Mater Misericordiae University Hospital and went on to work on the ophthalmology ward at St Elizabeth's as a staff nurse until July 2006. She worked in the Ophthalmology Outpatient Clinic at CUH Temple Street from 2006 until 2009 and before becoming a member of the phlebotomy team, servicing a busy outpatient clinic as well as providing a ward service. Clare has been an INMO representative since 2012.

Donna Hyland works on the rehabilitation ward at Sacred Heart Hospital, Castlebar, Co Mayo. Donna trained as a general nurse from 2006 to 2011 and graduated with an honours degree in nursing science , registered in the general nursing category. For the past six years she has worked in older person services in both the public and private sectors. She joined the INMO as a student nurse in 2006 and began supporting nurses on local issues as an INMO representative in 2016.

Niamh McKeon is a CNM2 in practice development at Roscommon University Hospital. Niamh received a bachelors degree in general nursing science in 2009 from NUI Galway. She worked in cancer care at St Luke's Hospital, Rathgar for six years before completing a PGDip in cancer care. She is currently undertaking a masters degree in quality and safety in healthcare management at the RCSI. An INMO representative since 2016, Niamh is an active member of the Roscommon Branch.

Ann Noonan is a senior staff nurse in the surgical day theatre at University Hospital Limerick. Ann received her RGN qualification from Limerick Regional Hospital and qualified as a RM from St Munchin's Maternity Hospital, Limerick. She has also worked extensively in ophthalmics at UHL. She has been an active member of the Limerick branch of the INMO for the past 15 years and was the Limerick representative at national theatre on-call talks.

Marie O'Brien is a CNM1 at Ennis General Hospital, Co Clare. Marie qualified as an RGN and RM at Limerick Regional Hospital and St Munchin's Maternity Hospital and completed a management course at University of Limerick. She has been a workplace representative since 1988 and was present at LRC and WRC discussions as a nurse/midwife representative and worked with the INMO as part of the action committee that fought for the retention and development of services at Ennis Hospital during the reconfiguration of the ED and ICU services.

Sean Shaughnessy trained as a RGN in Romford, Essex in the 1990s before completing his postgraduate education in high dependency nursing and teaching in the clinical setting. He started out working in a neurosurgical ICU/HDU unit as a staff nurse before progressing to a general high dependency unit. He currently works in the surgical day ward at University Hospital Galway. Since November 2017, Sean has been the INMO representative for UHG and Merlin Park Hospital Galway and is the union-appointed health and safety representative for UHG.

Bernadette Stenson is an ANP candidate at St. Vincent's University Hospital. She has also worked as a RGN, SVUH and RSCN at Children's University Hospital, Temple Street. Bernadette holds a HDip in adult emergency nursing and a HDip in children's emergency nursing, a BSc in nurse management/leadership/healthcare planning and organisation. She is currently undertaking a masters in advanced practice. She has been involved with the INMO for 17 years both as the ED and workplace representative. She is currently involved with the taskforce on staffing and skill mix in the ED.

Grainne Walsh is an assistant director of PHN at Waterford Community Care. She completed her nurse training in 1993 before spending two years working on a surgical ward at the Luton and Dunstable Hospital, England. She completed her midwifery training at the National Maternity Hospital in 1997, graduating with a HDip in Midwifery. In 2003 she completed a PGDip in theatre nursing and began working at Waterford Regional Hospital in the ENT and orthopaedic theatres. She has been an active member of the INMO for 18 years and is currently secretary of the Waterford Branch.

Introducing Executive Council 2018/2020

Administration

Helen Butler is a director of nursing, St Luke's Hospital, Carlow/Kilkenny. Helen trained in London and has a diploma in HR and industrial relations, a BSc in health services management and a diploma in executive coaching training from LIT. Helen has been a member of the INMO since 1987, having served as chairperson, treasurer and secretary at branch level. She is currently the chairperson of the Directors of Nursing/Midwifery/PHN Section.

Karen McGowan is a registered ANP in the emergency department at Beaumont Hospital, Dublin. Karen trained as a RGN at Beaumont Hospital and completed her bachelor of nursing science at DCU. She later undertook a PGDip in emergency nursing and an MSc at the RCSI. Karen also holds certificates in drug prescribing and ionising radiation, as well as a certificate in advanced assessment from UCD. Additionally, she serves as a local nurse representative.

Margaret Frahill is a CNM 3 at Mercy University Hospital Cork. She trained in general nursing at the Mercy University Hospital and in midwifery at the Doncaster Royal Infirmary in the UK. She has worked in the theatre department of the Mercy University Hospital since 1986. Margaret has been involved with the INMO for many years and has held a wide range of positions including the office of second vice-chairperson on the Executive Council.

Student

Ethan O' Regan is in his fourth year of a general nursing degree at UCC with his practice based in the Mercy University Hospital. He has been active with the INMO since 2015 and was elected as secretary of the Cork Student Branch at the beginning of 2017. He was also elected secretary of the Student Section and was offered the student seat on the Executive Council in August 2017. Having filled the role for six months, Ethan was elected as student officer to this National Executive.

In the eye of the storm

Newly appointed director of industrial relations Tony Fitzpatrick is on red alert for a winter of discontent. Interview by **Tara Horan**

WHEN Tony Fitzpatrick was officially appointed as INMO director of industrial relations this summer, he was well aware of the difficult road ahead, having acted in the role for almost a year after being an IRO since 2002. While industrial relations between the INMO and the HSE have never been easy, the current skirting around the real issues behind short staffing and overcrowding by both the HSE and the Department of Health is causing growing unrest among nurses and midwives.

"The big issues are pay and safe staffing on the frontline," Mr Fitzpatrick told *WIN*. "When the INMO accepted the Public Service Stability Agreement (PSSA) last year, it was on the clear understanding that the Public Service Pay Commission would look at nurses and midwives' pay first and would issue its report on this in early summer this year. That was delayed and when we finally received it last month, what it stated was extremely disappointing. Our members are clearly telling us that the number one issue for them is pay."

The Pay Commission failed to make any recommendation on the basic pay scales for nurses and midwives. In brief, it only moved to increase the specialist qualification and location allowances, to pull back the granting of the senior staff nurse allowance from 20 years to 17 years, and extend the location allowance to maternity services.

However, Mr Fitzpatrick said the biggest concern for the INMO was where Minister for Finance and Public Expenditure and Reform Paschal Donohoe stated this process was not a pay review. "The INMO is clear from the side letters from the PSSA that the Commission was going to be examining pay – the wording is 'total remuneration' – so that is obviously pay."

When we spoke, the INMO was expecting to enter talks with the Department of Health and DPER to negotiate a set of proposals around the Commission's recommendations. It expected to be then in a position to put proposals to the special delegate conference on September 26, and subsequently to a ballot of the entire membership *(see page 8)*.

"Nurses and midwives deserve to be paid better and so we need to build on the Pay Commission proposals and, from the negotiations, see what set of proposals we have and put them to our members. If they are not good enough, then we'll have to go back to the table or devise a strategy to secure better pay and conditions for staff," said Mr Fitzpatrick.

"Pay is the major issue behind the current shortages that exist everywhere within the health service; inpatient wards, specialist wards such as ICU theatres, community care areas, intellectual disability services, emergency departments – they're all chronically short staffed. There are 2,000 fewer funded positions than in 2007 as well as hundreds of vacancies throughout the country. Take Cork University Hospital with 50 vacancies, Limerick with 75 vacancies – you can pick any site and they're all short staffed and there is a multitude of beds closed as a result."

The Pay Commission failed to find that pay levels were the reason behind the recruitment and retention difficulties in nursing and midwifery. "It agreed pay may be a factor but it's not *the* factor. We raised concerns with the Pay Commission that it did a survey of nurses and midwives, and that out of 44 questions it asked, only one of those questions was on pay. Added to this, the return rate on that survey was very poor at around 9-11%. The Commission is saying there are other factors causing the staffing shortfall, such as conditions on the front line, access to reduced working hours and so on.

"The crux of the matter is that if we can't staff the hospitals and community services currently, then the plans that the government is devising such as the bed capacity report that says we need 2,600 additional acute beds and 13,000 additional residential beds, is not deliverable. In addition, Sláintecare will require a significant increase in nursing resources in the community – this is not deliverable if they don't address pay."

Opportunity

While pay is a complex issue in the public service, as evidenced by the lengthy negotiations ahead of all national pay agreements with demands from all sectors, the key element of the current PSSA for the INMO was that the Pay Commission process would examine nurses and midwives' *pay*.

"It is clearly written in Section 3 that

there would be protection from relativity knock-on claims from other grades. There was a great opportunity here to address nursing/midwifery pay once and for all. But the Commission didn't take that opportunity. The government still has an opportunity to address these issues.

"We're at a critical tipping point. If things get any worse we're going to lose more staff and that will bring the service to its knees. The greatest resource of any service is its people – nothing is deliverable without people. All the research shows that if you have adequate staffing, appropriate numbers of nurses and midwives, appropriate skill mix, you have better care for patients, you have lower mortality, you have less failure to rescue, less secondary infections, better outcomes for staff because they stay and want to work in a stable environment. But that's being missed by this government."

Politically, the government has prioritised redressing new entrants' pay (section 4 of the PSSA) over addressing areas with recruitment and retention difficulties (section 3 of PSSA).

"I view this as rewriting the agreement. Areas that have recruitment and retention problems were to get priority. The problem with the Pay Commission report is, and the Commission said this itself, the data received from the HSE was poor and that impacted upon the conclusions reached," Mr Fitzpatrick said.

"Nurses are the lowest paid healthcare professionals; they work the most hours of all the healthcare professionals in Ireland; they work longer hours than their counterparts in Canada, the UK and Australia. Nurses' pay has to be addressed and there are questions to be answered by the government and also by Fianna Fáil the other partners in the confidence and supply agreement. We have been lobbying so that they get a true picture of what it's like on the ground in the Irish health service."

INMO members are mobilising throughout the country to highlight the difficulties in their workplaces. Protests have been ongoing over the past month in Limerick, Cork, Galway, Cavan, Kilkenny and Dublin. "There is no doubt that members are sick and tired of waiting. Their patience has run out. We have to hold the government to account," he said.

Investment

"Money spent on health is not a cost, it's actually an investment. It's an investment in ensuring that the government can deliver a health service for the citizens of this country. All the evidence is there – if you invest in nursing, stabilise the nursing workforce on the ward, have a proper skill mix of 80:20, it's better for the patients and it's better for the staff."

As a person with a positive outlook on life who is constantly striving for that 'better place', Mr Fitzpatrick could be forgiven for despairing at times. "You could despair at the behaviour of the HSE and the Department of Health – at their short sightedness and sometimes ignorance with regards to the real issues. I despair at the structures within the HSE where there's no accountability and no responsibility. We have layers upon layers of management. Even now we have proposals on community health structures which would see hundreds more senior managers put into place by the HSE. You could despair but we have to strive for something better."

Collective might

"We have to use all our abilities – the collective might of the INMO membership – to influence the political system and the Department of Health to realise that they need to invest in nurses and midwives.

"We have to break through and focus on our goals. Those goals are clearly that we want to have a first-class health service, and we want to have nurses and midwives at the cornerstone of that, as the Commission on Nursing said in 1999. We need to empower our nurses and midwives to stand strong. We have to keep banging on the door to get the proper outcome that will deliver better services for citizens," he said.

The INMO is working hard to get this message across. The industrial relations team is holding the HSE and the Department of Health to account all the time.

"Last month when we met at the WRC on the ED agreement progress (or lack thereof), coincidentally it was the same day that the NHS launched its accident and emergency plan for the winter with £145 million extra investment, 900 additional beds etc. But the HSE couldn't tell us its plan for the winter, even though CHOs and hospital groups made submissions on this months ago. The winter plan should be drawn up in early summer – we've been saying this for years and years and years. We're heading into the worst winter possible. We used to talk about ED overcrowding, it's now hospital-wide overcrowding."

Mr Fitzpatrick points to the Mid Staffordshire report in the UK which clearly showed that when the focus is on budgets, patient care suffers. "There are significant problems in our hospitals with regards to missed care and to adverse outcomes for patients. An increasing number of nurses are being called to the Coroner's court. All the science shows that when you're short staffed and reduce the skill mix, when you don't have sufficient nurses on duty, then adverse outcomes increase and mortality rates increase.

"This is why we need to address the issue of nurses and midwives' pay and terms of conditions of employment. We need to recruit and retain them, but we also need to use the scientific tool – the framework on safe staffing and skill mix – to ensure that we've safe staffing levels throughout the entire health service.

"We are heading into a perfect storm at this point of the year: we have community services cutting back on their budgets, we have severe overcrowding throughout hospitals, we have a dire shortage of nursing/midwifery staff, hundreds of vacant posts, and these are just the funded posts, not the safe staffing level that's required.

"All of these factors are leading to an extremely difficult winter. We need to make the government realise now that we're serious about the concerns that we're bringing forward. We are determined to pursue what is right and, as far as we're concerned, nurses and midwives' pay needs to be improved, their conditions of work need to be improved. Right is on our side."

Team player

Tony Fitzpatrick was appointed director of industrial relations with the INMO, following an open competition, having acted in the position since last autumn.

Having been an IRO with the INMO since 2002, he covered the South East for a number of years and subsequently Dublin and the North East. From Co Cavan, he trained as an RGN in Our Lady's of Lourdes Hospital, Drogheda. He then travelled to Australia for a year, where he worked in hospitals in both the public and private sector.

His return to Ireland was just ahead of the nurses dispute of 1999. He worked in the ED of Beaumont Hospital, Dublin, where there was horrendous overcrowding at the time, driving him to become active in the INMO. He has a passionate memory of joining the pickets outside Beaumont Hospital and the Mater Hospital.

Married with three young children, Tony now lives back in Cavan from where he commutes every day, leaving home at 5.30am to arrive in headquarters around 7am, like many nurses who commute in to Dublin every day. His wife is a PHN and an INMO member so, both at work and at home, Tony is acutely aware of the challenges faced by members on the ground. Once a keen Gaelic player, he now coaches his son and daughter's under-7s team at the weekends.

Tony holds a higher diploma in emergency nursing from RCSI, an MBA from the University of Wales and an advanced diploma in employment law from Kings Inn.

Safe staffing saves lives

INMO symposium sends clear message to legislators that international evidence shows appropriate staffing allows for optimal care and saves lives. **Alison Moore** reports

AS THE framework for nurse staffing and skill mix continues to roll out and gather positive evidence supporting appropriate staffing levels, outside of the pilot sites nurses and midwives across Ireland have little choice but to continue to work in environments with unsafe staffing levels.

To highlight this issue, the INMO hosted a symposium last month on safe nurse staffing to discuss how best to tackle understaffing in the health service and the resulting overcrowding. The symposium comes after a record-busting month for overcrowding in Irish hospitals, where almost 8,000 people were forced to wait on trolleys for care over the month of August.

The conference heard from international speakers who each presented their experience on the need for appropriate staffing levels based on patient acuity.

The Welsh experience

Joanna Doyle, the all-Wales nurses staffing programme manager for Public Health Wales, spoke about the introduction of legislation in Wales in 2016. The Act aims to ensure that nurse staffing levels within the Welsh NHS are "sufficient to provide safe, effective and quality nursing care to patients at all times".

The Nurse Staffing Levels (Wales) Act 2016 became law in March 2016 and requires health service bodies to have regard for the provision of appropriate nurse staffing levels, and to ensure that they are providing sufficient numbers to allow the nurses time to care for patients sensitively. It initially applies in adult acute medical and surgical inpatient wards.

Ms Doyle's role is to support NHS Wales in delivering the nurse staffing programme and the health boards in meeting the requirements of the Act.

Wales was the first country in Europe to legislate on nurse staffing levels and according to Ms Doyle, the Act is designed to empower nurses and ward managers, with the evidence to support and inform their professional judgement when determining nurse staffing levels on their wards.

She explained that from April 2018, in accordance with the new Act, NHS organisations in Wales have a duty to use a triangulated approach to calculate the nurse staffing levels in adult acute medical and surgical inpatient areas. In these areas, they must take "all reasonable steps to maintain the nurse staffing levels and report compliance in maintaining the nurse staffing levels as a means of providing assurance to the public, the Board and Welsh government.

"What the Act is saying is that we need to identify the needs of our patients and match the resources to that demand. This turns the whole system on its head," she said.

"Although we will be looking at nurse:patient ratios, there is a triangulated approach that we need to adopt to work out what the staff skill mix within each area needs to be," she added.

As the Act initially applies to adult acute medical and surgical inpatient wards, depleting staff in other areas in order to meet the demands in the mandated areas must be avoided, and therefore this has been dealt with in the legislation.

The retention and wellbeing of nursing staff is also central to the Act's requirements, with each health board having to submit reports to the Welsh government on the extent to which the level of registered nurses has been maintained and the impact and actions taken in response to not maintaining that level.

The triangulation model, according to Ms Doyle, underpins a rigorous process of gathering the evidence to monitor and report against the Act. Taking patient acuity, nurse staffing levels, quality indicators and professional judgment into account, Ms Doyle described it as a "world leading" methodology that was unique to Wales.

Also under the Act, Ms Doyle outlined how health boards are required to provide assurance to the Welsh government and the public. Every participating ward must be monitored to ensure compliance with the Act. Robust systems for gathering and validating evidence within an overarching governance framework must be set up. The extent to which nurse staffing levels have been maintained must be reported on. The impact the health board considers that not maintaining nurse staffing levels has had on care provided to patients by nurses – such as pressure ulcers, falls, increased incidents of harm, complaints and medication errors – must be measured and reported. Actions taken in response to not maintaining nurse staffing levels must also be fed back.

Looking to the future, Ms Doyle said that work to support the retention and recruitment of staff will be ongoing and additional steps will include:

- A suite of measures to enable comparison across wards to aid local triangulation and validation will be developed
- Audit will be extended into specialist and high throughput areas
- Utilise existing systems with a requirement


Joanna Doyle


Donna Kelly-Williams


Steve Pitman

for ongoing engagement informatics and performance management
- Support operational teams in meeting the requirements of the Act
- Collate the information required to undertake the reporting process
- Develop, test and evaluate workforce planning tools for areas of speciality
- Engage and inform stakeholders
- Health boards and NHS Trust must be prepared for the extension of the Act into additional areas.

Massachusetts

Donna Kelly-Williams, president of the Massachusetts Nurses Association (MNA), has been leading a campaign for legally-binding safe staffing levels in her home state for several years.

This autumn, Massachusetts voters will have the opportunity to vote for setting safe patient limits in legislation — an initiative driven by the MNA.

Ms Kelly-Williams said that the link between safe patient care and safe nurse staffing limits was clear. She cited more than a decade of studies and the 15 years of experience of safe staffing legislation existing in the state of California, which made it clear that having too few nurses increases patient complications, infection rates and rates of re-admission, all the while leading to even higher mortality rates.

"When RNs have too many patients to care for, we see a dramatic and dangerous impact on safety and patient outcomes. Study after study shows that there is an absolute need to set a maximum limit on the number of patients that can be assigned to each registered nurse in order to avoid serious complications, mistakes, and preventable readmissions," said Ms Kelly-Williams.

Short staffing also forces nurses from the bedside into other jobs or into retirement, something we cannot afford as our population ages, she said.

A survey commissioned by the MNA found that 77% of nurses reported they were assigned "too many patients to care for at one time", 86% of the nurses surveyed supported changing the law to mandate safe patient limits, and a staggering 90% reported that they do not have time to "properly care for patients".

> 90% of nurses surveyed in Massachusetts reported that they did not have enough time to care for patients properly

Nevertheless, Ms Kelly-Williams said that hospital management continues to argue against setting safe patient limits, "ignoring not only the evidence but the voices of nurses everywhere", nurses who, based on their experiences of working in understaffed environments, overwhelmingly support the introduction of laws to set safe patient limits.

"Nurses, just like nurses here, who thought 'I can no longer do what I was trained to do as an RN' as they were thrown on to the ward and told to do the best they can," she said.

She pointed to the evidence of California where in 2002, before the safe staffing legislation was introduced, there was a shortage of nurses, but by 2005 over 100,000 nurses returned to the bedside.

With the new limits in place, many of these previously burnt-out nurses chose to return to nursing.

Detail from Donna Kelly-Williams' presentation

"So limits are already working. We're not reinventing the wheel. This actually works in a lot of places. Patient limits improve patient care," Ms Kelly-Williams said.

Experts

Also speaking at the seminar were Prof Christine Duffield, University of Technology Sydney, an expert on impact of nursing skills and workload on patients; Mary Heffernan, nurse and manager of a safe staffing pilot ward in Beaumont Hospital; Rachel McKenna, deputy chief nurse, Department of Health; Prof Jonathan Drennan, UCC expert on safe staffing levels; Dr Conor Keegan, ESRI; and Dr Tom Healy, Nevin Economic Research Institute.

"Whether you talk to academics or patients, the message is clear: nurses save lives and are vital for a safe, cost-effective health service," said Steve Pitman, INMO head of education, also speaking at the symposium.

"We see dangerous understaffing and too many unfilled vacancies in hospitals across Ireland. Today we have made the case for why it's so important that we get a properly staffed health service."

This piece focuses on the international context. We will look at the Irish situation in subsequent issues

Q and A Bulletin Board

With INMO director of industrial relations Tony Fitzpatrick

Query from member

I would like to avail of cost neutral early retirement. I am employed in the public health service since April 2004, so my minimum retirement age is 65. I am 57 years of age and as someone in PRSI Class A1 I would like to know how will this affect me accessing supplementary pension?

Reply

If your normal retirement age is 65 you can retire between ages 55 to 64. If you decide to retire early, both your gratuity and pension will be subject to an 'actuarial reduction' to take account of the fact that your gratuity is being paid earlier than anticipated and that your pension will now have to be paid over a longer period. The reduced rate of pension applies throughout the lifetime of your pension (Department of Health Circular 10/2005). Supplementary pensions, where appropriate, will be paid to those availing of cost neutral early retirement on reaching the relevant preserved pension age (60 or 65 years as appropriate). At 57 you will receive your lump sum and a partial pension, however as your minimum age to retire is 65 you will not receive supplementary pension until you reach age 65 and this will be paid until you can access the Old Age Contributory Pension.

All applications for cost neutral early retirement are considered based on business needs and may not always be granted. Nurses and midwives opting for this scheme should contact their superannuation department.

Query from member

I have been appointed as a CNM1 and am wondering could you clarify for me my annual leave entitlement. My contract states it depends on my years of service. I have under 10 years of service. With my new promotion would I be entitled to extra annual leave? I am liable to work a five over seven roster?

Reply

The annual leave entitlement for a CNM1 with five to 10 years of service is 26 days. In lieu of your liability to work weekends you have an entitlement to have your nine public holidays added to your annual leave, which is 35 days of annual leave in total. This is based on working a 39-hour week.

Know your rights and entitlements

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

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

INMO

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

How to deal with workplace bullying

The INMO's student and new graduate officer **Neal Donohue** offers advice to students on placement who are affected by bullying in the workplace

THE ongoing recruitment and retention crisis in the health services has created an intolerable working environment. When faced with low wages, high rents, long working hours, missed breaks and an ever increasing workload with fewer staff, it is understandable that the workforce is really struggling. One of the dreadful consequences of our overburdened nursing and midwifery workforce is that inter-personal conflicts and bullying appear to be a common experience of many staff and students.

The Code of Practice for Employers and Employees on the Prevention and Resolution of Bullying at Work, under the Safety, Health and Welfare at Work Act 2005, is aimed at preventing and dealing with bullying in Irish workplaces. It is a code for both employers and employees and is the basis for any organisational policy, including the HSE Dignity at Work Policy.

The Health and Safety Authority define workplace bullying as "repeated inappropriate behaviour, direct or indirect, whether verbal, physical or otherwise, conducted by one or more persons against another or others, at the place of work and/or in the course of employment, which could reasonably be regarded as undermining the individual's right to dignity at work".

The key characteristics of bullying are that the behaviour is regular and persistent and not just a single event. Bullying can have serious effects on an employee's mental and physical well-being therefore it is imperative that staff and students are supported in dealing with and preventing inappropriate behaviour.

Advice for students:

- You are entitled to be treated with respect and dignity, and no person has the right to undermine this
- It is important to have support from friends, family or colleagues. Since bullying can have a negative impact on your mental health consider attending counselling for extra support
- Accusing someone of bullying is serious and should only be done with a reliable set of circumstances indicating that what you are experiencing does constitute bullying. I advise members to keep a diary of events so that you can clearly outline the circumstances that undermine your dignity and show a pattern of behaviour
- Maintain confidentiality and approach the issue in a professional manner. Read up on the topic and be clear in your understanding of what bullying is and what it is not. The HSE Dignity at Work policy was devised specifically to deal with bullying, harassment and sexual harassment. It clearly states what constitutes bullying and gives examples of bullying behaviours
- As a student member of the INMO you may contact me, the student and new graduate officer, and I will explain the policy and advise you on your options in dealing with the situation. There is also a support contact person in each workplace who is an employee of the HSE and has volunteered and received training to provide information on the Dignity at Work policy to colleagues. While on placement you may ask for support from your CPC, preceptor, CNM1, or CNM2. It is important to notify third-level institutions of difficulties that arise on placements
- Try to assess what is happening objectively. This may be difficult because you may feel hurt or angry, but it is important to consider the situation carefully before acting. Is the behaviour upsetting you due to other reasons? Is it a personality 'clash'? Is it a repeated pattern of behaviour, targeted towards you, and does it undermine your dignity at work?
- When there is conflict in the workplace it is important to try to find a resolution. The person who is behaving inappropriately may not be aware of the effects. Approach the person and point out the behaviour(s). Clearly state to them that you wish them to stop. If you do not feel you can approach the person, document the behaviour and its effects and bring the matter to your line manager on an informal basis. Sometimes the inappropriate behaviour is intentional, and this must not be tolerated. The employer has an obligation to prevent this and to deal with it in an appropriate manner
- If your complaint about bullying has not been dealt with properly then you should contact your union representative or you can come to me for advice. Further steps may be taken to find a resolution if an informal approach is unsuccessful including mediation or formal investigation.

Zero tolerance

There must be zero tolerance of bullying where all staff and students are afforded their right to be treated with dignity and respect. Most people enter the professions of nursing and midwifery because they are compassionate, caring people who want to take care of others but exposure to constant stresses can erode a person's empathy and affect their interaction with people.

Clearly more work needs to be done to eradicate bullying, but it is a symptom of an overburdened and unsupported workforce. The wellbeing of nurses and midwives and students from all disciplines must be considered paramount within the health services.

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

Quality & Safety

A column by Maureen Flynn

Introducing the Irish National Orthopaedic Register

THIS month's column follows our series introducing National Office of Clinical Audit (NOCA) audits. In August 2010, an implant used for hip replacements by DePuy (ASR) was recalled globally due to poor patient outcomes and adverse events. In Ireland, an estimated 3,500 people had received this implant following hip replacement surgery. This could not be confirmed by the Department of Health as there was no electronic system that had all of that information and hospitals were required to review paper records to identify patients who may have received these implants. This global recall highlighted the need in Ireland to have a national register for such implants.

Irish National Orthopaedic Register

NOCA collaborated with the Irish Institute of Trauma and Orthopaedic Surgeons (IITOS) in 2014 to set up the Irish National Orthopaedic Audit (INOR). The audit uses an electronic system for recording and monitoring elective arthroplasty (joint replacement) surgery in Ireland. It is expected that the INOR will define the epidemiology of joint replacement surgery in Ireland, provide timely information on the outcomes of joint replacements and identify risk factors that may highlight poor outcomes in patients.

Benefits of INOR

The primary objective of the INOR is to provide information that is designed to help improve the quality of care and clinical outcomes of patients undergoing joint replacement surgery. The introduction of the INOR will enable early detection of failing implants, details of surgical procedures, hospital performance and patient outcomes. Implementation of the INOR will increase patient safety and confidence in this surgical procedure. It will enable orthopaedic surgeons to monitor patient's outcomes and participate in clinical audit.

INOR Irish National Orthopaedic Register

How are we using the INOR?

Unlike other international arthroplasty registers, where the data is collected retrospectively, the INOR collects data in real time. It is a fully bespoke, secure web application that allows nurses, doctors and patients to enter data during the pre-operative, peri-operative and post-operative phases of care. Patient reported outcomes measures (PROMs) are also captured when the patients are followed up in the longer-term.

The INOR went live in South Infirmary University Hospital Cork (SIVUH) in May 2016 and delivered real-time scanning of components in theatre for the INOR - an international first for arthroplasty registers. The real-time scanning supports the primary objective of the INOR in monitoring the safety of implants and supports the hospitals should an implant recall occur again like the ASR recall.

In the event of a recall, patients can be identified promptly and hospitals are notified of any patients who have the relevant component.

Who's involved in your hospital?

The INOR is managed locally by a clinical lead (an orthopaedic surgeon) and an arthroplasty nurse specialist (ANS). The ANS manages and supports the staff locally with regard to the INOR, trains new staff and ensures good data quality processes in the capture of accurate data. One of the key success factors for the INOR is the support locally by pre-operative assessment nursing staff, theatre nurses and the ANS who have all undertaken process changes to ensure the implementation of the INOR within their service.

The INOR is currently live in five hospitals nationally, South Infirmary, Cork; Tullamore; Croom Orthopaedic Hospital; Kilcreene Orthopaedic Hospital and Our Lady's Hospital, Navan, and will be implemented in all 12 public elective hospitals by the end of 2019. Engagement with the private hospitals has commenced with the rollout of 16 private hospitals being planned at this time.

The implementation of the INOR is a joint venture between NOCA, IITOS and the HSE Office of the Clinical Information Office. These organisations provide both the clinical and project leadership for the development and ongoing implementation of the INOR.

Get involved

Although the INOR is still in the early stages of the project, a preliminary annual report is planned for late 2019. Within your hospital, speak to your ANS or orthopaedic nurse manager about obtaining information for your service. One of the purposes of the INOR is to facilitate national and local clinical audit and research.

If you have any queries about the INOR, you are welcome to contact the national INOR co-ordinators, Suzanne Rowley at email: suzannerowley@noca.ie and Debbie McDaniel at email: deborahmcdaniel@noca.ie

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

Acknowledgements
Thanks to Suzanne Rowley and the NOCA team for assistance in preparing this column

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive
Quality Improvement Division

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

Tús Áite do Shábháilteacht Othar
Patient Safety First

Coping with the Coroner's Court

Edward Mathews offers advice to members on giving evidence when called as a witness to the Coroner's Court

CORONER'S inquests are relatively common occurrences, however they can engender a degree of anxiety among those compelled to attend. The inquest can be a traumatic experience for family members and loved ones of the deceased and can also be a difficult experience for nursing, midwifery or medical staff who are called to give evidence.

While most inquests are uncontentious, in that they simply and in a non-adversarial manner seek out information relating to the death, it is regrettable that this is not always the case. In fact, a minority of cases can be quite adversarial with robust questioning of professionals. The more difficult cases tend to emerge where there are conflicts of evidence between professionals as to what occurred, or where family members feel there have been deficits in care in the time leading up to death.

Understanding the roles of those involved, how the process works, what you should do to prepare and what help you should expect from your employer are important parts of a nurse or midwife's knowledge base.

Role of the coroner

The coroner is a state official who must be either legally qualified or medically qualified, or both, and who makes legal determinations in relation to the cause of death. The central role of the coroner is the investigation and certification of death in circumstances where there is some question or lack of clarity concerning that death, in essence where there are sudden or unexplained deaths.

In many cases the coroner needs to do little more than satisfy themselves that no further inquiry is necessary, however, where necessary they have powers to facilitate a broader investigation or inquest.

The investigation will generally take the form of a post mortem, whereas the inquest is a formal exercise where the coroner, with or without a jury, hears sworn evidence to establish the cause of death without apportioning blame. The object of an inquest is to establish answers to four basic questions:

- Who is the deceased?
- How did the deceased die?
- When did the deceased die?
- Where did the death occur?

The process establishes the facts surrounding the death, places these on the public record and answers the relevant questions. While the coroner may make recommendations to prevent the re-occurrence of such deaths, neither the coroner nor inquest process may establish or apportion any blame for the death which occurred.

Circumstances in which a death must be reported to the coroner

There are wide range of cases in which a report must be made to a coroner, and these are determined in law and by local practice. Essentially, any sudden or unexplained death must be reported. Deaths of suspected natural causes where the person has not been seen by a medical practitioner for a month prior to death must also be reported.

Most relevant to nurses and midwives, deaths directly or indirectly the result of any surgical or medical treatment, or any procedure, must be reported to the coroner. Any death suspected as arising from negligent or violent processes must also be reported.

Coroner's response

As mentioned the coroner need not investigate or hold an inquest in every case, and if they are satisfied following informal inquiries that nothing untoward has occurred they may direct the issuing of death notification certificate. However, they may conduct further investigations in the form of a post mortem examination. If satisfied that the death was due to natural causes they may then issue a Coroner's Certificate. However, in other circumstances the coroner may decide to hold an inquest.

In most instances the coroner has a discretion as to whether to convene an inquest, however, one must be convened where death is suspected to have occurred in violent or unnatural circumstances or suddenly, and is of unknown cause. An inquest may sit with or without a jury, but a jury must be involved, where:

- Death may be due to homicide (or a suspicious death)
- Death occurred in prison
- Death was caused by accident, poisoning or disease requiring notification to be given to a government department or inspector
- Death resulted from a road traffic accident
- Death occurred in circumstances which may be prejudicial to the health or safety of the public
- The Coroner considers it desirable to hold an inquest with a jury.

The inquest process

The inquest seeks to establish the facts surrounding the death and to answer the four basic questions mentioned above. In theory the inquest is an inquisitorial process, in that it is not one side versus the other but is an inquiry into the circumstances surrounding the death without the attribution of blame.

The inquest involves the coroner hearing evidence from witnesses. These may include those involved in the care of a person prior to and at the time of their death. The coroner is the person who determines from whom evidence may be taken.

Evidence may be given in writing, orally or both. Written evidence normally takes the form of a deposition and advice should be sought prior to making such a submission to an inquest.

If you are directed to attend an inquest

to give oral evidence a refusal to attend, or a refusal to answer questions if in attendance, may amount to contempt of court. Again, advice should be sought prior to attending to give oral evidence.

Having heard the evidence, the coroner, or jury, as the case may be, returns a verdict that establishes the answers to the four questions and essentially establishes the cause of death.

The verdict may be relatively brief or take a more extensive narrative form. Common verdicts associated with cases where nurses and midwives may be called to give evidence include: accidental death; death by misadventure; medical misadventure; suicide/self inflicted death; want of attention at birth; stillbirth; death by natural causes; and open verdict. While recommendations may be made, no blame may be attributed.

Giving evidence at an inquest

The primary purpose of the inquest is to establish the circumstances of the death and as such it should be an uncontentious exercise for a witness, whereby they give an account of relevant matters and this is what occurs in most cases. However, as mentioned, some cases may be more contentious where different witnesses have differing accounts of what occurred. Additionally, the facility for certain persons to ask questions can give rise to a degree of contention.

Questions may be asked of witnesses by the coroner. Also, any person who has a proper interest in the inquest may personally examine a witness or be legally represented by a solicitor or barrister. Properly interested persons include:

- The family and next-of-kin of the deceased
- Personal representatives of the deceased
- Representatives of a board or authority in whose care the deceased was at the time of death, eg. hospital, prison or other institution
- Those who may have caused death in some way, eg. driver of a motor vehicle
- Representatives of insurance companies
- Where death resulted from an incident at work
  - Representatives of trade unions
  - Employer of the deceased
  - Inspector of the Health and Safety Authority
  - Others at the discretion of the coroner.

Such persons may not call evidence, but they may question witnesses on matters relevant to the death. This has led some nurses and midwives to experience sustained and difficult questioning where there is a conflict of fact or where a family is trying to establish that the death was associated with some want of care.

Preparing for the inquest

Preparation is crucial and is essentially divided into two categories, personal preparation, and appropriate engagement with your representative.

Personal preparation

- Read all the notes carefully
- Ensure you have a chronological account of what occurred, when it occurred, why it occurred, who was there, and what happened afterwards
- Remember look at the person asking questions, then direct your answer to the coroner
- Do not engage in any argument with the person asking questions, ask for a break if necessary and try to remain calm
- Tell the truth and remain focused on what occurred.

Preparing with your representative

- Your employer is obliged to provide you with a competent and impartial legal representative at the inquest
- You must have time to consult with your representative before the inquest, and you must seek their advice before making any written submission
- Ask your representative if there is any conflict between you and anyone else they are representing (your colleagues or the employer), if there is, seek another representative from your employer
- Ask your representative for advice on the type of questions you will face, and how to best deal with the process
- Ask your representative are they sure they can legally represent your best interests at the inquest.

If you encounter any difficulties with accessing a representative from your employer, or with the conduct of the representative, please contact your INMO Official immediately, who will in turn seek an alternative representative from your employer.

In summation, the majority of inquests are uncontentious and do not give rise to any concerns. However, understanding the process, preparing well and knowing what to expect from your representative are your best protections. If you have any concerns you should contact your INMO official.

The Organisation recently launched a new information leaflet to advise members in relation to coroner's inquests which can be accessed on our website, and in addition paper copies are available from INMO offices.

Edward Mathews is INMO director of regulation and social policy

INMO SAFE PRACTICE WORKSHOPS

The Professional Development Centre is providing a nationwide series of workshops in venues across the country. This programme provides safe practice tools to protect the nurse and midwife and patient within current healthcare settings. This is an awareness session to ensure all staff have an understanding of the process involved regarding patient alerts, clinical incidents and thorough assessment, while remaining focused on patient and individual staff. The programme addresses patient safety and staff safety and provides five key tools on areas of documentation, clinical incident reporting, safety statements, best practice guidelines regarding assessment, and communication practices in a complex multifaceted healthcare arena. 'Tools for Safe Practice' is Category 1 approved by the Nursing and Midwifery Board of Ireland and awarded with 4 CEUs.

To arrange a safe practice workshop in your workplace please contact your Industrial Relations Officer or log on to our website to view all scheduled workshops.

Tools for Safe Practice

Fee: INMO members FREE
€150 non-members

Visit: inmoprofessional.ie
to book your place

Setting the standards

The Midwifery Unit Network and the European Midwives Association have collaborated to influence maternity policies relating to the safety and health of women and their babies. **Deirdre Munro** reports

RESEARCHERS at City University London, in partnership with the Midwifery Unit Network (MUNet) have launched new standards to support the growth of midwifery units across Europe. As international officer of the INMO's Midwives Section and one of the researchers involved in this project, I proudly attended its launch in London at the Midwifery Unit Network Conference this summer.

More than five million women give birth each year across the European Union, yet despite a significant improvement in maternity care and a large number of well-educated midwives, inequalities in access to women's healthcare persist in Europe.

There is a convincing and ever-expanding body of evidence indicating that continuity of midwife-led care is particularly suitable for healthy women with uncomplicated pregnancies in settings with well-trained midwives and good health systems. This has been translated into policy at national and global level.

In similar contexts, with well-functioning referral systems, midwife-led care in out-of-hospital settings is associated with maternal reports of more positive pregnancy and birth experiences when compared to women using hospital-based maternity care. Better outcomes are also reported for healthy women of any parity, along with similar perinatal outcomes, especially for second and subsequent babies. These findings are also reflected in national policy documents.

The aim of the standards is to guide midwives, managers and commissioners across Europe in creating and developing midwifery units, which provide a safe and cost effective alternative to hospital obstetric unit care for healthy women with uncomplicated pregnancies. This in turn should improve the quality of midwifery unit care and reduce variability in practice.

Endorsed by the European Midwives Association (EMA), the 29 standards, based around 10 themes, focus on the philosophy of care and the organisation of services. This development involved a robust and inclusive co-production process, including an evidence-based process, a systematic review, delphi study, interviews and stake holder co-design meetings. The creation of the Midwifery Unit Standards responds to the needs highlighted by national and international policies. Covering specific aspects such as: women's pathway of care; environment; facilities; and leadership, the standards help to provide a framework for quality improvement and facilitate the advancement of the midwifery-led units and to scale up their implementation.

"We've developed these standards on the philosophy and organisation of care in midwifery units throughout Europe as there is still a huge potential for growth considering the benefits of midwifery-led care," said project lead, Dr Lucia Rocca-Ihenacho, a research fellow and midwifery lecturer in the School of Health Sciences at City University.

"If midwives, other healthcare professionals and policymakers can show leadership in Europe in developing the kind of services these Standards represent, this will be a powerful model and incentive for change in low-income countries across the world," said Franka Cadée, president of the International Confederation of Midwives.

Soo Downe, professor of midwifery studies and Jacky Nizard, president of the European Board and College of Obstetrics and Gynaecology, in their introduction to the Standards document, said that as health systems strengthen in low and middle income countries, the Standards could also be a catalyst for change in settings where both in and out of hospital maternity care provision is sub-optimal.

"We congratulate Midwifery Unit Network in taking this initiative and developing standards using an inclusive, co-production methodology. We would encourage professional organisations and individual leaders to use this tool for quality improvement and take the initiative forward," they added.

The full document is available to download here: **bit.ly/MidwiferyStandards**

In future instalments of Midwifery Matters, we will explore the full list of standards, as set out in the *Table* opposite.

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

Midwifery Unit Network

The Midwifery Unit Network (MUNet) offers support to those wishing to develop midwifery units (birth centres), and to already established midwifery units. The network acts as a hub to share good practice and information resources and be a community of practice with a shared philosophy essential to offer consistent, excellent and safe care for women and their families. The aim is to maximise potential for a positive childbirth experience, and to enhance the physical and psychological wellbeing of childbearing women and their babies, through the promotion and support of midwifery units (birth centres). For further information, visit: **www.midwiferyunitnetwork.com**

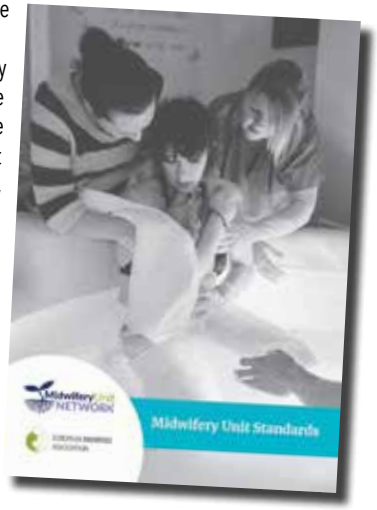


Table: Midwifery Unit Standards

Theme 1:	**Bio-psychosocial model of care**
Standard 1:	The midwifery unit has a written and public philosophy of care setting out shared values and beliefs
Theme 2:	**Equality, diversity and social inclusion**
Standard 2:	The midwifery unit has a policy relating to respect, diversity and inclusion
Theme 3:	**Working across professional and physical boundaries**
Standard 3:	There is a shared written commitment to mutual respect and cross-boundary working across the whole maternity service
Standard 4:	The midwifery unit has a linked lead midwife, obstetrician and neonatologist
Standard 5:	There is a clear policy and procedures for transfers
Theme 4	**Women's pathways of care**
Standard 6:	The midwifery unit commits to a philosophy of providing information as early as possible, and keeping decisions open
Standard 7:	The midwifery unit is a hub integrated with the local community
Standard 8:	The midwifery unit pathway is open to all women for personalised and individualised care
Standard 9:	The midwifery unit has clear referral pathways
Theme 5:	**Staffing and workload**
Standard 10:	Essential staffing includes a core staff team and midwifery leadership on site to promote high standards, a sense of ownership and an appropriate philosophy of care
Standard 11:	Assessment of workload should include all activities on the midwifery unit, not just the intrapartum care and number of births
Theme 6:	**Knowledge, skills and training**
Standard 12:	There is a written agreed list of knowledge and skills required of midwives in order to work in a midwifery unit
Standard 13:	The midwifery unit has plans for education and continuing professional development
Standard 14:	The midwifery unit has a framework for preceptorship and orientation
Theme 7:	**Environment and facilities**
Standard 15:	The midwifery unit offers an environment that promotes a bio-psychosocial model of care and building relationships
Standard 16:	The midwifery unit offers an environment which supports mobilisation and active birth
Standard 17:	The midwifery unit offers an environment that protects and promotes relaxation, privacy and dignity
Standard 18:	The physical layout and design of the midwifery unit conveys the bio-psychosocial values of the care model
Standard 19:	The midwifery unit is visible and accessible in the community
Theme 8:	**Autonomy and accountability**
Standard 20:	The midwifery unit has a policy acknowledging midwives' autonomy and accountability
Standard 21:	The midwifery unit has a policy acknowledging women's autonomy
Theme 9:	**Leadership**
Standard 22:	There is a visible and consistent leadership within the midwifery unit
Standard 23:	The midwifery unit has high-quality transformational leadership
Standard 24:	There is a multidisciplinary and service users advisory group, which sets out a vision for the midwifery unit
Theme 10:	**Clinical governance**
Standard 25:	The midwifery unit has evidence-based guidelines, policies and procedures subject to regular review
Standard 26:	The midwifery unit has guidance on eligibility criteria and choice of place of birth
Standard 27:	The midwifery unit demonstrates commitment towards continuous improvement
Standard 28:	The midwifery unit has a robust information system
Standard 29:	The midwifery unit includes plans for communication and marketing

Inhaled corticosteroid use in COPD

The issue of inhaled corticosteroid use in chronic obstructive pulmonary disease is not always straightforward. **Ruth Morrow** provides a guide

THE role of inhaled corticosteroids (ICS) in chronic obstructive pulmonary disease (COPD) is somewhat controversial. A number of challenges face clinicians in that guidelines are recommending discontinuation of and delaying starting ICS in patients who do not experience exacerbations and are classified as 'COPD A or B'. However, in clinical practice this is not as straightforward as it seems. This article seeks to address and provide some clarification in this area.

The definition of COPD has been revised to recognise the importance of precipitating factors. "COPD is a common, preventable and treatable disease that is characterised by persistent respiratory symptoms and airflow limitation that is due to airway and/or alveolar abnormalities usually caused by significant exposure to noxious particles or gases. The chronic airflow limitation that is characteristic of COPD is caused by a mixture of small airways disease (eg. obstructive bronchiolitis) and parenchymal destruction (emphysema), the relative contributions of which vary from person to person".[1]

The cornerstone of treatment in COPD is bronchodilator therapy. Patients should be on maximum bronchodilator therapy before considering the initiation of inhaled corticosteroids. The role of inhaled corticosteroids in COPD has been controversial for some time and GOLD 2017 guidelines now recommend that inhaled corticosteroids (ICS) should not be used as a single agent in the management of COPD.

In patients with moderate to severe COPD, the use of ICS combined with a LABA is more effective than using either agent alone in improving lung function, health status and reducing exacerbations.[1]

Table 1: Pharmacological treatment options based on COPD classification (GOLD, 2017)

COPD classification	Treatment options
A – Episodic symptoms	Bronchodilator – LABA and LAMA
B – Persistent symptoms	Combination – LABA and LAMA
C – Exacerbations	Combination – LABA and LAMA or LABA and ICS
D – Further exacerbations	Combination – LABA, LAMA and ICS Consider roflumilast if FEV 1 is < 50% and patient has bronchitis Consider macrolide in former smokers

Why are inhaled corticosteroids an issue in COPD?

A meta-analysis of 24 long-term randomised controlled trials involving 23,096 participants showed a significantly increased risk of pneumonia with the use of inhaled corticosteroids in COPD. The increased risk of pneumonia was not accompanied by a corresponding increase in mortality. Patients most at risk were the elderly and those with more severe disease and lower FEV1s.[2] The meta-analysis included trials where participants were on ICS for varying duration and had varying COPD severity.

It is unclear whether the risk of pneumonia varies for different inhaled agents, particularly fluticasone and budesonide, and increases with the dose and long-term duration of use. Suissa et al[3] carried out a study comparing fluticasone and budesonide and the risk of pneumonia. The study included 163,514 patients, of which 20,344 had a serious pneumonia event during the 5.4 years of follow-up.

Current use of ICS was associated with a 69% increase in the rate of serious pneumonia. The risk was sustained with long-term use and declined gradually after stopping ICS use, disappearing after six months. The rate of serious pneumonia was higher with fluticasone, increasing with the daily dose but was much lower with budesonide.

In 2014, Kew et al[4] carried out a Cochrane review of inhaled steroids and the risk of pneumonia in patients with COPD. The objectives of the review were to assess the risk of pneumonia associated with the use of fluticasone and budesonide for COPD. Randomised controlled trials (RCTs) of at least 12 weeks' duration were included. Studies were also included comparing budesonide or fluticasone versus placebo, or either ICS in combination with a LABA versus the same LABA as monotherapy for people with COPD.

More evidence was provided for fluticasone (26 studies; n = 21,247) than for budesonide (17 studies; n = 10,150). Fluticasone increased non-fatal serious adverse pneumonia events requiring hospital admission and there was no evidence to suggest that this outcome was reduced by delivering it in combination with salmeterol or vilanterol or that different doses, trial duration or baseline severity significantly affected the outcome.

Budesonide also increased non-fatal serious adverse pneumonia events compared with placebo, but the effect was less precise and was based on shorter trials. Some of the variation in the budesonide data could be explained by a significant difference between the two commonly used doses: 640µg was associated with a larger effect than 320µg relative to placebo.

The risk of any pneumonia event (ie. less serious cases treated in the community) was higher with fluticasone than with

budesonide. However, this finding should be interpreted with caution because of possible differences in the assignment of pneumonia diagnosis, and because no trials directly compared the two drugs. There was no significant difference in overall mortality rates between either of the inhaled steroids and the control interventions.

The authors' conclusions from this Cochrane review are that budesonide and fluticasone, delivered alone or in combination with a LABA, are associated with increased risk of serious adverse pneumonia events. The safety concerns highlighted in this review should be balanced between exacerbations and quality of life. This is one of the challenges for clinicians as discontinuing inhaled ICS may impact on the patient's quality of life and their ability to live an optimal quality lifestyle.

Challenges for clinicians

A number of challenges face clinicians in relation in to the use inhaled corticosteroids:

- Discontinuing inhaled corticosteroids in patients who have been on them for years – for patients who are established on ICS and are in COPD A or B, it is recommended that ICS is titrated down rather than suddenly stopping treatment
- Patients who present with an asthma component with their COPD – patients who are over 40, have a history of asthma/atopy and who smoke may have an asthma component to their COPD. These patients will require ICS as ICS is the cornerstone of asthma management,[5] and ICS is best used in combination with a long acting bronchodilator (LABA) to optimise bronchodilation and address the underlying eosinophilic inflammation[6]
- Titrating down of inhaled corticosteroids – for patients who have been on ICS for a period of time, titrating down of medication is advised. For patients who are on fluticasone an option is to titrate down to budesonide or beclomethasone and gradually reduce the dose. This should be carried out over a three-to six-month period and the patient will require review or interaction with the clinician.

Conclusion

This article has addressed the role of inhaled corticosteroids in the management of patients with COPD which has been somewhat controversial over the past years. Studies have been reviewed to demonstrate an increased risk of pneumonia in elderly patients with a low FEV1.

Clinical guidelines now suggest ICS should only be used in patients who are experiencing exacerbations of their COPD or if there is an asthma component to their COPD.

However, this is not as clear cut as it seems and challenges remain for clinicians in relation to discontinuing ICS in patients who have been on them for a considerable length of time.

Ruth Morrow is a registered advanced nurse practitioner (Primary Care)

References

1. Global Strategy for the Diagnosis, Management and Prevention of COPD, Global Initiative for Chronic Obstructive Lung Disease (GOLD) 2017. Available from: http://www.goldcopd.org/

2. Singh S, Loke YK. Risk of pneumonia associated with long-term use of inhaled corticosteroids in COPD: A critical review and update. Current opinion in pulmonary medicine, 2010; 16(2):118-122

3. Suissa S, Patenaude V, Lapi, F Ernst P. Inhaled corticosteroids in COPD and the risk of serious pneumonia. Thorax 2013; 68(11), 1029

4. Kew KM, Seniukovich A. Inhaled steroids and risk of pneumonia for chronic obstructive pulmonary disease. Cochrane Database Syst Rev. 2014 Mar 10;(3):CD010115

5. Global Initiative for Asthma, 2017. Global Strategy for Asthma Management and Prevention (updated 2017)

6. Global Strategy for the Diagnosis, Management and Prevention of COPD & Global Initiative for Asthma, 2015, Diagnosis of Disorders of Chronic Airflow Limitation: Asthma, COPD, Asthma-COPD Overlap syndrome (ACOS)

INMO Professional DEVELOPMENT CENTRE

THE ROYAL COLLEGE OF MIDWIVES

RCM i-learn

NOW AVAILABLE AT

https://inmoprofessional.ie

Herpes zoster virus

The reactivated varicella zoster virus, or shingles, can cause severe inflammatory neuritis and motor weakness in addition to a host of complications, writes **Johnny Loughnane**

VARICELLA or chickenpox is caused by the herpes zoster virus (HZV). It is transmitted through droplet infection or direct contact with vesicle fluid and is very contagious. HZV is a neurotrophic virus, ie. it has the ability to invade and reside within neural tissue.

Primary infection with HZV results in the typical vesicular eruption of varicella (chickenpox). During the systemic, viraemic phase of varicella the virus invades the sensory nerve endings and travels up the sensory fibres, eventually settling in the cranial or dorsal root ganglia. Here it remains latent for the duration of the host's life, ie. it is a lifelong infection.

Reactivation of the latent infection, with replication of HZV in one or more of the dorsal root ganglia may occur at any point in the future. All who have had chickenpox in childhood are at risk of reactivation. With reactivation the HZV spreads along the sensory nerve from the dorsal root ganglion, giving rise to either asymptomatic shedding or a vesicular eruption of the skin dermatome supplied by the affected nerve (varicella zoster or shingles).

Figure 1: Herpes zoster on the back of the neck with vesicles

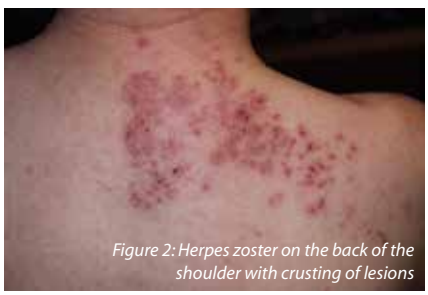


Figure 2: Herpes zoster on the back of the shoulder with crusting of lesions

It is rare that the HZV is transmitted to a close contact from a patient with herpes zoster. Such transmission may result in varicella. It is a popular misconception that patients with varicella or varicella zoster can cause herpes zoster in contacts. Such transmission can only give rise to varicella. Herpes zoster is a reactivation phenomenon, not an infection acquired from an individual with varicella or herpes zoster.

Those at increased risk include:

- Increasing age. T-cell-mediated immunity protects against reactivation of latent HZV. This declines with age. It is not related to antibody titres which may remain unchanged or increase with age.
- Immunocompromised patients with impaired T-cell immunity
- Patients on immunosuppressive treatments
- Patients with lymphoma, leukaemia, or HIV
- Rheumatoid arthritis, inflammatory bowel disease, COPD, asthma, chronic kidney disease, Type 1 but not type 2 diabetes mellitus.

In contrast with healthy individuals the increased risk in these patient groups is proportionally greater in younger age. Periodic exposure to individuals with chickenpox, throughout life, boosts immunity to HZV. Healthcare workers who are regularly in contact with children with chickenpox

infection probably benefit from such regular boosts to their immunity.

Reactivation

The reactivated HZV spreads down the nerve, eventually reaching the skin, leading to the vesicular eruption of herpes zoster. While progressing down the nerve HZV causes a severe inflammatory neuritis. This neuritis gives rise to the prodromal and acute phase pain of herpes zoster. Some 90% of patients experience prodromal pain in the affected dermatome. Usually this phase lasts for five to seven days before the rash becomes evident. The eruption is usually limited to one to three adjacent dermatomes.

Involvement of the anterior root may give rise to motor weakness. Reactivation, if accompanied by significant host immune response, may present with pain but no rash, so called 'Zoster Sine Eruptione'. Indeed, most attempts by the virus to reactivate are suppressed by the host's immune response, resulting in neither pain or rash. At the other extreme, in patients who are unable to mount an adequate immune response, the virus may disseminate, giving rise to a widespread, varicella-like eruption and multisystem organ involvement with a 10% fatality rate.

Clinical

Classical HZ presents as a unilateral, dermatomal rash. It generally starts proximally, before spreading distally along the affected dermatome, with new lesions developing over three to six days. The duration of the rash has been correlated with patient age – advancing age associated with longer duration – and site of infection, with the face healing more rapidly than other loci. The entire dermatome may not be involved. Initial lesions are erythematous macules or papules which develop vesicles within 12 to 24 hours.

Vesicles may become haemorrhagic or pustular. After five to seven days crusts develop and the lesions resolve, sometimes with either hypopigmentation or hyperpigmentation. Complications include encephalitis, myelitis, and motor paralysis. The thoracic dermatomes are most frequently involved (55%), followed by the trigeminal nerve (20%), cervical (11%), lumbar (13%) and sacral (2%).

Zoster-associated pain

There are three phases of zoster-associated pain (ZAP)

- Prodromal pain in the period before the eruption develops
- Acute phase pain occurs in the first 30 days
- Post herpetic neuralgia.

Prodromal and acute phase ZAP

Up to 90% of patients experience acute, neuritic pain and hypersensitivity due to the acute inflammatory neuritis in the affected sensory nerve. Pain often precedes the rash (prodromal) and may be continuous or episodic. It fades as the rash resolves. The degree of pain can be variable. Severe acute pain is correlated with an increased risk of post herpetic neuralgia.

Due to the latency between reactivation and the development of the eruption, the pain is often misdiagnosed as myocardial infarction, pleurisy, cholecystitis, appendicitis, duodenal ulcer, ovarian cyst, or prolapsed disc. Paresthesia (burning, stabbing, shooting, tingling), dysaesthesia (painful sensitivity to touch), allodynia (pain induced by non-painful stimuli) or hyperesthesia (exaggerated or prolonged response to a painful stimulus) may occur. In contrast with post herpetic neuralgia, which requires medication targeted at neuropathic pain, oral analgesics may be used to treat prodromal and acute phase pain – paracetamol, non-steroidal anti-inflammatory, codeine.

Apart from improving functional status and health-related quality of life, controlling acute ZAP is presumed to reduce the risk of post herpetic neuralgia, although evidence from controlled studies to support this presumption is not available.

Oral antivirals

HZ is generally a self-limiting disease and, in the absence of risk factors for complicated courses, treatment aims are to reduce:

- The extent and duration of the cutaneous manifestations and the severity and duration of acute ZAP
- The incidence, severity and duration of post herpetic neuralgia.

Oral antivirals hasten rash resolution and reduce both the duration and severity of ZAP but do not reduce the incidence of post herpetic neuralgia. Three antiviral drugs are licensed for treating zoster – aciclovir, 800mg orally five times per day, famciclovir, 500mg eight-hourly, and valaciclovir, 1g eight-hourly. There is limited evidence that famciclovir and valaciclovir are more effective than aciclovir at reducing zoster-associated pain.

There is no evidence to support continuing antivirals beyond seven days. All three antivirals are excreted by the kidney and it is advised to check creatinine in patients with known or suspected renal insufficiency.[1] There is no evidence to support giving antivirals more than 72 hours after the onset of the rash. Beyond this time antivirals might be given if new vesicles are still appearing in a patient at risk of a complicated course or with manifest complications (cutaneous, visceral or neurological dissemination, HZ ophthalmicus or HZ oticus, immunocompromised)

Post herpetic neuralgia

In the prodromal and acute phases of herpes zoster, neuritis results in nerve fibre damage. In the process of repair, nerve fibres may be wrongly 'rewired'. A nerve fibre transmitting touch may connect with a fibre transmitting pain. This explains why patients develop neuropathic problems post zoster. Allodynia is the perception of pain from a non-painful stimulus, such as touch. Hyperalgesia is an exaggerated pain sensation from a mildly painful stimulus. Other manifestations of neuropathy include reduced or loss of sensation in the affected dermatome and pruritus.

Post herpetic neuralgia is defined as dermatomal pain persisting at least 90 days after appearance of rash.20% of patients have some pain at three months. The incidence of post herpetic neuralgia following HZ rises with age (8% at 50-54 years, 21% at 80-84 years). Those with more severe pain during the prodrome and rash phase, the immunocompromised, number of lesions >50, cranial/sacral localisation, haemorrhagic lesions and those with trigeminal nerve involvement are also at increased risk of developing post herpetic neuralgia.

Prevention of post herpetic neuralgia

Trials of antiviral drugs were not designed to assess subsequent incidence of post herpetic neuralgia. We cannot say that antivirals reduce either the incidence or course of post herpetic neuralgia as what evidence we have is inconsistent. The addition of oral glucocorticoids to an antiviral medication decreases the pain of the acute phase HZ and speeds lesion resolution but does not reduce the incidence post herpetic neuralgia. They may be considered in the elderly provided there are no contraindications.

The European Dermatology Forum (EDF) in co-operation with the European Academy of Dermatology and Venereology recommend treating the following patient subgroups with an antiviral medication[1]

- HZ of any localisation in patients ≥50 years of age
- HZ of the head and/or neck area
- HZ of any localisation with
  - moderate to severe zoster-associated pain

- haemorrhagic or necrotising lesions
- Greater than one segment involved
- aberrant vesicles/satellite lesions
- involvement of mucous membranes

- HZ in immunocompromised patients
- HZ in patients with severe predisposing skin diseases (eg. atopic dermatitis)
- HZ in children and adolescents under long-term treatment with salicylic acid or corticosteroids

The EDF suggests IV aciclovir in patients with complicated HZ or who are at risk of a complicated course:

- HZ of the head and/or neck area, particularly in elderly patients
- HZ with haemorrhagic/necrotising lesions, >one segment involved, aberrant vesicles/satellite lesions, involvement of mucous membranes or generalised zoster
- HZ in immunocompromised patients
- HZ with signs of visceral or central nervous system involvement (dosage escalation up to 15mg/kg bodyweight 3x/d possible, treatment for up to 21 days).

An episode of herpes zoster boosts the host's immunity to the virus. Recurrence in immunocompetent patients does however occur in 6% of cases.

Vaccination

A live attenuated vaccine for HZ is approved for use in Ireland for persons over the age of 50 years. It is indicated for prevention of herpes zoster and herpes zoster-related PHN. It is the same vaccine strain as is used to prevent chickenpox in childhood, but given at a higher dose.

A large study of adults, the Shingles Prevention Study[3] over 60 showed that it reduced the incidence of HZ by 51% and PHN by 66.5%.

The vaccine is administered as a single dose. It is contraindicated in patients with haematological malignancy, HIV infection and those who are on long-term oral corticosteroids or who are pregnant.

Drug treatment of post herpetic neuralgia

Tricyclic antidepressants are recommended, eg. amitriptyline, starting at a dose of 10mg at night and titrated depending on response and side effects. The main side effect at this low dose is sedation that may persist into the following morning. As the dose is increased anticholinergic effects such as dry mouth and constipation may develop.

Anticonvulsant drugs may help, gabapentin starting at a dose of 300 mg TID titrated over three days, pregabalin starting at a dose of 25 to 50mg BD titrated to 300mg BD, if needed. Following an increase in the number of deaths linked to gabapentin and pregabalin between 2012 and 2016 the UK government reclassified pregabalin as a controlled substance and proposes reclassifying gabapentin.

Topical capsaicin cream 0.075% applied sparingly up to QID is an option if the patient is unable to or prefers not to use oral drugs.

Topical lidocaine is licensed for the treatment of post herpetic neuralgia. However, a systematic review concluded that there is no evidence from high quality studies to support its use in neuropathic pain.[2]

Johnny Loughnane is a general practitioner with a special interest in dermatology in practice in Co Limerick

Reference

1. Werner RN et al. European consensus-based (S2k) Guideline on the Management of Herpes Zoster – guided by the European Dermatology Forum (EDF) in cooperation with the European Academy of Dermatology and Venereology (EADV), Part 2: Treatment. J Eur Acad Dermatol Venereol 2017 (Jan); 31: 20-29

2. Derry S, Wiffen PJ, Moore RA, Quinlan J. Topical lidocaine for neuropathic pain in adults. Cochrane Database Syst Rev 2014; 7: CD010958

3. Oxman M, Levin M and Shingles Prevention Study Group. Vaccination against herpes zoster and postherpetic neuralgia. J Infect Dis 2008 Mar 1; 197 (Suppl 2): S228–S236. doi: 10.1086/522159

INMO Professional DEVELOPMENT CENTRE

Dyspraxia DCD Ireland

DYSPRAXIA AND DYSLEXIA:
Supporting Learners and Staff in Healthcare Settings

Facilitated by Kerry Pace, Founder of Diverse-Learners, specialist teacher, advisory member of the teaching team, School of Nursing and Midwifery at Plymouth University and reviewer for Nursing Education in Practice.

Date:
Thursday, November 1, 2018

Time:
10.00am - 3.00pm

Venue:
The Richmond Education and Event Centre, North Brunswick Street, Dublin D07 TH76

Fee:
€20 for INMO members; €75 for non members

Early Booking is advisable as places are limited
Book online via https://inmoprofessional.ie or call 016640641/18

Killing loneliness with kindness

EARLIER this year the Loneliness Taskforce called for €3 million annual funding to combat loneliness and social isolation in Ireland.

At the launch of its report *'A Connected Ireland'*, the taskforce also called for:

- Responsibility to combat loneliness to be allocated to a specific Minister and government department
- A public campaign to be undertaken
- Support for initiatives and organisations that alleviate loneliness as their primary function
- An action plan for volunteering
- Irish-specific research on loneliness.

As well as being endemic among the growing population of older people, the report highlighted that loneliness is not confined to the old, but that the rise in single-person households and the increased pressures on young people are also contributing to the risk of loneliness.

Such loneliness and social isolation is poignantly portrayed in *'Eleanor Oliphant is Completely Fine'* by Gail Honeyman. This is a moving account of the self-perpetuating nature of loneliness and how it seeps deeper and deeper into a person's very being.

Eleanor leads a simple life, dominated by routine. She wears the same practical clothes to work every day, eats the same food (meal deals, Tesco pizza and spaghetti hoops) and buys the same two bottles of vodka to drink, alone, every weekend. To the few people she interacts with, Eleanor is an oddball and the subject of fun for her colleagues, until one of them, Raymond, befriends her and shows her some kindness. It is this simple friendship that prompts Eleanor to move out of the shadows and begin to explore life outside her daily routine.

This is a moving and thought-provoking story, that follows Eleanor's emotional journey from her traumatised past to a future where she might "have a life, not just an existence".

Despite all her efforts to appear otherwise, it is evident that Eleanor Oliphant is not completely fine and is in need of simple acts of kindness.

At times hilarious, deeply sad at others, this is an observant exploration of how a person devoid of social interaction confronts everyday life. The many reasons for Eleanor's isolation and social ineptitude are gradually revealed by the skilful author, Gail Honeyman, who won the Costa First Novel Award in 2017 for this book.

– Tara Horan

Eleanor Oliphant is Completely Fine by Gail Honeyman. Harper Collins, 2017, ISBN: 978-0-00-817214-5, €10.99

CROSSWORD Competition

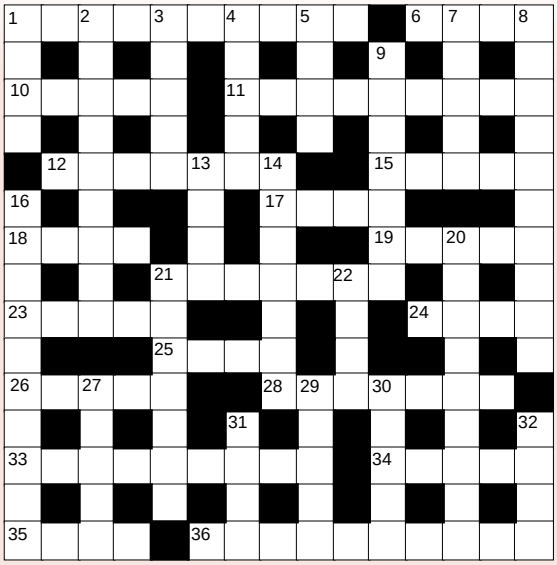
WIN a €30 gift voucher

Across

1 The pontiff finds this moving – wherever he goes! (10)
6 Fashionable (4)
10 Put the artist in a box with this chemical substance (5)
11 Percussion instrument (5,4)
12 Bridge call? No, American President! (2,5)
15 Powerful light beam used in certain types of surgery (5)
17 Operatic song (4)
18 Jewellery for the finger (4)
19 Educate (5)
21 Thankless type found tearing around (7)
23 Not yet ignited; in darkness (5)
24 Famous English Public School (4)
25 In a frenzy (4)
26 Salivate (5)
28 Popular tourist region of Portugal (7)
33 & 34 Echidnas limber up to provide health-enhancing plants (9,5)
35 Formal votes against the motion (4)
36 A laxative will get you to survive - right, sailors? (5,5)

Down

1 'Locals' (4)
2 How to enrol pens into human resources (9)
3 Soft drink you have with spirits (5)
4 Broom (5)
5 Piece of foliage (4)
7 What leverets grow up to be (5)
8 Understand (10)
9 Let the air out, or destroy hope (7)
13 The second word of most fairy tales (4)
14 Hungarian red pepper (7)
16 Is this the guy who prepares the pitch or the guy for the coffee? (10)
20 Perhaps a rival tin contains such a drug (9)
21 Sloped letters (7)
22 The taste of gnat turnover (4)
27 In a strange way (5)
29 In this French city, the French embrace the sick (5)
30 One of The Three Musketeers (5)
31 Letters traditionally seen above the cross in depictions of the crucifixion (1,1,1,1)
32 One sister will identify a goddess (4)



September crossword solution

Across: 1 Cab 3 Glove puppet 8 Rescue 9 Recovery 10 Usury 11 Total 13 Bills 15 Tussled 16 Rebecca 20 Kiosk 21 Yo-yos 23 Whole 24 Catheter 25 Copied 26 Demolishing 27 Mar

Down: 1 Circulatory 2 Biscuits 3 Gaudy 4 Variola 5 U-boat 6 Pretty 7 Thy 12 Legal tender 13 Break 14 Steak 17 Chromium 18 Monarch 19 System 22 Shell 23 Wrong 24 Cad

The winner of the September crossword is: Brenda Elphick Bere Island, Co Cork

You can now email your entry to us at nursing@medmedia.ie by taking a photo of the completed crossword with your details included.
Closing date: Friday, October 19, 2018
If preferred you can post your entry to: Crossword Competition, WIN, MedMedia Publications, 17 Adelaide Street, Dun Laoghaire, Co Dublin, A96E096

Name:
Address:

MONEY MATTERS

Making the most of your pension

Invest in a single premium AVC to maximise your money before you retire, writes **Ivan Ahern**

EVERY year, thanks to single premium AVCs, hundreds of public sector employees receive thousands of euro extra in a tax-free lump sum upon retiring.

Tax-free lump sum shortfall

If you are approaching retirement, it is important to check if the tax-free lump-sum that you will receive when you retire is the maximum that you are entitled to.

You will receive a tax-free lump sum from your employer that is based on your service and salary. However, this could be less than the Revenue maximum that you are entitled to for a number of reasons:

- If you have less than full service
- If you have any non-pensionable earnings
- If you have received a reduction in pay in the last number of years
- If you have more than 40 years' of service and are over the age of 60
- If you are retiring under the cost neutral early retirement scheme.

If you fall into any of these categories, and have not yet retired, then there is still time to maximise your money in retirement with a single premium AVC– also known as a 'last minute' AVC.

Shortfalls can be complex to calculate, so, if you are unsure if you have a shortfall or not, it is important to seek the advice of a professional. Cornmarket can help you with this.

What is a single premium AVC?

A single premium AVC presents you with an opportunity to increase your tax-free lump sum at retirement. It allows you to invest a single lump sum contribution before you retire, in order to maximise the tax relief available to you.

An example

With the help of a financial consultant, Susan identified that the superannuation tax-free lump sum she would receive at retirement would be €65,000. However, the Revenue maximum that she was entitled to was €80,000. In order to make up for her shortfall of €15,000, and also make the most of the tax relief available to her, she decided to make a lump sum contribution into a single premium AVC before she retired:

- Having taken out her single premium AVC
- After investing and completing a tax return, she received €6,460 back from Revenue
- After retiring – she received her shortfall of €15,000
- In total, the profit that Susan made was €5,310.

For simply investing this lump sum before retirement, her bank account was much better off.

You can only invest in a single premium AVC before you retire. For more expert advice on why a single premium AVC could be right for you and other key factors that you should consider before you retire, contact Cornmarket at Tel: 01 420 0973.

Table: Single premium AVC investment example

Lump sum contribution	**€15,000**
Plus fee and contribution charge	**€1,150**
Susan's total investment	**€16,150**
Less tax relief back received (tax at 40% p.a.)	**€6,460**
Actual cost to Susan	**€9,690**
Single premium AVC profit	**€5,310**

Ivan Ahern is a director of Cornmarket Group Financial Services Ltd

Warning: The value of your investment may go down as well as up. This product may be affected by changes in currency exchange rates. If you invest in this product you may lose some or all of the money you invest. If you invest in this product you will not have any access to your money until you receive your Superannuation benefits.

Cornmarket Group Financial Services Ltd is regulated by the Central Bank of Ireland. A member of the Irish Life Group Ltd which is part of the Great-West Lifeco Group of companies. Telephone calls may be recorded for quality control and training purposes

WHO commends HSE on HPV campaign

HPV vaccine uptake rate has risen by 15% in little over a year

THE HSE has confirmed the latest provisional uptake rate for the HPV vaccine at 65%, marking an increase of 15% in over a year, with two in every three Irish girls now protected.

The approach taken by the HSE, in co-operation with partner agencies and bodies, in successfully addressing the significant drop in uptake rates over recent years has been commended by the World Health Organization (WHO). The WHO is encouraging countries experiencing similar issues to consider adopting a broad collaborative approach. The WHO Regional Office for Europe has also invited Irish HPV vaccine advocate Laura Brennan to participate in its forthcoming International Day of the Girl campaign.

Laura Brennan, a 25-year old from Co Clare whose advocacy has been pivotal to the ongoing success in achieving higher vaccine uptake rates, said: "My only reason for getting involved in this campaign was my desire to save other families from going through what mine is going through, to save other parents from watching their child suffer from a preventable illness, caused by a virus which the majority of people in this room have had or will have at some point in their life. I was just unlucky that I caught a cancer causing strain of the virus and my body couldn't fight it off. That's why I got cervical cancer. "

Pointing to the latest uptake rates Laura noted: "Sixty five per cent isn't where I want the vaccine rates to be, but I do understand that figure is likely to rise once all the figures are validated. As everyone knows I won't be happy until as many of our girls are protected as possible. But it is going in the right direction. It shows that once again the people of Ireland are listening to reason and using reality and evidence as a basis for their decision making.

"Really though, I'm five months older. My cancer is five months older. It's getting stronger and I'm getting weaker. I've always said that I won't stop until my body does. I'm facing my death and the reason is a virus that your child doesn't have to get. I'll be gone in a few years. Once I'm gone there is nothing more I can do about it so I hope you all listen to me while you have the chance," she said.

With school vaccination teams now in second level schools administering the vaccine to first-year girls, the latest phase of the HSE Vaccine Information Campaign is already underway. The schedule involves national and regional radio advertising, along with regional newspaper advertising, social media promotion, digital search advertising and organic social media posts on Facebook and Twitter.

Launching the campaign, Minister for Health Simon Harris said: "Prevention is better than cure, and this is especially true of cervical cancer. We are lucky to have a vaccine that can potentially prevent 70% of cervical cancers, and I am pleased to say that our increased provisional uptake figures last year have been internationally recognised. This very welcome increase reflects the huge amount of work being done across the medical community, including school vaccination teams, GPs and pharmacists, to provide accurate and trusted information.

"Extending the national immunisation schedule to include HPV vaccination of boys is a priority for me, and subject to a favourable recommendation from HIQA, the Government will seek to extend this vaccine universally as a priority. Today, I want to be unequivocal again in saying that the HPV vaccine protects young people's lives and I urge parents to vaccinate their daughters this autumn."

Dr Sean Denyer, interim head of the HSE National Immunisation Office, described the 15% increase in the uptake rate as "extremely encouraging".

"We know this vaccine is safe; we know it works and we are now seeing the majority of parents throughout the country move to protect their daughters. We understood that parents wanted to do the right thing for their children, so we set out to provide them with scientifically and evidence-based information.

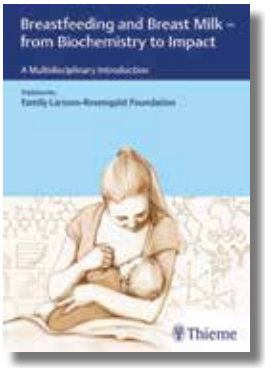
New aid for decision-makers to increase breastfeeding rates

BREASTFEEDING is one of the most under leveraged strategies in improving children's health and reducing later health and disease risks. That is why the WHO challenged the world to increase rates of exclusive breastfeeding in the first six months of life up to at least 50% by 2025. The new book, *Breastfeeding and Breast Milk – from Biochemistry to Impact*, can help governments and influencers take up that challenge.

This evidence-based book presents a holistic overview of key topics linked to the influence of breastfeeding and breast milk on children's health and development. With scientifically robust arguments, the international authors encourage governments to answer the WHO's challenge by creating breastfeeding-friendly environments and shifting their focus from isolated activities to collaborative, multi-country, multi-stakeholder partnerships.

Breastfeeding and Breast Milk – from Biochemistry to Impact provides a scientifically robust overview of key topics written by leading experts from a wide range of disciplines, including medicine, sociology, political sciences, culture and economics.

Based on sound science, yet written in popular science style, the book provides decision makers with the knowledge required to move breastfeeding higher on the public health agenda and to increase the overall promotion, protection and support for breastfeeding and the use of breast milk. Midwives and lactation consultants can also benefit from this multidisciplinary perspective.



"While it is heartening to see promotion, protection and support of breastfeeding moving higher on many governmental agendas, there is still more work to be done. No other single health intervention has the potential to reduce inequalities in health and prevent newborn and child deaths on the same scale as breastfeeding," said Göran Larsson, chairman of Family Larsson-Rosenquist Foundation Board.

Major new cancer trial opens in Ireland

Trial to investigate if aspirin can prevent cancer from returning

THE world's first ever large scale trial to investigate whether aspirin can prevent early-stage cancer from coming back after treatment, has opened in Ireland.

The trial, called Add-Aspirin, aims to investigate whether taking aspirin daily for five years after undergoing standard cancer treatment, including chemotherapy and surgery, can prevent the disease from returning.

The Irish trial is part of an international trial involving the UK and India. A total of 11,000 people from these three countries will take part.

In Ireland, 300 volunteers who have, or previously had, cancer of the breast, oesophagus, stomach, colon, rectum or prostate will join the trial. Their cancer must be early-stage cancer which has not spread.

The Irish leg of the trial is being co-ordinated by Cancer Trials Ireland, with funding coming from the Health Research Board and the Irish Cancer Society.

Aspirin is already used as a painkiller, and to prevent and treat heart attacks and stroke. However, studies which looked at the effect of aspirin on heart disease found that fewer people taking the drug went on to develop cancer. Furthermore, among those who did develop cancer, it appeared to be less likely to spread.

However, as these studies were not specifically designed to investigate the impact of aspirin on cancer, there is not enough scientific data to support its use to prevent the disease, which is why a large clinical trial is warranted.

The trial aims to produce this scientific evidence, looking at both potential benefits and side-effects among people who have had early stage cancer.

Groundbreaking

The trial's chief investigator for Ireland is Dr Gregory Leonard, a consultant in medical oncology at Galway University Hospital. He noted that while aspirin has been used as a painkiller in Ireland for more than 100 years, and more recently to prevent heart attacks and stroke, evidence about the drug's potential as an anti-cancer agent has been growing.

"This is the first trial ever to investigate if aspirin could stop or prevent the return of cancer among such a significantly large group of patients with early-stage cancer. At a time when we are used to new cancer treatments being relatively costly, the possibility of re-purposing an inexpensive, generic drug that is available worldwide to stop or slow cancer is potentially groundbreaking," he said.

He insisted that the results of this trial could have "a huge impact on the global cancer burden, particularly given the increasing cancer incidence in lower resource countries".

Participants will be recruited over a three-to-six-year period and they will be expected to self-administer tablets on a daily basis for at least five years. They will then be followed up for a further 10 years after treatment.

The trial will have three groups. One group will receive a placebo, while the other two will receive different doses of aspirin, as it is not known how much aspirin may be needed to have an effect. This will be done randomly, and neither the participants or the researchers will know who is receiving what.

Anyone interested in taking part in this trial should speak to their oncologist, who will be able to determine if they are a suitable participant.

For more information on cancer trials taking place in Ireland, see **cancertrials.ie**

Cornmarket continues support of INMO PDC with €20,000

Cornmarket has reaffirmed its long-standing relationship and commitment to Irish nurses and midwives by presenting the INMO with a cheque for €20,000 to support the continuing education and professional development of nurses and midwives. As a socially responsible company, Cornmarket believes in the commitment to provide opportunity for nurses and midwives to access quality and up-to-date programmes and resources as part of life-long professional development. Cornmarket is the main sponsor of INMO Professional

Pictured at the presentation were (l-r): Steve Pitman, INMO head of professional development and education; Phil Ní Sheaghdha, INMO general secretary; Ivan Ahern, director of Cornmarket Group Financial Services Ltd; Martina Harkin-Kelly, INMO president; Dave Hughes, INMO deputy general secretary; Eilish Fitzgerald, INMO second-vice president; and Edward Mathews, INMO director of regulation and social policy

October

Wednesday 3
Telephone Triage Nurses Conference, INMO Richmond Education and Event Centre. Contact jean.carroll@inmo.ie for further details

Saturday 6
PHN Section Meeting, INMO HQ. 11am – 1pm. Contact jean.carroll@inmo.ie for further details

Saturday 6
Community RGN Section Meeting. INMO HQ. 11am – 1pm. Contact jean.carroll@inmo.ie for further details

Saturday 13
ODN Section Meeting. 11.30am, Cavan General Hospital. Contact jean.carroll@inmo.ie for further details

Saturday 13
Midwifery Section Meeting, 2pm, Limerick University Maternity Hospital. Contact jean.carroll@inmo.ie for further details

Thursday 18
All Ireland Midwives Conference, Crowne Plaza Hotel, Santry, Dublin 9. Contact jean.carroll@inmo.ie for further details

Thursday 18
SALO Group Meeting. INMO HQ. 12pm. Contact jean.carroll@inmo.ie for further details

Tuesday 23
Care of the Older Person Section education session on diabetes, and Section meeting. INMO Cork office. Bookings essential. Log onto www.inmoprofessional.ie or contact the INMO directly on 01-6640641

Tuesday 23
Evidence into Action Conference, School of Nursing and Midwifery, Trinity College. See www.tcd.ie/mammi for more information

November

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

Friday 16
Third Level Student Health Nurses Section Meeting. INMO HQ. Contact jean.carroll@inmo.ie for further details

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

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

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

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

December

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

INMO Membership Fees 2018

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

Condolences

- The INMO extends its deepest condolences to Margaret Frahill and her family on the death of her brother Ricky Burke. May he rest in peace
- The INMO wishes to extend its condolences to Sinead O'Connor from our Galway office on the death of her mother Laserina Peters. RIP.

Retirement Planning Seminar

Date: Thursday, October 25

Venue: The Richmond Education and Event Centre, North Brunswick St, Dublin, D07 TH76

cornmarket group financial services ltd

INMO Professional DEVELOPMENT CENTRE

€10 for INMO members €45 for non members

Book online at inmoprofessional.ie or Tel: 01 6640641/01 6640618