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WIN

World of Irish Nursing & Midwifery

INMO
Journal of the
Irish Nurses and Midwives Organisation

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No pressure, no progress

"NO PRESSURE, no progress." This is a line from the recent book on the INMO's first 100 years and the backing track to nursing and midwifery issues for the past decades. The HSE and wider government can be a slow-moving machine, resistant to forward planning and slow to make changes. All members will doubtlessly share the frustration at just how slow that machine can be. But with pressure there can be progress. And thanks to the pressure of 40,000 nurses and midwives standing together in their union, we are making progress.

New graduates faced serious difficulties in securing the full-time, permanent contracts which the Minister for Health had pledged. Issues remain in three workplaces, but thanks to INMO pressure and representation, we have ensured that well over 1,100 graduates have received what they were promised and what our understaffed service needs. We will continue to apply pressure until every single qualified graduate gets a full offer.

The implementation of the strike settlement has shown a similar pattern. The HSE has stalled, the departments of Health and Public Expenditure have debated, and progress in implementation has been hindered by attempts to undo the gains you achieved. We have not tolerated this. We have relied on the strong recommendation of the Labour Court and reverted to the Court to prevent any dilution. This has resulted in HSE instructions to offer higher-paid contracts to staff nurses and midwives, increase existing allowances by 20% and roll out allowances to maternity services, PHNs who don't get allowances now, and surgical and medical areas. All of that will be backdated to March 1, 2019.

From November, staff nurses and midwives with 17 years or more experience can access the senior staff nurse/midwife increment, which will mean basic pay exceeding €50,000 – before allowances and premium pay.

Recent figures obtained via Freedom of Information, show that between 2015 and 2019, 1,800 nurses and midwives were victims of assault in HSE hospitals. That is inextricably linked with staffing levels, overcrowding and underinvestment. The real figure is far higher, as many cases go unreported and the figures do not include voluntary, Section 39 and community services.

This is part of the reason that 40,000 nurses and midwives sought funding for safe staffing in the strike. This again is now being rolled out. Following much pressure, draft implementation documents have been issued to the INMO, confirming a rollout of the Safe Staffing Framework to medical, surgical and emergency areas in – initially – the nine Model 4 hospitals. Once complete, that will continue to Model 2 and 3 hospitals.

The staffing system will come with a new IT system for monitoring staffing and patient load, a specific budget line in the HSE, an oversight group to implement, and eight new safe staffing co-ordinators. Furthermore, the safe staffing framework will now apply to the community and elderly care. This is a significant issue for our members in these services, which are traditionally very understaffed and difficult to recruit to.

We will continue to apply pressure – to lobby, campaign, meet, debate, publicise and protest – to improve the working conditions of our 40,000 members and to support a decent health service. That means working to end the government's destructive and counterproductive recruitment pause, which wreaks havoc with careers, leaves services understaffed, and endangers patients – while increasing agency and litigation costs. We have had some success breaking pieces off the pause and securing appointments, but it is clear that the policy must go in its entirety across nursing and midwifery.

Progress also means working through our strike settlement line by line, ensuring that every hard-won piece is implemented in full. It also means looking at the wider national context, which our pre-Budget submission covers. Be in no doubt that this union will continue to work on your behalf, combining the power and knowledge of 40,000 skilled, trained, respected professionals to achieve change. No pressure, no progress.

Phil Ní Sheaghdha
General Secretary, INMO

Your priorities with the president

Martina Harkin-Kelly, INMO president

Planning for winter

FAIL to plan: plan to fail, or so I was led to believe in the family in which I was reared. The HSE is yet to publish a winter plan for 2019, to deal with the usual increase in demands on our health service in winter. The problems previously confined to winter have become a year-round issue. The impact falls heavily on frontline staff in the health service, who continue to work to keep their heads above water. This is simply not a safe environment for patients or members alike, given the high number of vacancies across the whole health service – from hospital wards to the community. That is why this union will continue to pursue safe staffing levels, an end to the recruitment ban, and curtailment of services until that is achieved.

Graduate symposium

I WAS delighted to speak with the next generation of nurses and midwives at our graduate symposium in September. I aimed to motivate, but in turn found that I left with a renewed faith in our mission, thanks to the opportunity to talk with so many enquiring minds and fresh additions to our professions. I reminded them of the words of Roisin O'Connell, a recent graduate nurse who spoke at this year's annual delegate conference: "Each and every Irish nurse is worth their weight in gold if not more".

After years in practice as a nurse, I left them with the following advice: never falter, believe in what you can do and the difference you can make, stay true to your professional values and remember that learning is a lifelong mission.

Care of Older Persons nursing conference

THE COOP Section's annual conference, which had been postponed due to the industrial action, took place on September 10. The conference focused on the dementia epidemic, which affects so many of our older citizens. The speakers presented their evidence-based insights into improving care for such patients, which can be a particular challenge for frontline nursing staff. The conference also looked at the issue of sexuality in older person's care – an issue which is sadly often ignored. The conference heard from representatives of LGBT Ireland along with speakers from the HSE. The day concluded with a session on complementary therapies for older people, including a 'meeting' with Mylo, a companion robot aimed at averting loneliness and improving companionship *(see page 23)*.

Centenary celebrations

2019 is, of course, the INMO's 100th year, and we are planning to conclude the year in a number of ways, which were recently discussed by the National Centenary Committee in early September. The Irish Patchwork Society and several INMO members are progressing with a tapestry to mark the union's centenary. The design is by artist Robert Ballagh, with the intricate work being done in panels by the talented stitchers. The banner will reflect the importance of the branches and sections, the four corners of Ireland where our members work, and our proud, international, multicultural workforce.
If any member wishes to get involved in the project, please get in touch with HQ.

There will be a celebratory event on November 28, which branches and sections will be contacted about in the coming weeks. The event will include the Nurse and Midwife of the Year Awards – I encourage members to get submissions in before October 31, via the INMO website.

Finally, many local branches will be working with local councils and elected representatives to host civic receptions across the country, to recognise the incredible dedication and work of Ireland's nurses and midwives. This is not only a celebration of our work, but also a chance to maintain our strong political profile.

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

Quote of the month

"Management is doing things right; leadership is doing the right things"

- Peter Drucker

Report from the Executive Council

THE National Executive most recently met on September 2 and 3, as ever, dealing with a mix of internal, profession and national issues.

Union management updated the Executive on the ongoing attempt by the Revenue Commissioners to remove tax entitlements for nurses and midwives, relating to uniforms and uniform cleaning costs. Revenue bizarrely contend that "the laundry of a uniform does not arise in the actual performance of the duties of a nurse". Needless to say, this is being robustly contended by the INMO.

There was discussion about the HSE's failure to offer all graduate nurses and midwives contracts. The union has had success across the country in overturning this policy, with well over 1,100 permanent contracts issued. At time of going to press, there remain some issues, but officials are confident that they can be overcome.

We also filled the vacant student post on Executive and I would like to welcome Corrinne Rushe as the student nurse representative on the Executive. She is a welcome addition.

The Executive also supported Trade Union Friends of Palestine (TUFP), which is hosting a conference in Dublin in November. This will focus on the suffering of Palestinian children.

The next Executive Council meeting will be held on October 7/8, 2019.

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

INMO calls for multi-annual funding for Sláintecare from Budget 2020

BUDGET 2020 must prioritise the delivery of an integrated, universal health service, as envisaged in Sláintecare, the INMO stressed in its pre-Budget submission to the government last month.

To do this, the government must ensure appropriate funding and staffing, which in turn will ensure high quality, safe patient care.

Multi-annual transitional funding must commence from Budget 2020 to support the implementation of Sláintecare, the INMO states.

On nursing and midwifery staffing and pay, the INMO is calling for a commitment to a funded workforce plan for nursing and midwifery, based on patient need and dependency. This is recommended in the Labour Court Recommendation and set out in the Department of Health's *Framework for Safe Nurse Staffing and Skill Mix* and the *Maternity Strategy* for adequate nursing and midwifery staff.

In addition, the INMO is seeking budgetary provision for the full implementation and expansion of this model across acute, primary and long-term care. This will require investment to correct the current nursing and midwifery staffing numbers.

In addition the INMO said that the government must now implement a sustainable workforce strategy to ensure Ireland can rectify the current nurse and midwife staffing problems in the public health service and compete within an international labour market for healthcare professionals.

The INMO called for no changes to be made to the current flat rate allowances as has been announced, which allow employees to claim back on work-related expenses such as uniforms for healthcare professionals. This change would in effect reduce the income of frontline nurses and midwives, thereby penalising them to a greater extent at a time when the pay is being restored for all public servants, and would undermine recruitment and retention initiatives. The INMO and the ICTU have made numerous submissions to Revenue on its position in relation to flat rate expenses, pointing to other areas that warrant greater attention such as corporation tax losses.

The union also warned of the threat of Brexit to nursing and midwifery recruitment and retention. "Ireland is experiencing a significant increase in the intensity of determined recruitment of nurses and midwives. The current recruitment pause introduced by the HSE must be removed and must exempt nurses and midwives," the submission states.

In addition, the INMO called for an increase in the number of undergraduate nursing and midwifery places. "This country must become self-reliant with regard to training and retaining Irish trained nurses and midwives in our public health service, the INMO said. "This increase must, as a minimum, grow the number of undergraduate placements and see an increase of 250 by 2020 and a further 250 by 2021."

The INMO submission detailed the staffing increases needed in the areas of:

- Midwives, where a shortfall of 206.7 WTE staff currently exists in Irish maternity services
- Children's nurses, with the new National Children's Hospital alone needing an increase of a minimum of 300 nursing posts over the next two years
- Public health/community health nursing, in which Sláintecare has identified the need to invest in a further 900 generalist nurses to work in the community.

The INMO submission also calls for Budget 2020 to make allowances for several taxation and societal issues, including broadening the tax threshold, Brexit, climate change and housing.

The full *INMO Pre-Budget Submission 2020* can be viewed at: **www.inmo.ie**

Post-Brexit recruitment drive likely to hit Ireland

Seven in 10 nursing/midwifery students offered overseas posts

THE UK is likely to step up its recruitment of Ireland's nurse and midwives following Brexit, the INMO warned in its pre-budget submission.

UK hospitals currently recruit nurses and midwives from across the European Union, but this is likely to become more difficult as migration controls are put in place following Brexit.

The Common Travel Area for Ireland and the UK means that Irish nurses and midwives will be "prime targets" for UK health recruiters.

New figures from an INMO student survey show that, as of June 2019, over 68% of nursing and midwifery students have been approached by overseas recruiters.

When asked for the main factors that might keep them working in Ireland, 47% pointed to staffing levels and working conditions.

The INMO's pre-Budget submission calls for funding to reach safe staffing levels throughout the health service, more undergraduate places for nurses and midwives, and resources to fully implement the safe staffing framework, as agreed following the INMO strike earlier this year.

INMO general secretary Phil Ní Sheaghdha said:

"Ireland's nurses and midwives are prime targets for UK health service recruiters. After Brexit, it's likely that British hospitals will step up their efforts to draw more nursing and midwifery staff away.

"Even before Brexit, the vast majority of our graduating nurses and midwives have received offers to work overseas – often in better conditions.

"We need to make the Irish health service an attractive place to work – that means getting staffing levels right.

"The upcoming Budget is a chance to kickstart that process, by investing in safe staffing, more student places, and implementing Sláintecare. The alternative is understaffed, overstretched services, where patients suffer and staff burn out."

Solidarity with climate activists

THE INMO joined the youth-led and organised Global Climate Strike on Friday, September 20. Students across the world took part in what has been described as the largest climate protest in history.

Standing in solidarity with the young activists, the INMO took part in this action in Ireland along with ICTU and many other Irish trade unions.

In its pre-Budget submission to the government, the INMO said: "It is imperative that the government pushes forward on its Action Plan on Climate Change, including the transition to a low carbon economy and investment research and development funding for alternative energy sources."

However, it also stressed the need for a commission on just transition to "ensure real, valued alternative jobs for sectors and communities depending on traditional carbon-driven industries."

Pictured at the protest (right): are Ruairi Shelley and his daughter Lua Rose, with Caoimhe Kerins and her daughter Síofra

Over 1,300 nursing and midwifery posts now vacant in acute hospitals

"Recruitment ban has got to go," says INMO

IN EXCESS of 1,300 funded nursing and midwifery posts are being left vacant in Ireland's acute hospitals due to the HSE's recruitment ban, recent figures from the INMO revealed.

Across staff nursing and midwifery in acute hospitals, 7% of funded posts were vacant, with 1,251 vacancies out of 17,623 posts. There are also 66 unfilled nurse/midwife management roles in acute hospitals, bringing the total number of vacant posts to 1,317.

In addition, there are 420 vacancies in the community health services, which covers care of the elderly, public health and intellectual disability.

Midwifery staffing is being hit the hardest, with one in six (17%) of funded staff midwife posts now vacant: 284 vacancies in a workforce of 1,687.

INMO general secretary Phil Ní Sheaghdha: *"The figures are stark: the government is refusing to fill frontline healthcare posts"*

In 2017, the HSE had pledged to increase the number of midwives from 1,409 by 210 by the end of 2018 to ensure safety levels. However, as of July 2019, the number of midwives had gone down to 1,403.

The INMO points to the HSE's recruitment "pause" as the key driver of unfilled posts. The union has met with the HSE to call for curtailment of services until staffing reaches safe levels.

The recruitment pause has been used as a reason not to offer graduating nurses and midwives full-time, permanent posts.

However, following intervention by the INMO, over 1,100 students have now been offered contracts, with officials working to resolve the issue in the remaining workplaces where problems remain.

INMO general secretary Phil Ní Sheaghdha said: "The figures are stark: the government is refusing to fill frontline healthcare posts.

"Make no mistake: this will lead to compromised patient care and staff burnout.

"Midwifery is being hit particularly hard by the government's recruitment ban. One in six posts are left vacant. Even if we filled all of these posts, we would still fall far short of the safe staffing levels promised by the government. Midwifery vacancies disproportionately affect women. This is yet another unwelcome example of government's approach to women's health.

"The recruitment ban has got to go. It breaches agreements with the INMO, drives up agency costs, puts frontline staff under extra pressure, and puts patients' lives at risk.

"Until we can get staffing up to safe levels, we are calling on the HSE to scale back services and close many non-essential wards."

Call for direct, high-level HSE intervention at UHL

AS TROLLEY figures once again hit record high levels at University Hospital Limerick, the INMO has called on the HSE to make a high-level intervention.

With 81 admitted patients waiting without a bed at the hospital on Monday, September 23, 2019 – a number which matches the record-high number of trolleys recorded in any hospital in the country, which also occurred in UHL on April 3, 2019 and July 11, 2019.

UHL is consistently the most overcrowded hospital in the country, with over 10,000 waiting without beds in 2018 and, as we went to press, the hospital was set to record its worst September on record.

The INMO has called on the HSE to make a high-level intervention at the hospital to:

- Curtail services to clear the overcrowding
- End the recruitment ban, which has led to 100 unfilled nursing vacancies in UHL alone
- Immediately offer full-time, permanent contracts to graduating nurses and midwives, many of whom have still not been offered roles at UHL
- Open a review into the ongoing trolley overcrowding at the hospital.

INMO assistant director of industrial relations Mary Fogarty said: "This is a matter of public safety – 81 patients on trolleys is what you'd expect after a natural disaster, not on an ordinary Monday.

INMO assistant director of IR Mary Fogarty: *"At the root of the overcrowding is understaffing. There are 100 unfilled nursing posts in UHL and the HSE is not allowing management to recruit graduating nurses and midwives"*

"It's time for direct, high-level HSE intervention. Services should be curtailed immediately to clear this overcrowding.

"At the root of this is understaffing. There are 100 unfilled nursing posts at the hospital, and the HSE is not allowing management to recruit graduating nurses and midwives. The recruitment ban has got to go.

"Our members are looking to winter with a sense of dread. If this is what's happening in temperate months, things can only get worse as accidents and illnesses increase in colder weather."

Nursing/midwifery salary scales as at September 1, 2019

Incremental point	1	2	3	4	5	6	7	8	9	10	11	12
Student nurse/midwife/intellectual disability	14,688 *(degree students 36 weeks rostered placement)*											
Staff nurse/midwife (post qualification, pre-Registration)	25,538											
Staff nurse/midwife	29,860	31,654	32,734	33,951	35,487	37,019	38,546	39,866	41,189	42,506	43,824	45,119
LSI after three years on max												46,501
Senior staff nurse/midwife	48,736											
Enhanced nurse/midwife dual qualified nurse/midwife	36,433	38,728	39,952	40,895	41,933	43,315	44,661	46,643				
LSI after three years on max												48,027
Senior enhanced nurse/midwife dual qualified nurse/midwife	50,337											
Clinical nurse/midwife manager 1	45,969	46,811	48,000	49,207	50,397	51,594	52,929	54,172				
Clinical nurse/midwife manager 2/ specialist	49,914	50,741	51,439	52,582	53,843	55,081	56,320	57,714	59,010			
(plus allowance of €801 pa payable on a red-circle basis to theatre/night sisters who were in posts on 5/11/'99)												
Clinical instructor	52,081	52,923	53,547	54,705	55,872	57,131	58,397	59,662	60,924			
Clinical nurse/midwife manager 3	57,436	58,572	61,446	62,576	63,712	64,863						
Nurse tutor	58,747	59,545	60,339	61,139	61,936	62,735	63,528	64,329	65,127	65,924		
Principal nurse tutor	61,611	62,774	63,835	67,151	68,311	68,354	69,682	71,462				
Student public health nurse	33,738											
Public health nurse	48,636	49,441	50,130	51,215	52,462	53,671	54,888	56,256	57529			
(plus allowance of €1601 pa payable on a red-circle basis to staff who were in posts on 5/11/'99)												
Asst dir of public health nursing	57,439	60,595	61,892	63,087	64,294	65,946						
Director of public health nursing	75,408	77,694	79,987	82,376	84,569	86,862						
Advanced nurse practitioner	57,991	59,113	60,197	63,523	64,571	65,787	66,924	68,054	71,466			
Advanced nurse practitioner candidate	57,436	58,572	61,446	62,576	63,712	64,863						
Asst dir of nursing band 1	57,991	59,113	60,197	63,523	64,571	65,787	66,924	68,054	71,466			
Asst dir of nursing non band 1 hospitals	55,072	56,246	57,440	60,595	61,892	63,087	64,294	65,945				
Director of nursing band 1	76,919	79,058	81,200	83,334	85,471	87,616	89,752					
Director of nursing band 2	71,557	73,498	75,445	77,384	79,334	81,278	83,223					
Director of nursing band 2a	71,005	72,226	73,450	74,669	75,893	77,112	78,335					
Director of nursing band 3	67,106	67,530	68,969	70,395	71,816	73,248	74,669					
Director of nursing band 4	62,703	64,601	66,491	68,390	69,219	71,060	72,898					
Director of nursing band 5	58,658	59,928	61,196	62,462	63,729	65,003	66,272					
Area director – nursing and midwifery planning dev unit	80,912	83,330	85,724	87,777	90,065	92,401	94,703					
Director – nursing and midwifery planning dev unit	73,716	75,707	77,900	80,310	82,952	85,665						
Director centre of nurse education	67,446	68,496	70,540	72,585	74,629	76,674	78,718	80,849				
Hospital group director of nursing and midwifery	99,863	104,301	108,739	113,175	117,615	122,053						

In IR Update this month, Tony Fitzpatrick, INMO director of industrial relations, urges members to check their payslip

Enhanced salary scale now applies

ALL grades of nurses and midwives received a pay rise of 1.75% on September 1, 2019. Members are advised to ensure they are being paid correctly – see *opposite page* for the updated salary scales.

In recent weeks, the HSE issued two circulars which allow implementation of the two Labour Court Recommendations and strike settlement secured by the INMO.

HSE HR circular 022/2019 implements the enhanced nurse/midwife salary scale. This applies retrospectively to March 1, 2019 and therefore, individuals who have progressed on the increment scale since March 1, 2019 and who have reached the fourth point of the staff nurse/midwife salary scale should apply to go on to the enhanced nurse/midwife scale. Staff whose increment dates are due should ensure to apply for the enhanced scale. The process is that you would move from your current point on the scale to the next point on the staff nurse/midwife scale and migrate onto the enhanced nurse/midwife scale at the next upward point.

For example, if you were due an increment on October 1, 2019 and you are currently on point 5 of the salary scale, you will go to point 6 on the staff nurse/midwife scale and then migrate onto the enhanced nurse/midwife scale.

The application process involves completing the HSE HR form, which is attached at appendix 2 of the circular. The form must be signed by your director of nursing/midwifery and your local HR unit.

Assimilation to the enhanced nurse/midwife salary scale will occur on an individual's increment date and is subject to submission of a completed and signed contract to the local HR department. The contract is the contract that was successfully negotiated by the INMO further to the Labour Court Recommendation. The INMO has prepared a full comparison document of present contracts of employment, to the proposed contract which is available on **www.inmo.ie**.

There has been some misinformation circulating about the probationary period. Please be clear that in section 3.3 of the contract, it clearly states that "where you have already completed a probationary period with the employer or have completed 12 months temporary employment with the employer, no period of probation applied to this contract of employment".

To be clear, assimilation onto the new enhanced nurse/midwife salary scale occurs on everyone's increment date. Assimilation will be to the nearest cost point upwards on the enhanced nurse/midwife salary scale immediately thereafter on that date. Individual increment dates will not change.

Senior staff nurse/midwife

Those eligible for senior staff nurse/midwife status should apply as normal in September and October each year. Eligibility for senior staff nurse/midwife status is now at 17 years, rather than 20 years. Therefore, as a result of the eligibility period being three years shorter, individuals with 20 years, 19 years, 18 years and 17 years service are eligible to apply for the senior staff nurse/midwife this year. Those meeting the qualifying criteria specified in section 1.2 of the contract will be entitled to go on to the senior enhanced nurse/midwife salary scale.

The national circulars have been issued to payroll departments, therefore your local line managers and HR departments should be implementing these. If you require any clarification or need any assistance, do not hesitate to contact the INMO at Tel: 01 664 0600.

Community allowances

Several circulars have issued by the HSE to implement the settlement terms further to the recent INMO strike.

Public health nurses, community RGNs and community RMs currently in receipt of a specialist qualification allowance, should see that allowance increase by 20% to €3,350 per annum. Members should check their payslip to ensure that they have received retrospective payment of this increase back to March 1, 2019.

PHNs not currently in receipt of a specialist qualification allowance are now entitled to a location allowance worth €2,230 retrospective to March 1, 2019.

Alarm at unsafe understaffing at Saolta hospitals

INMO officials have warned that understaffed services must be curtailed for safety reasons in several hospitals in the Saolta University Healthcare Group.

The affected hospitals include Galway, Letterkenny, Mayo, Merlin Park, Portiuncula, Roscommon, and Sligo University Hospitals.

INMO officials met with senior hospital group management to establish which services the group planned to withdraw or curtail due to understaffing. However, no answer was forthcoming.

The INMO warned Saolta management that they should be "gravely concerned" due to the high levels of missed care, delayed care and poor patient outcomes arising from the number of nursing and midwifery vacancies. The union estimates there are more than 200 such vacancies in the Saolta group alone.

Anne Burke, INMO IRO for Galway, Mayo and Roscommon, said: "There are 64 staff nurse vacancies in UH Galway and a further 20 in Mayo UH. Understaffing like this is a recipe for disaster. We provided management with specific examples of missed care and impacts on patients, but services have still not been curtailed to ensure safe staffing."

Maura Hickey, INMO IRO in the North West, said: "Nurses and midwives are struggling daily to deliver safe care in unsafe environments. Other hospitals have closed beds due to unfilled vacancies – it's time for a similar approach in the Saolta group."

Dean Flanagan, IRO in the Midlands, said: "Nurses and midwives in Portiuncula UH are in a critical situation. The hospital is often crammed full, while patients and staff await a new unit to be built. Bed closures in Tullamore hospital will only increase the pressure on Portiuncula."

Recruitment ban at the core of now year-round dangerous overcrowding

MORE than 9,500 admitted patients were forced to wait without a bed in Irish hospitals in August, according INMO trolley/ward watch analysis.

The total figure of 9,562 – of which 48 were children – is the highest ever recorded in the month of August.

The record-breaking total represents a 197% increase on August 2007, a 167% increase on August 2006 – the year INMO trolley records began – but only a 20% increase on August last year, as figures this high are fast becoming the norm.

The daily national trolley figure was also higher every day in August than the same day in 2018, with a 28% higher average daily total.

The hospitals with the highest figures in August were:

- University Hospital Limerick – 1,197 patients
- Cork University Hospital – 1,051 patients
- University Hospital Galway – 655 patients
- South Tipperary General Hospital – 597 patients
- University Hospital Waterford – 561 patients.

INMO general secretary Phil Ní Sheaghdha said: "This is the tragic ongoing reality in Ireland's health service. To see nearly 10,000 patients on trolleys is bad in itself, but this is a summer month. These figures signal an even more dangerous winter, when extra demands are typically placed on hospitals.

"At the core of the problem is staffing, as there are well over 1,300 nursing and midwifery vacancies in Ireland's acute hospitals. This is no time for recruitment bans. Vacancies need to be filled so that patients get the care they need. The HSE's recruitment ban has got to go."

Table 1. INMO trolley and ward watch analysis (August 2006 - 2019)

Hospital	Aug 2006	Aug 2007	Aug 2008	Aug 2009	Aug 2010	Aug 2011	Aug 2012	Aug 2013	Aug 2014	Aug. 2015	Aug 2016	Aug 2017	Aug 2018	Aug 2019
Beaumont Hospital	32	408	713	520	504	596	304	508	490	678	335	265	177	91
Connolly Hospital, Blanchardstown	162	259	255	152	359	354	386	464	271	364	138	187	260	241
Mater Hospital	197	315	487	385	354	333	328	82	285	218	316	436	288	489
Naas General Hospital	206	68	2122	199	292	221	65	40	230	273	95	304	266	331
St Colmcille's Hospital	39	42	48	145	96	126	171	47	n/a	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	75
St Vincent's University Hospital	385	545	271	354	509	587	432	74	191	335	284	134	289	387
Tallaght Hospital	227	399	319	237	457	335	47	357	188	395	121	381	330	390
National Children's Hospital, Tallaght	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	1
Our Lady's Children's Hospital, Crumlin	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	14	10
Temple Street Children's University Hospital	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	11	34
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**	**1,734**	**2,049**
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	78
Cavan General Hospital	216	141	263	177	168	382	142	228	42	84	27	67	13	149
Cork University Hospital	319	189	329	272	453	418	151	261	115	399	473	457	604	1,051
Letterkenny General Hospital	330	59	24	35	36	70	32	7	152	235	128	241	359	409
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	n/a
Mayo University Hospital	131	97	28	64	126	8	109	15	10	105	175	114	118	115
Mercy University Hospital, Cork	90	108	69	38	117	44	137	122	130	98	243	256	183	333
Midland Regional Hospital, Mullingar	16	2	5	5	46	264	109	178	410	149	254	391	304	203
Midland Regional Hospital, Portlaoise	31	8	13	7	9	125	20	100	82	77	287	260	215	114
Midland Regional Hospital, Tullamore	5	2	5	7	71	89	77	22	169	267	290	452	431	244
Mid Western Regional Hospital, Ennis	94	9	17	23	26	20	24	n/a	n/a	5	20	n/a	n/a	20
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	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	40
Our Lady of Lourdes Hospital, Drogheda	301	91	293	289	236	776	604	165	346	680	391	93	192	89
Our Lady's Hospital, Navan	77	34	90	57	50	93	13	36	33	56	35	164	53	106
Portiuncula Hospital	2	10	2	67	62	97	32	45	48	49	40	52	162	129
Roscommon County Hospital	23	9	14	25	106	n/a	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	416
South Tipperary General Hospital	12	82	52	33	4	1	153	166	82	115	470	489	342	597
St Luke's Hospital, Kilkenny	n/a	n/a	n/a	n/a	13	52	55	139	84	255	197	432	365	455
University Hospital Galway	76	123	238	256	232	554	195	146	319	458	400	643	619	655
University Hospital Kerry	94	55	9	9	37	70	81	49	95	108	148	170	300	266
University Hospital Limerick	29	32	85	105	186	342	247	224	458	618	610	835	969	1,197
University Hospital Waterford	n/a	n/a	25	18	64	76	120	180	47	159	291	486	435	561
Wexford General Hospital	293	13	189	344	140	490	44	73	135	70	101	197	220	286
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**	**7,513**
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**	**7,936**	**9,562**
Of which were under 16	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**30**	**48**

Percentage increase/decrease:

2018 compared to 2019: 20%
2017 compared to 2019: 23%
2016 compared to 2019: 56%
2015 compared to 2019: 47%
2014 compared to 2019: 106%
2013 compared to 2019: 144%
2012 compared to 2019: 117%
2011 compared to 2019: 44%
2010 compared to 2019: 94%
2009 compared to 2019: 137%
2008 compared to 2019: 132%
2007 compared to 2019: 197%
2006 compared to 2019: 159%

WRC issues set of proposals for difficulties at St Patrick's, Kilkenny

Problems relate to rostering and stepping back from promotional posts

A NUMBER of issues of dispute in St Patrick's Centre, Kilkenny were jointly referred to the Workplace Relations Commission by the INMO, SIPTU and FORSA trade unions, who represent members at the centre.

Among the long-running issues in dispute are rostering arrangements, 'stepping back/down' from promotional posts, and matters relating to part-time contracts for staff employed since 2017 in the service.

A conciliation conference was held on June 17, 2019 and the WRC issued proposals on August 19, 2019.

Rostering arrangements

These proposals commit management and unions to adhering to the Roster Toolkit which was agreed in the service in 2018, including the consultation process included therein. This is important as members had been reporting that management was not consulting appropriately with them in relation to rosters prior to the WRC hearing.

Liz Curran, INMO IRO:
"The WRC outcome addresses some of the long-running issues in dispute"

It was also proposed that, for staff employed prior to March 2017, management in St Patrick's Centre will draft eight-week 'rolling predictive rosters' which will mean that "the first week of a roster rolls over onto the ninth week of the roster".

In addition, the WRC proposals state that "a combination of 8, 9, 10, 11 and 12 hour shifts can apply to any roster, but each roster should incorporate a reasonable mix of these, subject to a maximum of eight shifts per fortnight. This will apply on a pro-rata basis for those on reduced hours as is the norm."

Post-2017 contracts

Staff employed after March 2017 will also be encompassed by the rolling predictive element of the roster, irrespective of being employed on contracts requiring them to work a maximum of five shifts a week.

In addition, in the event of 39-hour contracts becoming available in the future, staff on post-2017 contracts of 30 hours per week will be given first offer of increasing their existing contracts to 39 hours per week.

Stepping back/down from promotional posts

In relation to 'stepping back/down' from promotional posts in the service, management committed at the WRC to reviewing the role of team leaders in the service "in the context of full de-congregation and stabilisation" of the service.

The unions have insisted that such a review be a joint exercise involving the three unions representing staff in St Patrick's Centre, and focusing on the workload of the team leader posts in the context of the previously agreed team leader job description.

Speaking on the matter, INMO IRO Liz Curran said: "This WRC outcome addresses some of the long-running issues in dispute in St Patrick's Centre, particularly with regards to rostering arrangements and contracted hours for part-time staff.

"A joint general meeting of the INMO, SIPTU and FORSA members was held on September 10 to discuss the proposals with staff in St Patrick's Centre, and a ballot on the proposals will be held in the coming weeks for INMO members working at the centre."

Mater Private pay increase

The INMO sought payment of the 1.75% increase for its members in the Mater Private Hospital from September 1, 2019 in line with the Public Service Pay Agreement (PSSA).

The Organisation has now received confirmation from the hospital that the payment has been approved. It is expected that the increase will be paid to members shortly.

– Albert Murphy, INMO IRO

Rep training for Cork and Kerry activists

A VERY successful Basic Rep Training course was held for INMO activists in Cork and Kerry on September 17-18, 2019.

"Members said the training course was both relevant to them and met their requirements to represent local members and potential members of the Organisation. With enthusiasm they headed back to their workplaces to encourage local activism, and update and share information with colleagues. They look forward to attending more INMO training events," said Mary Power INMO assistant director of industrial relations, who ran the course with colleagues Dave Hughes, deputy general secretary, and Liam Conway, IRO in the region.

WRC hearing on students' reflective practice issue

A DISPUTE over the issue of protected reflective time for student nurses at the Daughters of Charity Services was heard recently at the Workplace Relations Commission.

The matter relates to what is contended is the incorrect and insufficient allocation of protected time of four hours per week for students undertaking internship placements.

Protected reflective is part of an agreement reached under the auspices of the WRC in 2014 and covered by HSE Circular 030-2009. It provides an opportunity for students to reflect on their practice and improve their learning experience.

Among other things it was argued that the inclusion of routine mandatory orientation that is given to any employee does not constitute reflective practice time within the relevant definitions.

David Miskell, INMO IRO for Dublin North East, said that protected time for internship students forms an integral part of the learning experience and it is essential that there is compliance with the spirit of the WRC agreement.

The WRC process has been adjourned to allow for detailed consideration of documentation by both parties and will be reconvened in the coming weeks.

Student Officer Neal Donohue commended the students of the Daughters of Charity for raising this issue through the industrial relations process and reiterated how important it was for students to be aware of their entitlements and to be active in the INMO.

Talks on formation of union/management forum at TUD

ENGAGEMENT on a terms of reference document for a union/management forum at Technological University Dublin (TUD) is ongoing.

The forum will comprise a series of joint meetings and an INMO-specific series of annual meetings. TUD is Ireland's first Technological University. Established in January 2019, it was formed by the amalgamation of three Institutes of Technology in the Dublin area – Dublin Institute of Technology, Institute of Technology Tallaght and Institute of Technology Blanchardstown.

David Miskell, IRO for Dublin North East, noted that this forum process will provide an important voice for INMO members and ensure that issues relevant to the nursing profession in the new university are addressed appropriately.

Tools for Safe Practice workshop

A Tools for Safe Practice workshop was held in St Raphael's Centre, Youghal, Co Cork last month. It was organised by local reps in the region and saw 22 INMO members attend from the East Cork area, including from St Raphael's Centre, Youghal Community Hospital and Cois Abhainn CNU.

News update

- ***Workplace Relation Commission:*** Recently in the Longford area the INMO has been successful in ensuring that a member had her substantive post recognised and returned to same after covering a period of extended maternity leave. This was a good outcome and it was supported and underpinned by the WRC. If you are in a similar position please contact the INMO to progress the issue.
- **St Hilda's, Athlone:** The INMO remains engaged with a number of issues in St Hilda's Services, Athlone and will be meeting management again in early October to discuss the proposal to change sick leave. This is being undertaken with the WRC and local workplace representatives have been present at all engagement to date.
- **Portiuncula University Hospital:** The INMO recently undertook a survey in relation to pay periods in the hospital and is currently collating the answers to formulate a claim regarding pay periods which are predominately paid monthly. We will update members in due course regarding same.
- **New 50-bed unit at Portiuncula:** The INMO has undertaken a lobbying exercise with local politicians in relation to the status of the new 50-bed unit in Portiuncula University Hospital. The Organisation has also met with representatives of the SAOLTA Group on progress of the proposed new unit, which is hoping to begin a rollout shortly.

– Dean Flanagan, INMO IRO

Public servants are the biggest contributors to the state's finances, writes **Dave Hughes,** calling for a fairer distribution of the tax burden

Public servants paying the most tax

DESPITE the publicity given to the growth of corporation tax in 2018, it remained as only third in the contributions to the state tax intake and has never reached the level paid through VAT or income tax.

PAYE workers contribute the highest to the state coffers. Public service workers, although numbering less than 20% of the workforce, paid almost 30% of the combined income tax and USC charges.

Gross Exchequer returns in 2018 amounted to over €77 billion. Income tax made up €23,469,722 of that, while VAT contributed €19,340,210. Corporation tax collected amounted to €11,442,132 which is just under 50% of that contributed by workers and the self-employed through income tax.

Significantly income tax is now consistently the highest tax contributor having toppled VAT from the top spot since the beginning of the recession a decade ago. There is nothing to suggest this will change as a result of the upcoming budget or that the patriot PAYE worker will revolt.

Public service workers pay more taxes than all other sectors. When health and social work activities, education, public administration and defence, and administration and support services are added together, over €5bn of the €17.5bn combined income tax and USC was taken directly from public sector wages. In addition, the public service pension levy yielded a further half billion to the state.

The self-employed paid €2,302bn including Schedule D (unearned) income and USC contributions. The combined PAYE and income tax collected from agriculture, forestry and fishing was €304 million.

PAYE workers are the silent but reliable taxpayer whose contribution is never acknowledged. Perhaps their only vent for paying the high price is support for campaigns against further so called 'stealth taxes', such as property or service charge taxes.

Yet a fairer distribution of the tax burden requires that those who don't pay income tax are required to make their contribution through indirect taxation or taxes related to wealth, property or services delivered.

So next time you hear yet another group claiming to have rescued Ireland from the worst recession ever experienced, remember you have paid more than your share and very likely much more than that paid by the voice you're hearing.

Table 1 shows a breakdown of Revenue's net receipts by sector *(source: Revenue Annual Report 2018)*.

Dave Hughes is deputy general secretary of the INMO

Table 1. Net receipts by sector (€ million) for tax year 2018

Type of tax:	VAT internal[3]	PAYE[1]	Income tax[2]	Corporation tax	Capital gains tax	Overall
A) Agriculture, forestry & fishing	-127.59	98.03	206.22	76.47	82.95	336
B/D/E) Mining & Utilities	336.03	259.89	15.31	149.08	0.77	761
C) Manufacturing	498.55	1,988.28	48.69	3,219.00	3.39	5,758
F) Construction	218.71	748.66	372.16	262.65	19.13	1,621
G) Wholesale & retail trade; repair of motor vehicles & motorcycles	5,613.67	2,095.09	102.75	768.05	31.55	8,611
H) Transportation & Storage	257.20	566.91	49.37	282.99	3.53	1,160
I) Accommodation & food services	661.21	315.58	53.00	118.61	10.72	1,159
J) Information & communication	625.61	1,736.92	22.85	2,094.50	17.73	4,498
K) Financial & insurance activities	381.23	2,255.48	62.69	2,105.40	73.67	4,878
L) Real estate activities	721.87	172.13	398.16	129.47	249.67	1,671
M) Professional, scientific & technical activities	1,868.82	1,698.06	529.44	341.14	94.92	4,532
N) Administrative & support service activities	558.00	880.00	27.33	772.05	5.32	2,243
O) Public administration & defence	342.63	1,609.33	12.16	-0.06	0.77	1,965
P) Education	102.34	1,185.03	19.32	7.35	4.70	1,319
Q) Human health & social work activities	66.09	1,552.54	184.18	-7.34	20.30	1,816
R/S/T/U) Other activities and sectors	211.64	510.07	198.37	67.64	376.88	1,365
All sectors total	**12,336**	**17,672**	**2,302**	**10,387**	**996**	**43,693**

[1] Includes USC and income levy charged on PAYE income; [2] Includes USC and income levy charge on Schedule D income; [3] Includes appropriate VAT MOSS

Focus on: National Care of the Older Person Section annual conference

The INMO National Care of the Older Person Section annual conference was held at the Richmond Education and Event Centre for the first time on September 10.

More than 80 colleagues attended. The entire day – from registration at 8.30am to close of conference and distribution of spot prizes at 4.30pm – ran like clockwork.

Having commenced with an uplifting address from INMO president Martina Harkin-Kelly, the conference heard from speakers on a variety of topics from pain recognition in dementia to the management of patients with challenging behaviours.

Topics were selected by the section officers in conjunction with INMO section development officer Jean Carroll.

Consideration was given to the feedback received from attendees of last year's conference which, along with current trends and developments in the care of the older person field, greatly influenced the final choice for topics.

Prof Laserina O'Connor, professor of clinical nursing at the Health Sciences Centre, UCD, presented on pain recognition in dementia. HIQA social services inspector Liz Foley covered the most recent HIQA guidelines on the use of restrictive practice.

'Management of Behaviours that Challenge' was presented by positive behaviour support manager Brian McDonald and ANP Maurice Healy.

The 'LGBT Champions' programme was covered by Colette O'Regan, training and information co-ordinator with LGBT Ireland. Deirdre Lang, DoN and national lead of older persons services and integrated programmes at the HSE, spoke on nursing's response to an ageing population.

The topic of complementary therapies in older people's services was covered by Niamh Hulm, CNS in complementary therapies.

The conference also featured a presentation on artificial intelligence in older people's services by Candace Lafleur, founder of Mylo, a companion robot designed to help people with dementia to retain their independence.

There were plenty of questions and lively discussions, and many presenters remained for the entire conference, making themselves available to discuss specific work-related issues. Attendees received a certificate and earned Category 1 approval of 6.5 NMBI CEUs.

As always, the trade exhibition stands gave colleagues the opportunity to discuss specific products used primarily in our area of nursing practice.

The facilities at the Richmond and the dedication of its staff ensured the day flowed smoothly. The written evaluation feedback received from attendees was valuable and will inform future conferences.

Section chair Caroline Gourley, vice chair Margot Lydon, education officer Eileen O'Keefe and secretary Noreen Watts would like to thank all members who attended.

– Noreen Watts, section secretary

Pictured at the conference were (l-r): *Brian McDonald, speaker; Noreen watts, secretary; Caroline Gourley, chair; Eileen O'Keeffe, education officer; Martina Harkin-Kelly, president; Margot Lydon, vice chair; Deirdre Lang, speaker; Niamh Hulm, speaker; and Maurice Healy, speaker*

Pictured with Mylo, the companion robot designed to help people with dementia to retain their independence, were (l-r): *Kerry Mullan, relationship manager; Jean Carroll, section development officer; Candace Lafleur, Mylo managing director; and Xiaofei Liu, Mylo project lead*

Upcoming conferences

OHN Section conference

The OHN Section conference will take place on November 21, 2019 at the Richmond Education and Event Centre. There is a stellar lineup of speakers including Dame Carol Black, principal of Newham University in Cambridge, UK.

Dame Black has spoken around the world on topics specific to the improvement of health outcomes in the workplace and we are delighted to be welcoming her to address the OHN Section.

Other interesting topics to be covered at the conference include sleep disorders, empowering neurodiversity, medication and risk. *See page 64* for further details or log on to: **www.inmoprofessional.ie**

All Ireland Midwifery Conference

The All Ireland Midwifery Conference takes place later this month on Thursday, October 17 in Armagh. To book your place visit **www.inmoprofessional.ie** *See page 54* for further details.

Q and A Bulletin Board

With INMO director of industrial relations Tony Fitzpatrick

Query from member

I am a newly qualified staff nurse and have been offered a post in the public health service. I would like to know: what salary should I receive?

Reply

When appointed as a staff nurse you will be placed on the first point of the salary scale for 16 weeks. After 16 weeks, you will be placed on the third point of the salary scale, skipping the second point. One year later, on your next increment date, you will be eligible for the enhanced nurse/midwife salary scale at the first point (as at September 1, 2019).

- 16 weeks – €29,860
- Third point of scale – €32,734
- One year later, first point of enhanced salary scale – €36,433.

Query from member

I am a staff nurse working in the private sector. I have a 10-year-old child but have exhausted my 18 weeks of parental leave. I have been made aware of changes to the parental leave legislation. How will these changes affect me?

Reply

Due to amendments made in the Parental Leave Act 2019, parental leave has been extended from 18 weeks to 26 weeks.

Therefore, anyone who has already availed of the 18 weeks of parental leave can apply for a further eight weeks of parental leave.

This additional leave will be on a phased basis, so as of September 1, 2019 onwards you can avail of a further four weeks and from September 2020 you can avail of the remaining four weeks.

Also, the age of a child has been increased from eight to 12 years of age, so you are eligible to apply for this leave as your child is 10 years of age.

Packaged with care

Freda Hughes talks to Maeve Kinsella, co-founder of Squirrel Bag, a company aiming to alleviate the fear and anxiety that often accompany a hospital stay

"I WOULD love to see this become part of every patient's journey. Nurses are so good at engaging with patients, seeing their holistic needs, and asking: 'what can we do to make a difference?' That is what I hope Squirrel Bag does."

Maeve Kinsella is a coronary care nurse and CNM at St Michael's Hospital, Dun Laoghaire. She is the eldest girl in a family of 10 and says nursing is in her blood, stretching back four generations. She and her brother founded Squirrel Bag in response to the hospital overcrowding crisis, which leaves patients stranded on trolleys in emergency departments and hospitals nationwide.

Squirrel Bag makes small pouches of hygiene and comfort essentials designed to ease a patient's hospital stay.

"I thought about doing something that helped patients at the forefront. There is so much fear when a patient and their family arrive in hospital, so much vulnerability. Fear about what will happen along with the challenges that present with illness. I thought about what I could tangibly do to make the patient's journey easier."

Ms Kinsella's brother Maurice is a lecturer and researcher at UCD. He came on board with the initiative and conducted extensive research to establish what had worked in other countries. They decided that, first and foremost these pouches needed to help with the specific daily needs associated with patient care and, in turn, help nurses to make a real difference and meet all of the *ad hoc* needs of ED patients. They decided the pouches also needed to align with the HSE's vision of the patient's journey.

Inside the pouch

The pouch contains a toothbrush and toothpaste, refreshing wipes, an eye mask and earplugs. The pouch also contains anti-slip socks that the company designed, which are anti-slip on both sides, comfortable and not overly warm. The pouch itself is reusable and doesn't take up too much space. Patients often use it to store their glasses, tablets and other personal belongings for safe keeping.

When Ms Kinsella's father was on a trolley in ED, all he wanted to do was sleep, so this inspired them to create a simple and effective pack that would ease the fear and anxiety patients feel when they are admitted to hospital.

"We focused on the environmental aspects, hygiene and safety. We're conscious of the sensory needs of patients. The noise and light in hospitals can be very unnerving for patients. Sleep is fundamental to good health."

While it is essentially a care pack, it is not branded as such. Ms Kinsella's mother came up with the name, which invokes images of squirrels bringing necessities together to help them through challenging times.

Expanding

Squirrel Bag's pouches are currently available free to patients in 13 hospitals across the country. In some hospitals they are available on a trial basis but in others it is a well established initiative. The company is also in discussions with a further five hospitals.

In EDs and general wards at participating hospitals, nurses hand out pouches to patients who are likely to be on a trolley overnight, but they are also used in ICUs to help patients sleep. Nurses at Children's Health Ireland (CHI) at Crumlin have also started giving the packs to families of young patients who are staying overnight at the children's hospital.

Recently, a palliative care nurse was in touch with Squirrel Bag with a view to providing the pouches for family members of patients in palliative care.

A few years ago, the ED registrar at St Vincent's University Hospital contacted Squirrel Bag and took on a pilot study using their product. That project won two Irish Healthcare Awards.

"For us the project's win was validation

that patients and nurses saw a real value in our product as a tangible means of trying to address the safety, comfort and sensory needs of patients. Nurses across the country love the simplicity and comfort of the product. Is it the same as a bed? No. Does it make a difference? Yes. It is something tangible to try to address the environmental, safety and comfort needs of patients," she said.

Ms Kinsella would love to see Squirrel Bags in every hospital in the country and has ideas for other products that could make a difference. Squirrel Bag now provides smaller pouches of sleep essentials with eye masks and earplugs. The company has also just entered the world of retail, based on feedback from patients and families who want to be prepared for a hospital stay. A number of pharmacies have begun to stock Squirrel Bag products commercially, while both public and private hospitals continue to provide them to patients free.

"I am eternally grateful to the nurses who have used Squirrel Bags as an initiative in hospital departments across the country. I don't underestimate the work involved," she said.

Nursing at the forefront

The progress has been gradual but steady, and Ms Kinsella and her team see Squirrel Bag as a simple and effective way of helping to give people back their autonomy and dignity during their stay in hospital or on a trolley.

"I think nursing is an extraordinarily privileged occupation to have. It is also a difficult profession with a lot of challenges and expectations. In some ways it is a really exciting time to be in nursing. The more you learn the more you realise how much you don't know, but the fundamentals don't change," she added.

Ms Kinsella feels that navigating the journey of bringing ideas to fruition or getting initiatives started within the health service can be challenging. She would like to see nurses and midwives encouraged and facilitated to bring their ideas to the table.

"Nurses are at the forefront of the healthcare system and it is important that we continue to have a voice and be given support when we present solutions to enhancing patients' experience in hospitals. It is important for nurses to have a voice when it comes to improving the health service and patients' experience."

For more information, email: hello@squirrelbag.ie or visit: **www.squirrelbag.ie**

> *"Nurses are at the forefront – we are the nucleus of the healthcare system and should be given more back-up and support when we present ideas that are going to improve patient care"*

Setting the agenda

Pamela Hussey and Sharon Farrell summarise the recent research activities of the Center for eIntegrated Care

THE research activity of the International Classification for Nursing Practice Research and Development Center DCU has evolved over the past three years into an interdisciplinary research centre called the Center for eIntegrated Care (CeIC). The mission of CeIC is to advance eIntegrated care in order to improve the health and wellbeing of citizens. A number of awards are in progress and additional research proposals, summarised in the *Table,* have been submitted.

Following the completion of strategic planning for the centre in 2018, we are now focusing our attention on two key areas. Firstly, on building structures to support eHealth Ireland and secondly, on increasing capacity and building on our core mission. We are focusing on developing infrastructure to support integrated care services in accordance with national policy, ie. the Sláintecare Implementation Plan.

We believe that for new organisational forms to advance, structure is required. No planned strategy can be implemented without the correct structure and the wrong structure will deliver the wrong strategy. Underpinning our structures is a health informatics, state-of-the-art evidence base. Moving away from old-school centralised structures where projects are micromanaged, we are embracing Open Innovation 2.0 in line with EU policy to assist practitioners in building capacity on informatics competencies and leadership skills.

These activities are focused on autonomous decision-making and critical thinking with clearly defined goals and timelines. Given the global trend on chronic disease and the skill mix, resource and retention issues facing health and social care, we believe this is the most pragmatic way to approach the challenges facing nursing and midwifery now and in the future.

National agendas

In early 2019, our chief informatics nursing officer, Loretto Grogan established a National Advisory Group. ICNP R&D, while not participating in this group, understands members are engaged in the development of a strategic plan for nursing and midwifery in Ireland. We hope that the standardisation of nursing language will form part of the focus for this group and we look forward to assimilating reports as they emerge. The national advisory group is coordinating with the Snomed CT National Release Centre of Ireland.

Table: Summary of ICNP R&D and CeIC activities

Activity	Deliverables
Chair of ICNP task force with members of ICNP community	Report to ICN, June 2019
Application for two Fulbright scholarships to explore IoT and its application in community services with nursing services on chronic disease management	Two Fulbright Scholarships awarded commencing in September 2019 – June 2020
Enterprise Ireland research funding	Three proposals funded
ICNP Milan meeting presentation on applied informatics research work funded through national eHealth Ireland Interoperability Platform	Presentation and network meeting in Milan, December 2018
Application for EU funding to coordinate large scale pilot of personalised and outcome-based integrated care services in four EU member states	Application for €4.9 million submitted in April 2019 with 12 EU partners, including EFN as a major partner for dissemination
Two publications submitted on research activity relating to terminology and modelling services to eHealth Ireland	Submitted in May 2019
Scholarship groups	Currently a number of scholarship groups in progress with proposals in draft: • Standardisation of nursing language for EHR • Intellectual disability services working group • International collaboration with ICNP agendas • Computer science heterogeneity and interoperability semantic ontology research cluster • Two undergraduate summer internships
Post-doctoral researcher	One
PhD by research current	Two
PhD by research new 2019-2020	Two

Education

We are progressing with activity relating to knowledge transfer and capacity building. Such initiatives provide the cultural glue required to instigate the eHealth transformation. CeIC continues to educate at undergraduate and postgraduate level on health informatics competencies. At postgraduate level, these modules are interdisciplinary focused and assignments relate to practice-based initiatives. We also provide training to industry, clinical and policy analysts. We have three PhD students active in the centre and additional applications for next year are in progress.

The purpose of our research is to create resources capable of evolving with contemporary health and social care needs and provide services that support sustainability. National leaders are implementing policy to re-orient the models of care; we advocate that nursing and allied healthcare professions have a critical role in participating in the design process, particularly in regard to clinical utility and patient safety. The overarching agenda for CeIC is to produce resources for the delivery of United Nations Sustainable Development Goal 3 – ensure healthy lives and promote wellbeing for all at all ages.

For further information contact sharon.farrell@dcu.ie – a recently published online open access paper about the center's activities can be accessed at **www.mdpi.com**

Pamela Hussey is the director of the Center for eIntegrated Care and Sharon Farrell is the project co-ordinator

Spotlight on: Shirley Ingram

SHIRLEY INGRAM is an advanced nurse practitioner (ANP) in cardiology working in Tallaght University Hospital. Her primary focus is assessment of patients who come to the emergency department with chest pain. It is her role to rule out acute coronary syndrome or heart attack. After these have been ruled out, she then assesses the patient for angina or other cardiac complaints. Her aim is to discharge the stable patient to a nurse-led chest pain clinic for further investigations.

Ms Ingram runs the chest pain service in Tallaght University Hospital with two clinical nurse specialists and another ANP. As an autonomous practitioner, many of her patients will not need to see a doctor, however she practises as part of a multidisciplinary team, for case management if needed. The team includes both cardiology and emergency doctors and nurses. She knows she can always rely on them for clinical support. A key part of her role is taking a comprehensive health history and advanced physical assessment, which included cardiac auscultation. These advanced skills assist her is forming a diagnosis.

Ms Ingram and her team started the chest pain service in 2012 and within the first two years they had reduced admissions due to chest pain to the hospital by 36%.

"Evidence shows that a nurse-led service can really have a powerful impact, not only on the patient's journey through the hospital, but also on bed capacity and admissions to the hospital."

Ms Ingram admits that at 17 she had little choice but to go into nursing as university was not an option for everyone at the time. Her mother really helped her to decide what she wanted to do with her life and played an instrumental role in steering her along the path to nursing. Her ultimate motivation, however, was to care for people, and this has stayed with her throughout her career.

She feels the caring role is vital for nurses, although there is a perception that the nursing/caring part of the advanced role is diminished. Ms Ingram however believes that the caring component is at the core of role.

Shirley Ingram: *"Nurses should always be ready because you never know when the circumstances could change"*

"You bring that with you all the way through nursing even as you advance your skills and role. Caring for the patient is the ultimate reason why I'm still in nursing."

Caring is a major part of all health professionals' work and healthcare is changing rapidly. There are more interdisciplinary teams now than ever before and this model of integrated care works well. However Ms Ingram would like to see clinical nurses play a greater role at national level on boards, steering committees and national review groups.

"As nurses we're so busy clinically that we don't think of the potential for us to play a greater role at a more strategic level. At present there is a national strategy reviewing the whole of cardiology services in Ireland and there is currently no clinical nurse on the working group. I would like to see this change. In cardiology we have many nurse-led services such as heart failure, arrhythmia, heart surgery, chest pain assessment, cardiac rehab, the cath lab, and yet it is very difficult for nurses to have a voice at that national level. Nurses bring ground up experience that can influence national service provision."

Ms Ingram has always been part of a nursing union. In the 1990s she and her colleague went to the Labour Court with the support of the INMO to fight for their right to practise and be recognised as clinical nurse specialists. Now as an ANP, as she practises autonomously, it is important for her to know that she is supported by her union. She feels that while the INMO provides a collective voice for nurses and midwives, it is not just for crisis times but also for the educational opportunities and the networks it provides.

The collective voice, however, is extremely useful and Ms Ingram believes clinical nurses have the solution to many of the health service's problems but often don't have a voice.

"Nurses should always be ready because you never know when the circumstances could change, for example Sláintecare, and your voice may be heard. If you see somewhere you can make a difference for patients, don't give up on it. I would like to see nurses play a greater role in strategy and planning. It can be very difficult so my advice after 34 years of experience would be to use your nursing networks, use your national associations, use your union and make your voices heard."

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

Leadership challenge

Rosemarie Sheehan describes her journey through one of the HSE's programmes designed to develop leadership in the health service

IN THE summer of 2017, I opened an email at work from my manager with a link to a new development from the HSE, the Leadership Academy, whose stated aim was to develop leaders across the health service to lead transformational change. Two leadership programmes were open to applicants; Leading Care 1, an executive leadership programme and Leading Care 2, a master's in leadership. As I had previous experience with the Irish Management Institute and an MSc in nursing, I decided to apply for Leading Care 1.

Up to this point I had enjoyed a varied career and had extensive clinical experience in the acute children's services and the private sector. At times I had felt emotionally burned out in nursing and felt I needed new energy and time for contemplation to help me decide the right path for my future, which led me to consider applying for Leading Care 1.

Leadership

To me, leadership appeared to be an ideal that could be learned through academia. I did not foresee the fundamental change in my thinking that was about to occur. Leadership starts first within, who you are, your behaviours and attitudes, your impact on others and knowledge and skills can be learned to enhance your leadership abilities.

This programme is structured to continually challenge you in ways that, at times, can feel unnerving. However, this uncertainty enables you to challenge yourself to reflect, grow and develop leadership attitudes, skills and behaviours. The patient is at the heart of this programme and learning aims to ensure patients receive high-quality care by engaged and compassionate staff at every level and in every service. The patient contribution to the programme was a very humbling experience.

Programme

On the first day of the programme I noticed a large poster with a set of leadership behaviours/outcomes that were highlighted to us as the programme learning outcomes. At the time they appeared abstract but I now reference these in my day-to-day work and they have become a real part of my working life and how I work.

The programme content was divided into three thematic modules delivered online and in face-to-face residentials. The first module 'Knowing yourself and others' was interesting and raised many challenging questions for me about myself, my behaviours and my response to others, as well as an understanding of the response and behaviours of others. A reflective lifeline exercise helped confirm the values that motivate and increased my awareness of the necessity to become reflective in my own journey otherwise I would not develop leadership attitudes, skills and behaviours.

The 'Broadening Horizons' module provided insight and knowledge to help me understand the complexity of the health system and the many difficult challenges in healthcare. A key message was the necessity to use a 'wide angle lens' to anticipate the implications of a rapidly changing landscape in healthcare as opposed to understanding the complexity of the past and the current climate in order to predict the future.

Another key message was the need for collective leadership across the service, where everyone takes responsibility for the success of the organisation and systems they work in, focusing on learning and improving quality of care delivered. This implies leadership is the responsibility of the teams and not individuals alone and is needed across all levels of the service.

Prior to this programme I had not understood my role in terms of the importance of contributing to public value for its investment in health and improving the health outcomes for the greater good of the population I serve.

The third module 'Making the case for change' provided me with knowledge on the impact of politics, unspoken agendas, the media and the many other barriers to implementing small- and large-scale transformational change. It also provided new approaches and tools to overcome these challenging barriers. I had never considered networks relevant for nursing but now see their importance as a forum for support, growth and learning. They enable nurses and midwives to influence at a higher level and to build alliances and collaborations.

Personal growth

In the early days of the programme, feeling like an imposter, I wondered whether I should be there. I was challenged to re-evaluate my mind-set and some prejudices that had naturally evolved with years of experience. This personal challenge enabled me to realise that a growth mindset is important in order to widen the spectrum of the possible, to embrace the potential of what can sometimes feel impossible.

Nursing and midwifery represent a large body of professionals within the health service, we have incredible potential that can be released through creative thinking.

The most important message came from something called the learning set. These are teams of fellow participants who you work with on assessing your written work and progress throughout the programme. This

group became my most important support and source of personal growth during the programme. The formation of this group is one of the many challenging surprises that occur throughout the year. No spoilers will be given on this except to say go with it.

The learning set experience provided me with a unique opportunity to experience and examine many of the challenges that senior leaders face: impact of leadership style on others, presenting ideas, holding one's self and others to account and giving and receiving feedback.

Being afforded the opportunity to read, reflect, critique and challenge the personal leadership journey of others taught me so much about leadership. Initially, I felt intimidated by the vast experience and seniority of the members of my learning set. However, I quickly realised that in order to progress I had to step up to the challenge of this programme. I saw the benefit of the learning set as a safe place to learn about feedback, challenges, respect for colleagues with different roles and experiences to me, working together and understanding the many different parts and challenges in the health services.

This programme placed a lot of emphasis on leadership behaviours and challenged us to look inwards first. Understanding why I behave in certain ways has enabled me look to change certain behaviours. I realised to be a fit leader that I needed to be able to mitigate against burnout, be resilient and have an open mind-set. To this end, I started to practise mindfulness. This is a skill that is necessary to ensure laser focus when navigating complexity and high stress situations, something nurses and midwives encounter daily.

I also focused on my physical wellbeing as physical wellness is an important foundation of emotional self-control and resilience. What I have found most empowering is that as my confidence grew during the programme, I was more willing to accept and admit that I can make mistakes and I am not threatened by others knowing this. I can also use mistakes to learn. True confidence is about humility in finding out what is right rather than being right.

This course runs over a year and requires full attendance at the residentials and the learning set meetings, which cover a total of 17 days. The amount of work required is approximately 10 hours a week depending on your level of engagement with the programme as you design your own learning contract.

I see this was an investment in me and my future role in the health services and I feel privileged to have had this opportunity to learn and develop leadership skills, attitudes and behaviours. Taking part in Leading Care 1 has been one of the most transforming journeys of my life and I highly recommend the programme to anyone looking to develop as a leader within the health services.

Further information

The Health Services Leadership Academy offers three leadership courses including Leading Care 1 (executive leadership), Leading Care 2 (masters) and Leading Care 3 (diploma in management) which nurses/midwives can access. For further information contact the Health Services Leadership Academy E: leadershipacademy@hse.ie. Leadership courses for nurses/midwives are also available via the National Clinical Leadership Centre in the Office of the Nursing and Midwifery Director.

Rosemarie Sheehan is a project officer for Children's Health Ireland/HSE

Professional DEVELOPMENT CENTRE

RCM i-learn

THE ROYAL COLLEGE OF MIDWIVES

Tuberculosis in pregnancy

TB in pregnancy is rare in western Europe but as certain patient groups remain vulnerable to it, midwives should recognise the signs

Tuberculosis (TB) continues to be a major health concern around the world. Pregnant women face higher risks of developing TB than the general population because of changes in the immune system during pregnancy, mainly due to T-cell suppression and reduced interferon-gamma production. While TB is slowly decreasing in eastern Europe, certain groups (such as those from countries with high rates of TB) remain vulnerable and require better access to prevention measures.

This module has been developed to support midwives and their teams in the important role they play in preventing TB. The information is particularly relevant to anyone who is working in an area where there are above average rates of TB. This will usually be in an urban area but TB can occur anywhere with anyone.

Learning outcomes

On completion of this i-learn module (Study time: 40 minutes) you will:

- Be aware of the risks to mother and baby associated with TB in pregnancy and childbirth
- Understand your role in the prevention of TB
- Understand key clinical aspects of TB and LTBI relevant to your practice
- Be able to identify someone at risk and take appropriate action to prevent TB
- Be able to recommend LTBI testing to eligible women, organise the test and give them their results
- Recognise someone who may be suffering with active TB and ensure the appropriate referral is made.

Why are midwives and support workers so important?

Midwives and support workers are important in identifying TB as they are the most likely point of contact that women of childbearing age have with health services. As such there are a variety of things midwives can integrate into their routine antenatal care. These will be covered in detail as this module progresses.

TB is a worrying and often stigmatising disease and midwives and support workers are best placed to offer reassurance to women in their care. Antenatal care is an excellent opportunity for TB screening. This is especially true for women who have limited access to health services such as migrants, who may only approach medical services when pregnant.

Think TB! Delay in starting treatment can lead to complications for mother and baby

TB in pregnancy

Active TB in pregnancy can result in an increased risk of maternal morbidity, such as anaemia and potentially impacts on foetal health including preterm birth, low birth weight, foetal distress and perinatal death. Outcomes appear to be worse when antituberculous treatment (ATT) is started late. In other words pregnant women with active TB have better outcomes when treatment is initiated in the first trimester in comparison to second and third trimester.

Diagnosis of TB is more difficult as symptoms might be masked by pregnancy. Weight loss may go unnoticed as it can be offset by pregnancy weight gain. Delayed foetal growth and a woman with a poor appetite may be suggestive of active TB.

TB is also often identified in groups who may experience other challenges during pregnancy due to, for example:

- Poor access to healthcare
- Poor nutrition
- Poverty
- Late presentation, such as either late booking for midwifery services or delayed recognition of symptoms
- HIV (HIV/TB co-infection greatly increases the risk of maternal and foetal morbidity and mortality).

Very rarely a woman with miliary (widespread) TB may give birth to a baby with congenital TB. Hopefully, the woman would already be on treatment and the baby would be started on treatment immediately after birth. If the woman's condition is not known and she is not on treatment the prognosis would be very poor for both the woman and the baby. Miliary TB is a very serious condition which affects the whole body and symptoms usually include cough, fever, night sweats and weight loss.

Course content includes

- Why are midwives and support workers so important
- What is tuberculosis?
- TB worldwide and in the UK
- The risks
- Treatment of active TB
- Prevention of TB in families along the antenatal care pathway
- What you can do
- Integrating TB care and prevention into an antenatal care pathway.

RCM i-learn access for INMO midwife members

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

www.inmoprofessional.ie/RCMAccess

Know your worth

Student and new graduate officer, **Neal Donohue**, delivers important information for 2019 nursing and midwifery graduates regarding pay

FOR those of you who are graduating in 2019 it is essential to be aware of how much you should be paid and how your increments are applied. The increases in pay and expansion of allowances – as won by your colleagues and union following the strike – are being implemented by the HSE.

This article sets out how these changes should be implemented and how much you can expect to receive in payment in comparison to previous years.

Pay scales and increments explained

When you qualify you will be placed on the pre-registration, post-qualification rate of pay, as set out in the HSE Consolidated Pay Scales of September 2019, amounting to €25,538 per annum.

It usually takes the NMBI up to eight weeks to process your application for registration. Once you receive your registration PIN you must forward this to your HR department. When you are registered you will be placed on to the staff nurse/midwife salary scale on point one of the scale – €29,860.

You receive incremental credit for your 36 week internship. The time you spend working as a pre-registered nurse also counts for incremental credit. Therefore, 16 weeks after you commence employment post-qualification you will have the equivalent of one year incremental credit.

As per the strike settlement, 16 weeks after you start work you will skip the second point of the pay scale and move to the third point of the scale, ie. move from €29,860 to €32,734 *(see Table)*.

One year later you will again receive incremental credit for your service. As per the settlement you will move to point four of the staff nurse/midwife scales and be eligible to apply for the enhanced nurse/midwife contract. When you move to the enhanced practice contract (one year and 16 weeks after you qualify) you will commence on point one of the enhanced practice scale at €36,433.

Table: Comparison between new salary scale and previous salary scale for 2019 graduates*

Timeframe	Previous salary progression	New enhanced salary scale	Difference to previous salary progression	Accumulation of increases
Pre-registration	€25,538	€25,538	n/a	
Registered nurse/midwife first point	€29,860	€29,860	n/a	
+ 16 weeks	€31,654	€32,734	+ €1,080	€1,080
+ 1 year	€32,734	€36,433	+ €3,699	€4,779
+ 2 years	€33,951	€38,728	+ €4,777	€9,556
+ 3 years	€35,487	€39,952	+ €4,465	€14,021
+ 4 years	€37,019	€40,895	+ €3,876	€17,897
+ 5 years	€38,546	€41,933	+ €3,387	€21,284
+ 6 years	€39,866	€43,315	+€3,449	€24,733
+ 7 years	€41,189	€44,661	+ €3,472	€28,205
+ 8 years	€42,506	€46,643	+ €4,137	€32,342
+ 9 years	€43,824	€46,643	+ €2,819	€35,161
+ 10 years	€45,119	€46,643	+ €1,524	€36,685

** The table above shows the projected pay increases for 2019 graduates on their basic earnings over a 10-year timeframe, taking account of the changes to the incremental scales. These figures do not include the allowances. Please note the nurse/midwife salary scale figures will change in line with Public Service Pay, eg. increase of 2% in 2020. You will continue to receive a higher rate of pay throughout your career under the new system*

Therefore, one year and 16 weeks after you qualify you will already be earning €3,699 more in your basic pay than nurses and midwives in the same position did in previous years.

RNID graduates working in intellectual disabilities services alongside or supervising social care workers will be regraded to CNM1. Staff nurses and midwives reach the senior staff nurse level after 17 years, instead of the previous requirement of 20 years' service. This will be applied from November.

Allowances are not just for staff nurses and midwives – they also apply to eligible PHNs and CNM/CMM1s and 2s.

The salary scales of all promotional grades will be reviewed by May 2020 to deal with the impact of the increased pay on the staff nurse/midwife scale.

Increases to and extension of allowances

The settlement also specified that the nursing/midwifery location allowance would be increased by 20% (from €1,858 to €2,230 per annum) and it would be extended to medical and surgical wards and midwifery. If you work in an area that qualifies for the allowances, you will receive an additional €2,230 on top of the increases in the incremental scales.

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

Quality & Safety

A column by Maureen Flynn

A clinical information system built for nurses by nurses

THIS month's column shares the story of how nurses are using technology to lead quality care while integrating systems. Older person services (OPS) in Donegal have been using electronic nursing records since 1999. Over time there has been a need to evolve and progress in response to evidence-informed practices and legislation. In response, CareNotes, a clinical information system, has been adopted across 11 community hospitals in Donegal.

CareNotes

CareNotes is an electronic solution, from IT service company Advanced, that comes with an 'assisted build'. It has core care forms pre-set for people's details (admissions and discharges) with the ability to design, personalise and link all later care forms. In Donegal this integrates information from (i) single assessment tool (SAT), (ii) comprehensive geriatric assessment (CGA), (iii) nursing care processes encompassing all transactions associated with care, (iv) HIQA Standards, and (v) quality care-metrics data collection. The clinical system is used to track care delivery and reduce the burden of measurement.

Leading the change

The development is led and supported by practice development, directors of nursing, specialist link nurses and front-line staff. Input was also sought from health and social care professionals at local and national level. The system was introduced, over nine months, with the help of the HSE Office of the Chief Information Clinical Officer (OoCIO). Technical, infrastructural and change management issues have been addressed and the system is cloud based in line with the OoCIO's cloud first policy.

All staff are also setup with a HSE Outlook Webmail account giving each individual an electronic footprint. As system is cloud based with a UK vendor, a VPN link was setup between the HSE and Advanced. All GDPR points have been addressed and the system is now used by 387 nurses caring for 375 people. Staff also train as system administrators and report writers.

Enabling implementation

Phase One of this project (development and implementation of replacement system) will be complete by end 2019. Feedback from the staff has been largely positive and staff are kept informed of updates through a monthly newsletter.

Staff engagement was key in order to plan for support and protected time, with the initial release for training and subsequent data input. Support is provided via an internal support team.

Opinions and suggestions are being actively sought for inclusion in Phase Two. Central to implementation phase has been the enthusiasm and willingness of staff to develop and implement a system to improve overall quality of patient care delivery and audit.

Phase Two will look to streamline processes and documentation further, aspiring to a paper-light nursing record. It is also intended to expand to other health professionals, eg. GPs, and integration of other information systems where possible.

Finally, the expansion of access to the system to other locations with CHO1, which covers Donegal, Sligo, Leitrim and West Cavan.

Opportunity to learn more

At your next team, unit or department meeting you might talk about plans for electronic patient records in your area and if information systems that you use might be incorporated. You can find out more above the developments in Donegal by contacting the nursing project lead AnnMarie Noone, email to: AnnMarie.Noone@hse.ie or carenotes.support@hse.ie, and OoCIO senior project manager: Lorraine Gilmartin at email: Lorraine.gilmartin@hse.ie

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

Acknowledgement: Particular thanks to Maura Gillen, nurse practice development officer, Older Person Services, Donegal, and Michelle O'Hara-Donnelly, QCM project officer, NMPDU North West, for collaboration in preparing this column

Benefits of the CareNotes clinical information system

- Continuity of care: each person has one electronic patient record that can be accessed between locations – eg. sharing of clinical information between community hospitals and day care centres
- Comprehensive care: responses to screening questions within the care needs assessment tool prompt nurses when developing care plans
- Consistency: workflow can direct nurses through a preferred care model to reflect agreed practices/policies
- Adaptability: electronic forms can be configured internally in OPS when necessary to meet the needs of various models of nursing or updates from practice development
- Visibility: improved workflow management with use of an interactive dashboard (currently in development phase)
- Accuracy: legibility and quality of updated information, eg. improving processes of CSARS applications/ QCM metrics data collection
- Traceability: all forms that are editable have audit history
- Efficiency: bespoke reporting aims to reduce significantly the time spent on manual reports by staff, with many able to auto populate details from set fields on the system
- Assurance: ability to ensure that all mandatory documentation supporting the nursing process is updated
- Quality improvement: early indications using QCM data collections suggest there is an improvement in person centred care plans with this system

advanced Carenotes

Family first

A lack of an agreed definition and clear understanding of family-centred care is a major barrier to its consistent and effective implementation, write **Siobhan O'Connor, Maria Brenner** and **Imelda Coyne**

THE WAY in which children's healthcare is delivered has changed dramatically over the past 60 years. Currently, many hospital-based services for children in Dublin are accommodated in facilities that are not fit for purpose. Consequently, children's healthcare in Ireland is undergoing a major reconfiguration with the development of a new children's hospital to replace the existing three children's hospitals in the city.

The plan for acute children's health services is outlined in the National Model of Care for Paediatric Healthcare Services in Ireland.[1] This publication describes how acute paediatric healthcare services are best provided within a national context, aiming to deliver acute paediatric health services as close to home as possible and with all specialised and national services consolidated centrally at the new children's hospital. Regional and local units will receive clinical support from colleagues in the new hospital. This reconfiguration is in line with international best practice and is supported by national and international health policy reports.

Evidence-based models of nursing care guide critical thinking and decision-making for professional practice.[2] Such frameworks support nurses in the assessment, planning, implementation and evaluation of care and the delivery of consistent, high quality patient care.[3]

The Roper-Logan-Tierney model[4] and a modified version of the Nottingham model[5] were introduced in Dublin children's hospitals during the 1990s. Evidence-based nursing care plans, which include the parents/guardians in the care of their sick child while in hospital, were developed to support the nursing models of care. These care plans continue to be in use today and are subject to ongoing audit, regular review and update to incorporate emerging evidence.

Table 1: Key attributes of family-centred care and their contributing attributes

Key attributes	Contributing attributes
Parental participation in care	• Parental participation in care • Parental involvement in care • Care-by-parent
Development of respectful and trusting partnerships	• A partnership formation with the child, family and the nursing team • The development of respectful and trusting relationships • Mutually agreed goals and a shared responsibility for the child's care
Information sharing	• Communication and negotiation • Patient and family empowerment
All family members as care recipients	• Recovery process for the child and the family starts with caring for the family

Background to family-centred care

Children's nursing has been described as a partnership, where the process of nursing is carried out in partnership with the child and family.[6] This partnership approach to children's nursing is recognised as a precursor to family-centred care as we know it today.[7] Although the term is widely used in children's healthcare, there is no internationally accepted definition. It is described as "a way of caring for children and their families within health services which ensures that care is planned around the whole family, not just the individual child/young person, and in which all the family members are recognised as care recipients".[8] The core concepts of patient- and family-centred care have been described as dignity and respect, information sharing, participation and collaboration.[9]

This definition is not child or healthcare setting specific, it applies to patients of all ages in any setting. Family-centred care has evolved in an unstructured and unco-ordinated fashion without any formal theory or process of evaluation. This lack of an agreed definition and a clear understanding of family-centred care has been cited as the main challenge to its consistent and effective implementation.[10,11] It is now timely to evaluate the appropriateness of family-centred care as a model of nursing care within which to deliver children's nursing in the 21st century in Ireland.

Concept analysis of family-centred care

Concept analysis is widely acknowledged as a form of inquiry to develop the knowledge base of nursing and provide clarification of the concept being analysed.[12] Family-centred care for hospitalised children/young people was critically analysed to identify related concepts, surrogate terms, attributes, antecedents and consequences for the child, the child's parents/guardians and children's nurses.

Surrogate terms – words or phrases which are often used to describe family centred care – included partnership-in-care, negotiated care and parent participation. Related concepts – a concept that bears some relationship to family-centred care – were identified as person-centred care, patient- and family-centred care and patient-centred care. The key attributes identified, and associated attributes are listed in *Table 1*.

A number of antecedents that must be in place in order for family-centred care to occur were identified. These antecedents largely refer to the understanding of and attitudes of nurses and parents towards family-centred care *(see Table 2)*.

The concept analysis revealed that there is some evidence that family-centred care enhances the hospital experience for both the child and parents as well as improving their wellbeing.[13] A lack of attention to cultural and societal changes, which impacts not only on those receiving care but also on those delivering care, was also highlighted. Developments in the delivery of acute hospital care have resulted in shorter length of stay, increased patient throughput and, consequently, increased patient acuity. These factors reduce opportunities for the development of trusting relationships between families and nurses and pose challenges to the effective and consistent implementation of family-centred care in practice.

Table 2: Antecedents of family-centred care and related attributes

Antecedent	Related family-centred care attributes
Parents at the bedside	• Parental participation in care
Parent's willingness to perform some aspects of their child's care	• Parental participation in care
Staff willing to collaborate respectfully with parents and families	• Respectful and trusting partnerships
Open, honest, respectful communication and negotiation	• Information sharing • Respectful and trusting partnerships
Adequate time for communication	• Information sharing
Flexible visiting arrangements	• Parental participation in care • Family members as care recipients
Facilities for parents to be resident	• Parental participation in care

Literature review

A literature review of primary research papers was also carried out. Reviewing the literature in qualitative research helps to position the proposed study within ongoing discussions and provides evidence to support the argument that the problem exists.[14] Five key themes were identified from the literature review:

- The importance of parental presence with their hospitalised child in the context of providing comfort, emotional support and reassurance for the child
- Parental willingness to participate in care of their sick child in hospital
- The value of forming a partnership relationship with members of the healthcare team
- Family needs, including emotional, informational and physical needs
- The challenges and barriers experienced when attempting to effectively implement family-centred care in practice.

A review of the literature confirmed that the fundamental principles of family-centred care, as identified in the concept analysis, are key concerns of parents when their child is in hospital. There is evidence that children's nurses have been applying some elements of family-centred care to their clinical practice for decades. However the concept continues to evolve, as does the context within which health services, including nursing, are organised and delivered. It is evident from this review that parents wish to participate actively in the care of their child in hospital; the degree to which they wish to do so, however, varies and needs to be negotiated between the nurse and individual parent and child on an ongoing basis.[15,16]

Implications for research and practice

Despite extensive empirical research there is still no hard evidence to inform children/young people, their parents and the healthcare community if the application of a family-centred approach to care makes a difference to the child's health outcomes or the family's healthcare experience.

Additionally, the voice of the child is noticeably absent from the literature. It is still unknown what the hospitalised child's and parents' experiences and expectations of family-centred care are, if family-centred care supports parents to care for their child in hospital and if family-centred care supports parents and children to make informed healthcare decisions.

Further research must examine these areas in the context of the current healthcare delivery system and must reflect cultural diversity and social norms. The evidence generated will inform practice and promote consistent and effective implementation of a model of care that is truly child- and family-centred. It will also promote a move away from the current *ad hoc* implementation of the model to a more systematic and evidence-based approach.

Siobhan O'Connor is a PhD researcher, Maria Brenner is director of research and Imelda Coyne is a professor of children's nursing, all at the School of Nursing and Midwifery, Trinity College Dublin

This research is in progress as part of a PhD study in conjunction with the School of Nursing and Midwifery in Trinity College Dublin and is funded by the National Children's Hospital Foundation, based at Tallaght University Hospital

References available on request by email to: nursing@medmedia.ie (quote O'Connor WIN 2019: 27 (8): 48-49)

Access all areas

Access to Medicines Ireland is committed to ensuring much needed medicines are available to patients at a fair price, writes **Ciara Conlon**

IN JUNE 2019 the INMO affiliated to Access to Medicines Ireland (AMI), a Comhlámh member group comprising medical professionals, activists and concerned members of the public. The group is committed to ensuring that medicines are made accessible at a fair price and that medical research and innovation is directed at the areas of greatest need. Nurses and midwives are at the forefront of care for patients who are frustrated by the inability to access medicines due to cost. This lack of access can have a significant impact on their quality and length of life.

As healthcare professionals, we want to do all we can to alleviate suffering and to offer the best possible care to our patients. When, for any reason, we can't provide that high standard of care it can lead to disillusionment and frustration on our part and to unnecessary suffering and even death on the part of our patients. This deficit in care is evident when new medicines are brought to market but are unavailable to patients due to cost. Recent examples include delayed access for patients in Ireland to medicines for cancer (Kadycla), cystic fibrosis (Orkambi) and Hepatitis C (Sovaldi).[1]

The prices charged for medicines have a long history of affecting patient care. In the late 1980s, medicines were developed using university research funded by the public that transformed HIV from a death sentence to a manageable chronic illness. There was a catch – you had to be wealthy enough to afford the treatment. The manufacturers insisted on a price tag of $12,500 per annum in African countries, even though generic manufacturers offered to produce and market antiretroviral (ARV) drugs for $350 per annum.[2]

Millions of people died in the early 1990s because they were unable to access treatment at the price set by manufacturers.

> "At Médecins Sans Frontières, we see the impact of high price medication for hepatitis C. Since we secured deals for generic hepatitis C treatment for as low as $1.40 per day, we have been able to treat people with hepatitis C in 11 countries. The overall cure rate is excellent. We see our patients feeling so much better and living happier lives and we strive to continue the fight to secure treatments at low costs for all people with hepatitis C. Getting a call recently from a member of the public in Cambodia who couldn't access treatment was difficult knowing that our patients in India have access."
>
> **– Beverly Stringer, paediatric nurse practitioner, anthropologist and health policy and practice programmes advisor with Médecins Sans Frontières**

> "I am a PHN in the community for just over a year now and I am unable to offer home help or homecare packages to people as I am repeatedly told by my manager that there is no funding. As a result of not meeting the care needs of older adults, they are presenting to the ED, admitted, discharged and the cycle of failed discharges occurs. Where is all the money being spent? The gross inadequacy of our government to run a health service budget affects our medication bill every year. It's a disgrace Ireland's sickest people can be faced with the added stress of unaffordable medications. It is so wrong."
>
> **– Carol Bergin, PHN**

Treatment activists took a stand and pressure was heaped on pharmaceutical companies and governments by university students, patients and their nurses and doctors, and organisations like Médecins Sans Frontières. These activists did not rest until generic production was allowed, which lowered the price to less than a dollar a day. ARVs were soon in widespread use across the world.[2]

Priced out of range

Today, the struggle for access to affordable medicines affects not only developing countries but also wealthier countries like Ireland. There are many examples of drugs that are priced out of the HSE's range.[3] The pharmaceutical industry states that such high prices are necessary to pay for research and development (R&D). However, a World Health Organization (WHO) report in January 2019 stated that "the costs of R&D and production may bear little or no relationship to how pharmaceutical companies set prices of cancer medicines. To add insult to injury, over one-third of medicines' R&D is funded through the public purse which surprisingly offers no advantage in terms of subsequent price control".[4]

The real explanation for the high price of medicines is that the reward for successful research is a patent that grants the holder exclusive marketing rights for a period of 20 years. During this period pharmaceutical companies can set the price as high as they please.[2] A further contributor to high prices is the enormous sums spent on advertising and promotion that amount to almost twice that spent on R&D. Finally, there are the large profits paid to shareholders that help to make the pharmaceutical industry one of the most profitable in the world.[5]

In Ireland today, patients are often forced into exerting public pressure with emotionally resonant messages in a lottery for treatment. Families often resort to crowdfunding in order to raise money for much needed medicines.

Another problem with the profit-driven research model is there is little incentive to develop drugs that have limited profit potential. Therefore there is a paucity in research for desperately needed antibiotics and medicines for diseases such as tuberculosis or ebola, which predominantly affect people in poorer countries. With few vaccines or treatments available for emerging infections like ebola or the zika virus,

the need for a new system of research and development is increasingly evident.

There are many potential solutions to the crisis of high priced medicines and many of these solutions would rely on policy changes at national and international level. For example:

- The pharmaceutical industry must be required to justify its prices and be transparent on alleged underlying costs
- Public funding contributing to medical research must be reflected in the drug price
- An alternative to the patent monopoly-based incentive must be created. This would involve the creation of a fund by governments to incentivise research directly through mechanisms such as grants or prizes
- Where a medicine is unaffordable, governments should give consideration to invoking international legislation and issuing a 'compulsory licence' to override a patent and to manufacture a drug 'generically' in order to ensure access
- Governments must negotiate in groups to increase their purchasing power.

In 2015 a few patients and healthcare professionals came together and in 2016, Access to Medicines Ireland (AMI) was formed. AMI is a Comhlámh member group, an organisation of volunteers interested in international development.

We have hosted three conferences with expert guest speakers from Ireland and abroad. Our conference at the RCSI in April was moderated by Steve Pitman, INMO head of professional development.

AMI advocates for systemic and transformative policy changes that would lead to affordable prices for all medicines for all patients. We have focused our efforts on influencing the government and have had numerous meetings with TDs and senators. We have made a number of presentations in Leinster House including a formal presentation to the Joint Oireachtas Committee on Health and Children earlier this year.

Our success has opened up opportunities to make medicines more affordable globally. In addition to our ongoing activities such as hosting public educational events and political lobbying, this year we intend to focus on building stronger partnerships with patients affected by or concerned about unaffordable medicines.

In order to take on new activities we need to expand the group's membership. Nurses have always had a special role as advocates for their patients. If you are interested in joining the campaign to improve access to medicines, thereby improving patients' lives, we would love to hear from you. We meet on the third Wednesday of every month in the Comhlámh office in Dublin.

To find out more, visit our website: **www.accesstomedicines.ie** or email us on accesstomedicinesireland@gmail.com

Ciara Conlon is an activist with Access to Medicines Ireland. This article was written with the help of Kieran Harkin and Sheila Fitzgerald, both patient advocates with AMI

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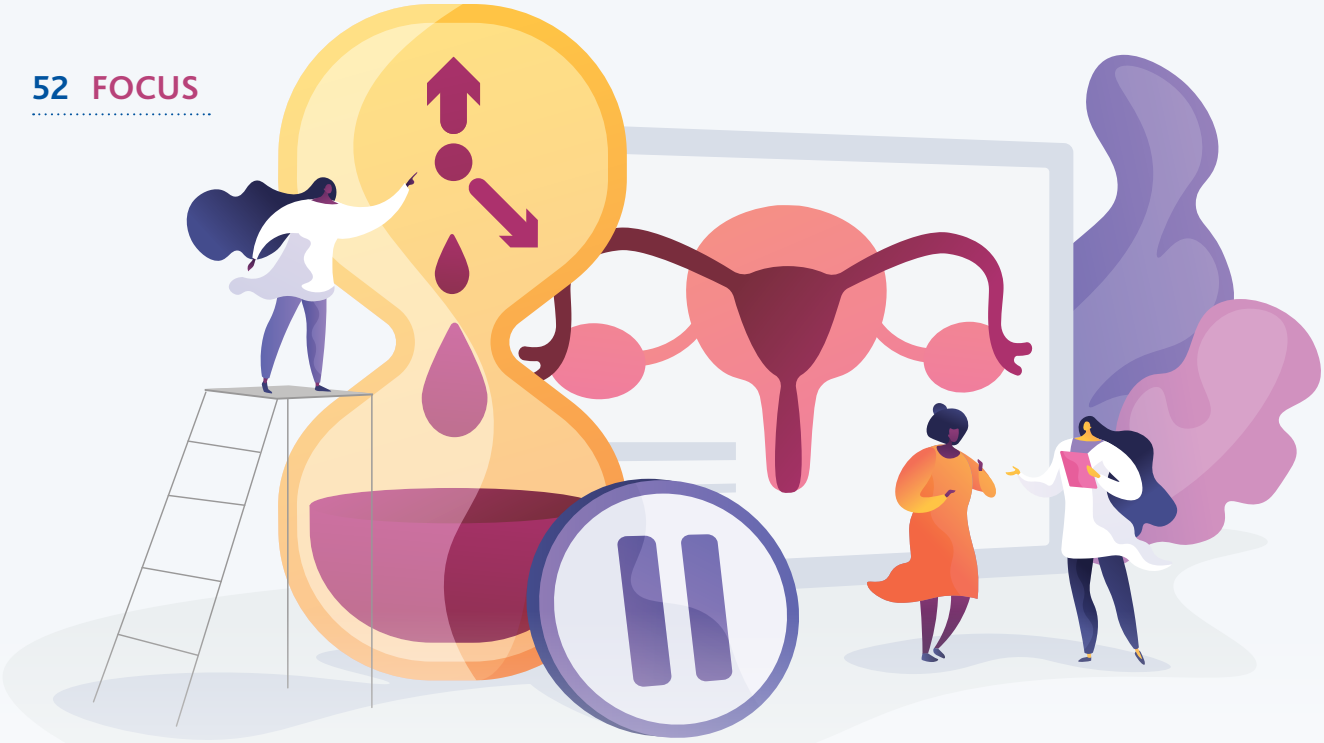

Menopause at work

Kathleen Kinsella discusses the issue of coping with menopause symptoms at work and what should be available to you

THE menopause has been recognised as an important issue that can affect women in the workplace. Organisations are beginning to see that in order to promote staff wellness and health, menopause symptoms must be considered. Menopause is also a gender and diversity issue as it may be treated differently in the workplace in comparison to other health-related conditions that affect both genders. As most nurses and midwives working in the Irish health service are women, it is vital that they receive the support they need in the workplace during their menopausal transition.

Menopause signs and symptoms

The menopause refers to the biological stage when periods stop and the ovaries lose their reproductive function. This usually occurs between the ages of 45 and 55, but in some cases women may become menopausal in their 30s or younger.

Every woman experiences the menopause differently. Symptoms can last from a few months to several years, and up to 80% of women experience physical and/or emotional symptoms during this time.

These symptoms can have a significant impact on women's health and wellbeing as well as their work and relationships. The menopause affects women in 'mid-life' when they are often juggling demanding jobs, school-age children and elderly parents.

This can have an impact on emotional wellbeing and lead to excessive levels of stress.[1]

The most common menopausal symptoms that women may experience are:

Hot flushes: these can start in the face, neck or chest, before spreading upwards and downwards. At night they are felt as night sweats. Most flushes only last a few minutes. The woman may sweat and the face, neck and chest become red and patchy. The heart rate can also become quicker or stronger.

Sleep disturbance: this can be caused by the night sweats, although it can also be caused by the anxiety women feel during the menopause. Sleep loss can cause irritability or lack of concentration at work. The menopause may also be linked to increased anxiety or depression.

Urinary problems: these may also occur during the menopause and many women have recurrent lower urinary tract infections, such as cystitis. It is common to have an urgent need to pass urine or a need to pass it more often than normal.

Heavy periods: these normally occur along with clots during the menopause and can be accompanied by longer periods.

Vaginal symptoms: these often include vaginal dryness, itching or discomfort. This problem occurs not only during the menopause and shortly after, but can occur in the in the period leading up to the change.

Women at work and menopause

With a predominately female workforce, there is a significant number of nurses and midwives who are experiencing menopausal transition. Approximately 1-10% of the population experience early menopause or premature ovarian insufficiency. This group of women will encounter the same symptoms as older women experiencing menopause.[2]

For some, going through the menopause may be uneventful and may not impact on their working life. For others, however, it may become increasingly difficult to function effectively at work and their working conditions may exacerbate their symptoms.

A study led by Prof Amanda Griffiths at the University of Nottingham into the menopause and work, reported that nearly half of the women surveyed found it somewhat or fairly difficult to cope with work during menopausal transition. Some 5% reported it to be very or extremely difficult. However, it must be stressed that women can work during this phase of their lives.[3]

The British Occupational Health Research Foundation published research that explored women's experience of working through the menopause.[4] This showed the following:

- Many women found they were ill prepared for the menopause, and even less equipped to manage its symptoms at work
- More than half had not disclosed their symptoms to their manager
- Most women felt they needed further advice and support

- Workplaces and working practices are not designed with menopausal women in mind.

Heavy and painful periods, hot flushes, mood disturbance, fatigue and poor concentration posed significant and embarrassing problems for some women, leaving them feeling less confident.

Women are not comfortable disclosing their difficulties to their managers, particularly if those managers are younger than them or are male. Where women had taken time off work to deal with their symptoms, only half of them disclosed the real reason for absence to their line managers. Some women said they worked extremely hard to overcome their perceived shortcomings.

Others considered working part-time, although they were concerned about the impact on their career if they did so, or had even thought about leaving the labour force altogether. More than half of the sample reported they were not able to negotiate flexible working hours or working practices as much as they needed to in order to deal with their symptoms.

Over half the women felt that it would be useful to have information or advice from their employer regarding the menopause and how to cope with their work.

Temperature in the workplace appeared to be an issue for many women. Nearly half the sample reported not having temperature control in their usual working environment. Some could not open windows or experienced interpersonal difficulties doing so in shared workspaces.

The Trade Union Congress in the UK (TUC) surveyed 500 safety representatives on the issue of menopause in the workplace.[5] This survey found that:

- 45% of respondents said their managers didn't recognise problems associated with the menopause
- Almost one in three respondents reported management criticism of menopause-related sick leave
- More than one-third cited embarrassment or difficulties in discussing the menopause with their employers
- One in five spoke of criticism, ridicule and even harassment from their managers when the subject was broached.

The survey identified the working environment as being responsible for making symptoms worse. Two-thirds of the safety representatives reported that high workplace temperatures were causing problems for menopausal women, and more than half blamed poor ventilation. Other complaints included poor or non-existent rest facilities or toilet facilities, and a lack of access to cold drinking water.

One of the biggest issues highlighted in the TUC report was the relationship between stress and increased symptoms, with 49% of respondents mentioning this as an issue. Working hours were also cited as a problem for women working through the menopause.

Support

There is much that employers can do to support women going through the menopause, although evidence suggests that the menopause is still a taboo subject in the workplace.[6] Attitudes to the menopause can range from empathetic and understanding to insensitive and jokey, to a complete lack of sympathy for employees who are experiencing this normal life event. In a recent report on supporting older workers, the UK government's adviser on older people called on employers to recognise the symptoms of the menopause in their workforce, speak openly about it, and understand the great advantages a 'mid aged' female workforce can contribute to any employment.[7]

The menopause needs to be recognised as an equality and occupational health issue, where work factors have the potential to impact significantly on a woman's experience of the menopause.

Women who are experiencing the menopause need support from line management. With any longstanding health-related condition this is crucial and can make a major difference. As already stated, the workplace can affect women going through the menopause in various ways, especially if they cannot make healthy choices at work. It is also important to remember that every workplace is different, but it can impact on female employees' management of their menopausal symptoms.[8]

The British Menopause Society suggested the following guidelines for workplaces:[9]

- Develop a menopause policy that is accommodating for women going through the menopause. For example, does the workplace have policies that allow work adjustments such as flexible working?
- Employ sickness absence procedures that allow women time off if needed for health appointments, or more breaks to help them during this temporary time of their menopausal transition
- If no menopause-specific policy exists, having the word 'menopause' mentioned in existing wellbeing and health policies has also been regarded as useful and should be highlighted within guidance
- The availability of support is another key aspect to address in guidance. Both formal and informal sources of support should be created and detailed. This should include who and where women and line managers can go to when they need some additional help and advice. This could be a named person in HR or maybe the occupational health team. It will be different for each organisation. There could be a named 'menopause champion'. Whoever it is, it should be clear in the guidance policy who they are and how they can be contacted
- Menopausal women also report that the physical work environment can have an impact on their menopausal symptom experience. This should be addressed so all staff are aware of the policies and procedures to help support women who may be experiencing problems related to their physical working environment. For example, are staff allowed desk fans, can they move their workstation to a window that can be opened, or closer to the toilet, and is cool water available?

Conclusion

Communication, support and sensitivity are essential in order to support and understand employees' needs during menopause transition.[10]

Having resources in place that are available to all staff will ensure that women are supported during this time and will raise awareness in the organisation of the work issues that can accompany menopause.

Kathleen Kinsella is an honorary senior lecturer at the RCSI. She is also director of Kinsella Leadership Development which provides management and leadership training for the healthcare industry

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Nutrition in pregnancy

Midwives can influence the long-term health of pregnant women and their babies through offering nutrition advice, writes **Eileen O'Brien**

YOU are what your mother ate, and maybe even what your grandmother ate. Not a catchy tagline for the promotion of nutrition in pregnancy, however current evidence suggests that the influence of nutrition in pregnancy has a transgenerational effect, impacting not only her child's health, but also that of her grandchildren.[1] Pregnancy is a golden opportunity to improve the health of future generations and help to promote healthier societies with reduced chronic disease.

Pregnancy has been described as a stimulus for positive behaviour change[2] and is a time when women are in regular contact with healthcare professionals,[3] which is in line with the National Standards for Safer Better Maternity Services.[4] Pregnancy, therefore, is an ideal time for midwives and nurses to provide top-line nutrition advice to women who can influence the health of future generations.

Resources

- *Healthy Eating in Pregnancy* booklet (HSE) – order at **healthpromotion.ie**
- *My Pregnancy* book (HSE) – to be given at antenatal clinic
- **www.mychild.ie**

Common questions

Should I eat for two?

Energy requirements increase as pregnancy progresses, with the greatest increases (450-500kcal per day) observed in the third trimester. However, given that most women slow down with less physical activity, the increases in energy can be met through reduced energy expenditure and an additional snack. Advise the woman to focus on eating a wide variety of whole foods that will provide the nourishment she and her baby need for growth.

I'm concerned about iron, what should I eat?

Iron requirements increase in pregnancy. Advise the woman to include haem iron dietary sources such as beef and lamb, two to three times per week. If she does not eat red meat, advise the woman to include pork chops, chicken or salmon.

Non-haem iron is not as readily absorbed and includes fortified breakfast cereal, baked beans, spinach, egg, wholemeal bread, broccoli and dried fruit. Absorption of non-haem iron can be enhanced with concurrent intake of vitamin C from fruit, fruit juice and certain vegetables. Tannins found in tea and coffee should be avoided at meal times as they can inhibit iron absorption.

What should I eat to help with constipation?

Encourage women to increase fibre intake and to take a variety of whole grains, fruit, vegetables, legumes (starchy beans, lentils and pulses), nuts and seeds (eg. flaxseed). Ensure the woman is drinking at least 2,300ml per day as dehydration can cause constipation. Some women find stewed prunes or prune juice helpful. Physical activity can also help bowel movements.

Can I eat fish?

Oily fish (salmon, mackerel, trout, herring etc) should be included once a week to provide omega-3 fatty acids (EPA and DHA), which are necessary for the normal development of the brain and retina. Vegetarians and vegans can get omega 3 from a variety of nuts, seeds and their oils.

Many women are concerned about the safety of fish. Mercury is a cumulative neurotoxin and exposure to high levels can lead to significant neurological and behavioural disorders. Excessive dietary mercury intake is mainly from large, predatory fish that are high in the food chain. Advise women to avoid shark, swordfish, ray and marlin. Tuna should be limited to one fresh steak or two 240g tins per week.

Do I need to take supplements?

Neural tube defects are the most common major malformation of the central nervous system in the developing foetus and include anencephaly and spina bifida. Advise women to take a 400µg folic acid supplement daily before conception and through to the 13th week of pregnancy. Women with a BMI >30kg/m^2 or with pre-existing diabetes should be prescribed a higher dose of 5mg folic acid supplement daily.

Many women in Ireland have low vitamin D status. A daily vitamin D supplement of 10µg/day is recommended during pregnancy to promote calcium absorption.

Learn more about nutrition

A one-day, expert-led study day on nutrition for preconception and pregnancy is being organised by Maternity Dietitians Ireland on November 4 in RCPI, Kildare Street, Dublin 2. It is a free event funded by the Health Research Board and CPD has been applied for. The conference will launch the revised Nutrition for Pregnancy Clinical Practice Guideline (Institute of Obstetricians and Gynaecologists and HSE). Keynote speakers will include Prof Fionnuala McAuliffe and Prof Michael Turner and topics on the day will cover all aspects of nutrition in pregnancy and practical tools for healthcare professionals.

To register, go to the Eventbrite page: **www.bit.ly/nutritionforpregnancy**

Eileen O'Brien is a senior dietitian at the National Maternity Hospital

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Enabling women to breastfeed with confidence

Measuring the milk supply of breastfed babies is a simple process that can reassure concerned parents. **Alison Moore** reports

WHILE parents and health professionals should have confidence that exclusively breastfed infants are receiving sufficient breastmilk if they are showing steady growth, are generally alert and are producing wet and dirty nappies, this is not always the case. The most common reason cited by mothers for ceasing exclusive breastfeeding is a perception of insufficient milk supply.

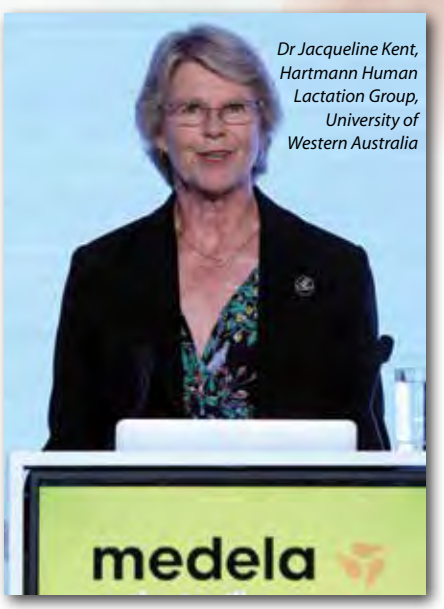
According to Jacqueline Kent, from the Hartmann Human Lactation Research Group at the University of Western Australia, this perception is based on the mother feeling that her infant is not satisfied after breastfeeds, her concern that her infant is not attached and sucking well during breastfeeding, and/or that her infant is feeding too often or too quickly.

Recent data from Dr Kent's research group indicate that more than half of all the mothers seeking assistance at the Breast Feeding Centre of Western Australia were concerned about the frequency of their infants' breastfeeds, or about the time taken for each breastfeed, and almost half of these mothers seeking professional assistance were not confident about their milk supply. This loss of confidence can lead to them weaning from the breast early and unnecessarily.

Speaking in London at Medela's Breastfeeding and Lactation Symposium earlier this year, Dr Kent stated that these perceptions can either be validated or shown to be inaccurate by using objective measurements.

"Objective measurements can help to confirm or refute a perception of insufficient milk supply, but when there is a perception of insufficient milk supply or oversupply, objective measurement of milk supply is rarely made.

"Every other biological function we have, we measure. The doctor doesn't just look at us and say, 'I think you're okay'. We measure. If we're concerned about blood pressure, we measure the blood pressure and compare that to a reference range. If we are within the reference range, we are happy. If we're not in the reference range, then we find out what is wrong and we do something about it," she said.



Dr Jacqueline Kent, Hartmann Human Lactation Group, University of Western Australia

Dr Kent believes that breastfeeding concerns should be approached in the same way as any other health concern in order to reassure mothers who lose confidence that their baby is getting enough milk.

"The same should apply to breastfeeding parameters. So, for breastfeeding mothers: how often should they or do they feed their infants; how long does the infant spend feeding; how much milk is transferred each time; and how much milk is transferred for the whole day?"

According to Dr Kent, by answering these questions you will obtain an objective measure of the mother's milk supply.

"An objective assessment of milk supply can be made when a mother measures her 24-hour milk profile. This involves the mother using accurate digital scales at home to weigh her fully-clothed infant before and after every breastfeed for a 24-26-hour period," she said.

To enter the data gathered, mothers taking part in Dr Kent's research, use a smartphone link to a secure website. They choose whether it's a breastfeed or an expression, indicate whether it was the left or right breast, and then enter the weight of the baby before and after the feed.

Dr Kent explained that this requires minimal interference in the infant's normal feeding and allows calculation of the frequency and duration of feeds, the amount of milk transferred during each breastfeed, and therefore the total milk intake over a day.

While a comparison of individual data with a reference range could establish whether the breastfeeding parameters are within normal limits, the problem remains that there is currently no established reference range for these parameters. Dr Kent and her team used the 24-hour milk profile technique to gather data from 71 mothers who were exclusively breastfeeding healthy term infants one to six months old.

"These data demonstrated very wide ranges among normal dyads, but further data are needed to create a well-established reference range. We now have data from 212 healthy, term breastfeeding dyads. The central 95% values are: six to 17 breastfeeds per day, six to 24 minutes per breastfeed, 32-131ml per breastfeed, and 528-1,116ml breast milk intake per day.

If there is a transfer of less than 550ml a day, Dr Kent said this warranted the baby being checked for normal growth.

"If there's anything of concern, we'd try to get milk production to come up a little bit, whether the mom needs to pump a bit more to increase supply, whether she needs to introduce an extra feed, it might be too long between feeds. She might need to do something else to increase her milk, such as adjustment of the positioning and attachment, which can make the transfer more effective," she said.

Dr Kent said that the message for health professionals is not to try to force every mother and baby to be average, but to allow them to be individuals. So while some babies will feed 12 times a day, or more, and some only six, the only thing that matters is that they get adequate milk for healthy growth.

Atopic eczema: a physical and financial burden

Irish Skin Foundation survey finds that 40% of households affected by atopic eczema report that the condition has an impact on finances

A NEW Irish survey has found that atopic eczema places a significant economic burden on the households that it affects, with over 40% of those surveyed reporting the need to cut household expenditure because of the day-to-day cost of managing the skin condition.

The findings were released by the Irish Skin Foundation (ISF) to correspond with World Atopic Eczema Day last month.

Atopic eczema, or atopic dermatitis, is a common, non-contagious, inflammatory skin condition. Atopic eczema can start at any time of life but is most common in childhood and is thought to affect as many as one in five children and one in 10 adults.

The cost of eczema treatments and doctors' appointments needed to manage the condition can be a significant financial burden. The ISF survey revealed that 42% of carers of children and 49% of adults reported cutting back on household expenses due to the cost of managing the condition. The figures suggest that one-quarter of those surveyed spend at least €2,300 annually on doctors' fees, over-the-counter management products and prescription treatments.

The survey findings also reveal the pronounced negative impacts that atopic eczema can have on quality of life, including sleep disruption, absences from school, as well as participation in exercise and social activities.

Sleep disruption

A major symptom of atopic eczema is intense itch, which is commonly reported to disrupt sleep, with findings revealing that the overwhelming majority of children (86%) and adults (84%) living with the condition experience ongoing sleep disturbance. Additionally, more than one-quarter (26%) of carers of children with eczema say their child missed one to two days of school per month due to their condition, with over one-third (34%) of children and two-thirds (65%) of adults admitting to avoiding exercise, activities and sport. More than half (52%) of adults surveyed avoid social activities altogether.

Hidden burden

Speaking on the survey results, consultant dermatologist, Prof Anne-Marie Tobin said: "These new Irish survey findings provide us with valuable insights into the often-hidden burden experienced by those living with or caring for people with moderate-to-severe atopic eczema. To mark the second World Atopic Eczema Day, the ISF survey findings further underscore that people living with this very common condition experience a whole host of challenges in their daily lives, beyond the pain and discomfort of this very common debilitating skin disease."

Irish Skin Foundation CEO David McMahon said: "The disruption and stress that moderate and severe atopic eczema can cause is very clear from the findings of our recent survey. And while we know that the family impact of atopic eczema can be profound, we were surprised how disturbed sleep, lost school days and potentially, productivity features so strongly.

"Our work with families impacted by eczema, particularly at this time of the year as the school term starts back, focuses on supporting people to re-establish care routines that will strengthen the skin barrier. This is quite important in advance of the weather cooling and central heating being turned on again in the autumn, both of which can be a challenge for vulnerable skin and can lead to flares.

"The Irish Skin Foundation has plenty of great simple tips, guidance and resources for anyone who wants to establish a new skin barrier care routine at **www.IrishSkin.ie** The charity also operates a freephone helpline with access to specialist dermatology nurses who provide one-to-one guidance about a range of skin conditions and problems."

The findings from the ISF's 'Living with Atopic Eczema Survey' were gathered from 454 participants living with predominately moderate-to-severe eczema or caring for someone with eczema in Ireland. The ISF released the findings to highlight the hidden burden of the disease ahead of this year's World Atopic Eczema Day.

This year the ISF is joining GlobalSkin, a unique global alliance committed to improving the lives of patients with skin conditions worldwide, in raising awareness and understanding of the impact of eczema on patients' lives.

An 'Atopic Eczema Panel Discussion' given by medical experts and patient advocates will take place at the ISF's skin-health information and awareness event, SkinSideOut, on November 16 at the Science Gallery, Trinity College, Dublin. Tickets for this event are available to purchase via Eventbrite (€5 per session). For more information on this event and more on other skin conditions included in the programme visit **www.IrishSkin.ie**.

'Living with Atopic Eczema' Irish Skin Foundation Survey

- Atopic eczema affects as many as one in five children and one in 10 adults
- Some 86% of children and 84% of adults surveyed report interrupted sleep
- More than one-quarter (26%) of carers report one to two days absent from school each month

Diabetes breakthrough

A drug targeting the immune system can delay diabetes onset by two years – *WIN* takes a look at some recent diabetes research

RECENT findings presented at the American Diabetes Association Scientific Meeting revealed that a drug targeting the immune system can delay type 1 diabetes for an average of two years in children and adults at high risk.

"This is an incredible advancement that gets us one step closer to our ultimate goal – a future without type 1 diabetes," said Anna Clarke, health promotion manager at Diabetes Ireland.

TrialNet is a clinical trial network that tests innovative clinical studies to find ways to maintain insulin production before and after diagnosis. It is funded by the US National Institutes of Health and the Juvenile Diabetes Research Foundation.

TrialNet's 'Teplizumab (anti-CD3) Pathway to Prevention Study' identified 21 adults and 55 children who were relatives of people with type 1 diabetes. All had two or more autoantibodies and abnormal blood glucose levels and were therefore considered to have an almost 100% lifetime risk of developing type 1 diabetes.

These high-risk individuals were randomly assigned to either the treatment group, which received a 14-day course of teplizumab, or the control group, which received a placebo. All participants received regular glucose tolerance tests until the study ended, or until they developed clinical type 1 diabetes. Some 72% of people in the control group developed clinical diabetes, compared to only 43% of the teplizumab group. The average time for people in the control group to develop clinical diabetes was just over 24 months, while the average time for the treatment group was 48 months.

Samples collected during the trial are being studied to help researchers understand why certain people responded to teplizumab better than others. After this, the researchers hope to conduct additional studies to look for ways to extend the benefits of the drug.

"This is the first study to show that a drug can delay type 1 diabetes diagnosis a median of two years in people at high risk. As anyone with type 1 diabetes will tell you, and particularly for children who are most commonly affected, every day you can delay this disease is important," said Dr Kevan Herold, professor of immunobiology and internal medicine at Yale University in the US.

"The key point for the millions of people at risk to develop this disease is we now have the first immunotherapy that significantly delays the onset of type 1 diabetes," said Bill Russell, TrialNet principal investigator and director of the Division of Paediatric Endocrinology and Diabetes at Vanderbilt University in the US.

"Eighty-five percent of the almost 3,000 patients in the children's diabetes programme at Vanderbilt have type 1 diabetes. The subject population all had positive diabetes antibodies in their circulation, indicating that their immune systems were targeting their beta cells in the pancreas," Dr Russell said.

"They also had impaired glucose tolerance, meaning their glucose response to an oral glucose tolerance test was not normal but it wasn't yet in the diabetic range. We now call this stage 2 of type 1 diabetes."

Dr Russell said people who are in stage 2, (antibodies plus impaired glucose tolerance) have an 85% likelihood of developing diabetes (stage 3) within five years.

"We are now exploring a full-blown prevention trial in people even earlier in the disease process," Dr Russell said. "And we are also looking at delaying or preventing progression to stage 3."

The study was published in the *New England Journal of Medicine*.

Lower heart failure risk with SGLT2 inhibitor for type 2 diabetes

The new category of drugs for type 2 diabetes, the so-called SGLT2 inhibitors, has been found to reduce the risk of heart failure, major cardiovascular events and earlier death, according to a major Scandinavian registry study.

Only an association was observed in the study, which means causality cannot be established, but the findings expand on similar insights made in 2017.

Sodium-glucose co-transporter-2 (SGLT2) inhibitors work by reducing the amount of glucose being reabsorbed into the blood within the kidneys so that it is passed out in the urine, therefore lowering blood glucose levels.

Researchers from Sweden, Norway and Denmark wanted to explore whether the drugs had a positive effect elsewhere on people's health. The findings were based on drug data from more than 21,000 people with type 2 diabetes who began using SGLT2 inhibitors between April 2013 and December 2016.

This information was then compared with an equally sized matched population who began treatment with a different diabetes drug, a DPP4 inhibitor. The primary outcomes in the study were major cardiovascular events (defined as myocardial infarction, stroke or cardiovascular death) and hospital admission for heart failure.

In the primary analysis, the patients were monitored throughout the follow-up period, regardless of whether they had completed their treatment. The researchers found that the use of SGLT2 inhibitors was associated with a reduced risk of heart failure but not with major cardiovascular events.

The risk of heart failure was 34% lower in the SGLT2-inhibitor group than in the DPP4-inhibitor group. The use of SGLT2 inhibitors was also linked to a 20% lower risk of death. The results are applicable primarily to dapaglifozin, which was the predominant SGLT2 inhibitor used in Scandinavia during the study period.

The results were published in the *BMJ*.

Focus on: Crohn's disease

Mary Nwaezeigwe and Valerie Byrnes discuss the case of a paediatric patient with Crohn's disease that was resistant to treatment

A 16-YEAR-OLD female with Crohn's disease continued to have clinical symptoms and endoscopic findings consistent with Crohn's ulceration throughout her colon despite multiple trials with steroids and 6-mercaptopurine. A stricture in the terminal ileum was confirmed by a magnetic resonance enterography (MRE). Following this she was commenced on infliximab.

A landmark randomised controlled trial (REACH clinical study)[1] demonstrated the efficacy of infliximab for the treatment of paediatric Crohn's disease. In accordance with international guidelines an early top-down approach with biologics therapy should be considered in patients with known high-risk factors.

These factors are defined as deep colonic ulcerations on endoscopy, persistent severe disease despite adequate induction therapy, extensive disease, marked growth retardation, severe osteoporosis, stricturing and penetrating disease, and severe perianal disease. As with the adult population, similar risks of opportunistic infections and malignancy can occur.

However, it is the occurrence of fatal hepatosplenic T-cell lymphoma that poses a major threat in this patient population. This fatal lymphoma tends to occur in male patients, in 50% of patients aged <20, and in patients who had been treated with long-term thiopurines either alone or in combination with anti-TNF agents. Current international guidelines[1] on the medical management of paediatric Crohn's states that concomitant azathioprine may be used during the first six months of treatment with infliximab. After six months, stopping azathioprine should be considered, especially in boys. The use of low-dose methotrexate can offer an alternative.

There have been no case reports of hepatosplenic T-cell lymphoma on infliximab alone, therefore this offers a safe treatment option for paediatric patients who need treatment escalation to manage their symptoms.

Dermatological manifestations of Crohn's disease

Having examined the patient's legs *(see Figure 1)* a diagnosis of erythema nodosum was made. The typical features of reddish, painful, sometimes multiple nodules seen below the knees, commonly seen at the extensor surfaces, were observed. It rarely requires a histological diagnosis but, if performed, the histology reveals a non-specific focal panniculitis.

The prevalence of erythema nodosum is higher in Crohn's disease than in ulcerative colitis, and is more common among female patients.[2] The pathogenesis of erythema nodosum is not well understood but it could be a type IV hypersensitivity reaction. This is usually associated with colitis flares, but not always with severity. Treatment in this case is based on controlling the underlying disease. Systemic steroids may be required in severe cases, as well as immunomodulators with azathioprine or biologics with infliximab or adalimumab.

Other skin manifestations of Crohn's disease include:[2]

- Pyoderma gangrenosum
- Sweet syndrome (ie. acute febrile neutrophilic dermatosis)
- Anti-TNF induced skin inflammation such as subcutaneous injection site reaction.

The patient was transitioned to the adult services and remained stable on infliximab.

Infliximab

The patient has been in remission for seven years raising the question of stopping infliximab. Long-term prospective data about outcomes following cessation of infliximab in patients with Crohn's are scarce. In stable patients, the indefinite use of biologic therapy is increasingly being brought up in clinics. Although there are no rules around stopping anti-TNF therapy in Crohn's, intentional cessation of therapy needs to be made conjointly between the gastroenterologist and the patient. Such decisions should be made on a case-by-case assessment with a frank discussion about the benefit-risk ratio at the forefront.[3]

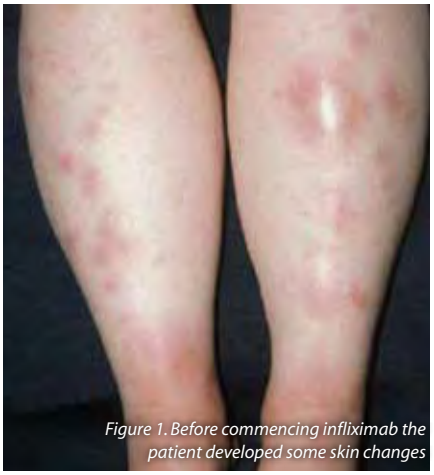


Figure 1. Before commencing infliximab the patient developed some skin changes

Endoscopic, biochemical and clinical remission must be achieved before considering withdrawal of therapy. This is defined as complete endoscopic mucosal healing, normal CRP and a Crohn's disease activity index of <150. Monitoring the trough levels of TNF and anti-TNF antibodies might play a role in aiding the decision to stop anti-TNF.

If the decision is made to stop, it is necessary to monitor CRP and faecal calprotectin every eight weeks to predict early clinical relapse. This should be followed by an endoscopic exam if these markers are elevated, and recommencement of treatment in the event of a relapse.

Mary Nwaezeigwe is a gastroenterology registrar and Valerie Byrnes is a consultant gastroenterologist, Galway University Hospital

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3. Papamichael K, Vermeire S. Withdrawal of anti-tumour necrosis factor otherapy in inflammatory bowel disease. World J Gastroenterol 2015; 21(16): 4773-8A stricture in the terminal ileum was confirmed by a recent magnetic resonance enterography (MRE). Following this she was commenced on infliximab.

School nurses play vital role in screening

Audiology screening by specialist school nurses is cost effective compared to other referral sources, writes **Pauline Roche**

PRIOR to 2016 there was only one school nurse in Co Wexford and many schools were screened by generalist public health nurses (PHNs) until that time. Following national review recommendations, changes in school screening personnel were made in Co Wexford. A second school nurse was appointed (of four recommended) and all school screening was then performed solely by school nurses.

We used this opportunity to examine the benefits of employing specialist trained staff by researching referral rates from both hearing and vision screening. It was also possible to examine separately the impact of changes in the school hearing screening protocol, recommended by a national audiology review and introduced at that time. More details on screening methodology are available on request from the authors.

This research was a randomised cross-sectional anonymised audit analysis of Co Wexford child health records (CHRs), designed and implemented jointly by the audiologist Theresa Pitt-Byrne[1] and the local school (public health) nurses[2] who worked together on the manual record audit; this was supported by the director of public health nursing.[3] The hearing and vision screenings and subsequent referrals to audiology and ophthalmology of almost 900 school children were analysed, as well as the children's preschool developmental referrals. Our objectives were:

- To analyse the impact of staffing changes (PHNs versus school nurses), and 2016 protocol changes,[4] on school hearing screening outcomes especially and to review trends over time in outcomes
- To summarise referral percentages for all preschool children to various allied health and medical specialists, relative to hearing status.

We audited cohorts born between 2004 and 2012. The age of initial school hearing screening fell from a mean of 6.4 years to 5.3 years for those cohorts. Age differences between school vision and hearing screening in earlier cohorts existed because screening was often done in classes a year apart. Since 2016, specialist school nurses conduct all screening in junior infants.[4]

Overall findings/referral rates

- School hearing screening (SHS) referral and repeat pass rates fell significantly to below 2%, when school nurses took over all the screening. However, protocol changes did not significantly affect referral rates
- School vision screen (SVS) referrals remained around 10% throughout, reflecting a consistent policy/methodology in ophthalmology training over many years
- Co Wexford referral rates compared well to European SHS/SVS data; SHS rates were much lower than in recent UK studies.[5]

Recommendation one: Employ more specialist school nurses, with wider scope for educational roles. Retain SHS otoscopy to assess repeats/referrals. SHS had low impact on audiology services, so such well-screened, high-yield referrals should get waiting list priority, for both audiology and ENT since most had conductive hearing loss. Preschool audiology referrals easily outnumbered SHS referrals (51 compared to 12 from SHS). No 'new' permanent hearing loss was identified at SHS during this audit.

Recommendation two: High priority for well screened SHS referrals to audiology. Caution is warranted on late-onset or progressive loss detection, due to low incidence of permanent hearing loss at under 0.2%.

Universal newborn hearing screen (UNHS) referral rates of 2% to audiology were costlier than SHS referrals. Documenting UNHS on all child health records in a standardised way better supports information access for HSE preschool service referrals. Experienced school nurses could provide 'special needs school services' to children with mild to moderate learning disability, if an audit of current services shows gaps in such screening. Automatic data transfer (as in UNHS) could easily centralise SHS/SVS audit data.

It was notable that the children referred to specialist preschool services, particularly speech and language therapy candidates with simple developmental speech and language delays, did not have significantly higher rates of referral from SHS, hence the need for hearing testing when young children have already had UNHS must be questioned. Parental opinion and close family history remain strong indicators, rather than automatic referrals from allied health specialists.

Recommendation three: Ensure UNHS results are documented on child health records so that community preschool services can access them through the PHN, perhaps helping to avoid unnecessary preschool referrals. School screening by school nurses is cost-effective for audiology services compared to other referral sources. The research identifies various benefits of specialist school nurses.

Findings from this research were presented as a poster at an Allied Health Professionals Conference in November 2018 and this poster won an award at the Institute of Community Health Nursing annual conference in May 2019.

Pauline Roche is a schools public health nurse in Wexford Community Care

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Acknowledgement

Ophthalmology review and comments from Dr Michele Fenton. Thanks also to all the local health centre administrative staff who supported file reviews

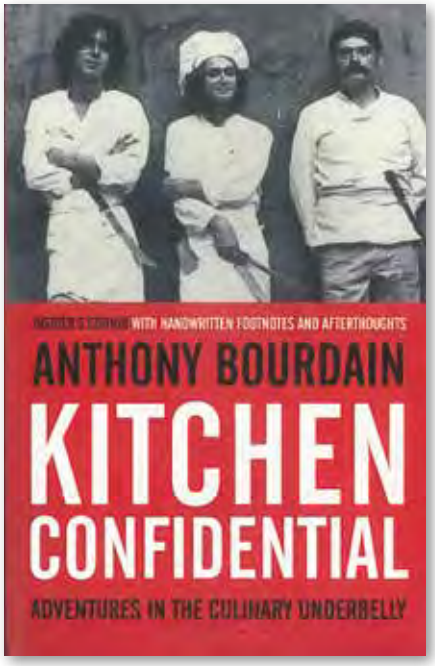
Confessions of a cook

IF you enjoy eating food, cooking food or need food to survive, *Kitchen Confidential: Adventures in the Culinary Underbelly* by Anthony Bourdain is the book for you. If you're looking for tips on wowing your dinner guests, however, or getting your roast spuds crispy on the outside and fluffy on the inside, perhaps you should look elsewhere.

Through the prism of his tumultuous career, the late Bourdain opens up about his mental health issues, his struggle with addiction and his eventual rise to culinary infamy, first as a line cook at various doomed-to-fail dives along the east coast of the US and later, as head chef at some of New York City's busiest establishments.

Bourdain describes falling in love with 'good' food as a child while on holiday in France. He recounts the 'wilderness years' of his career and introduces the reader to the variety of vagrant sous chefs, dishwashers, porters and 'fry guys' with whom he shared a kitchen over the years.

For a time the Bourdain was a carefree wunderkind whose ambition, manifested



in a healthy chef's pay cheque, led to a life of excess. Where before his taste for class A narcotics was simply a way of getting through particularly gruelling shifts, his addiction quickly became all encompassing to the point where his work was merely a means to finance his dependence.

Bourdain ultimately reflects on overcoming addiction and offers advice to readers with a desire to prepare food 'like the pros'.

Humour, often dark, is a constant throughout; explanations as to what happens to a steak that's ordered well done and why one should never order fish on a Monday, as well as a string of anecdotes about the kind of debasing behaviour that passes for camaraderie in the 'culinary underbelly' Bourdain describes so vividly.

Bourdain would later express his regret, however, in light of the #MeToo movement, that *Kitchen Confidential* "celebrated or prolonged a culture that allowed the kind of grotesque behaviours we're hearing about all too frequently". In that sense this book is of its time but the story, and the style and panache with which it's told, is truly sustaining.

– Max Ryan

Kitchen Confidential. Published by Bloomsbury Publishing RRP €13.99. ISBN: 9781408845042

CROSSWORD Competition

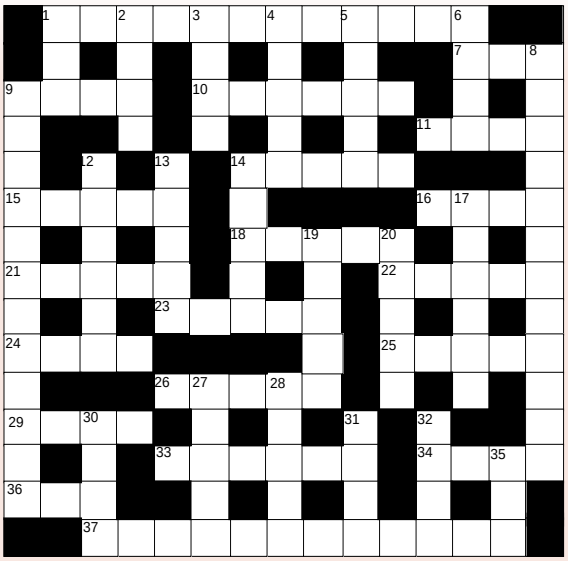
WIN a €50 gift voucher

Across

1 Eyesight disorder resulting from the vista of large measures of spirits? (6,6)
7 Choose? There's no point! (3)
9 Bet made before cards are dealt (4)
10 Feed for animals (6)
11 Plant used in the making of linen (4)
14 Is in need of (5)
15 Paddle this in either direction (5)
16 Mexican filled pancake (4)
18 Untouched by the censor (5)
21 Given medicine in part of a Barbados edifice (5)
22 Concerning the kidneys (5)
23 Brushed leather (5)
24 Glimpse the eastern agent (4)
25 Poisonous (5)
26 Dangerous physical reaction - to southern German wine? (5)
29 Make whiffs of smoke; swell up (4)
33 Dodged (6)
34 Large water jug (4)
36 Large, flightless bird of Australia (3)
37 Important date of a communist postal communication? (3,6,3)

Down

1 The professor starts debates on neutrality (3)
2 Availed of (4)
3 Attic (4)
4 Spirit associated with Russia, Poland etc (5)
5 & 9d A diet peaked? Skinny adapts to such nourishment (5,3,6,3)
6 Name which means 'Christmas' (4)
8 May a revenue official extol Colt car transformation? (3,9)
9 See 5 down
12 Blue-flowered minty herb found in a posy? Sh! (6)
13 Slides out of control (5)
14 Mature nit (5)
17 Wing that has been added to a building (6)
19 Brook (5)
20 Banal (5)
27 Wretched dwelling (5)
28 The trainee officer acted strangely (5)
30 Number represented by Roman numeral IV (4)
31 Heavy hand tool used for dressing or shaping wood (4)
32 Deceased (4)
35 Cathedral city in Cambridgeshire where lye is distributed (3)



September crossword solution

Across: 1 Cos 3 Articulated lorry 8 Tunnel 9 Counting sheep 10 Alice 11 Robes 13 Fades 15 Leopard 16 Pork pie hat 21 Franc 24 Halloumi 25 Came to 26 Taxidermist 27 Ska

Down: 1 Cottage loaf 2 San Diego 3 Abele 4 Include 5 Loner 6 Trilby 7 Dog 12 Sleep apnoea 13 Feral 14 Story 17 Pyrenees 18 Uranium 19 Hallux 22 Crowd 23 Start

The winner of the September crossword is: Catherine Gunn Listowel, Co Kerry

You can now email your entry to us at nursing@medmedia.ie by taking a photo of the completed crossword with your details included.
Closing date: Monday, October 21, 2019
If preferred you can post your entry to: Crossword Competition, WIN, MedMedia Publications, 17 Adelaide Street, Dun Laoghaire, Co Dublin, A96E096

Name:
Address:

Take control of your future

Ivan Ahern shares the first steps in creating a financial plan and when you should ask for help

IT'S TRUE – money makes the world go round. It's integral to your overall wellbeing and happiness. It fuels your future but can also cause significant levels of stress when things get difficult. We often assume earning more money will help us escape our financial challenges, but for many of us being prepared and making better decisions with the money we have is the solution we really need. Here are four key steps to help you create your financial plan.

Step 1: Your money

Take an honest look at your money and your budget – what is your monthly/weekly expenditure versus your income?

Incomings

Identify all of your sources of income, allowances and any extra earnings you receive. Review your payslip to ensure you are on the correct point of the scale and receiving any income tax relief and allowances available to you.

Expenditure

Make a list of your monthly/weekly spending. A good rule of thumb to categorise your spending is the 50/30/20 budgeting ratio:

- 50% needs – mortgage or rent payments, loans, insurance and utilities
- 30% wants – your livelihood, home improvements, cars and hobbies
- 20% savings – an additional voluntary contribution (AVC), emergency fund, holiday fund.

This ratio is a guideline only and is dependent on your situation. However it should give an indication if you are overspending. If your spending is more than your income, you will need to revise your budget.

Step 2: Your needs

Before you decide your needs, ensure you don't confuse them with your wants. Needs are essentials such as your home, utilities, food, insurance and so on. The wants are often things you think you need but when money pressure is on, you can do without. This is the important step in becoming financially fit for life as it identifies the money you need to financially survive if something unexpected happens.

Being unable to cover these costs is often one of our biggest financial stresses. Evaluate the cover you need to protect your family including income protection, health insurance and life insurance to cover all of life's events.

Step 3: Your goals

Your goals are unique to you and your family. Break them into short-, medium- and long-term goals *(see Table 1)*.

At this point, evaluate what money you currently have to fulfil your goals so you will know what amount to put aside.

Example of retiring early and travel goals

Catherine and Sarah are both nurses who want to retire at 60 years. Their situations are similar; they have the same years of service and salary at retirement. The difference is they started in the public sector at different times. *Table 2* outlines their annual incomes at retirement.

Sarah's income is significantly less and therefore she can't afford to retire early as planned. By identifying this early, Sarah can create a plan that will not only allow her to finish working earlier, but allow her to fulfil her retirement travel goals.

Step 4: Plan

The final step in creating your plan is identifying what to do with your money to make your goals happen.

Keeping your money in deposit accounts like savings and current accounts might not deliver the returns that you need for your long-term goals. Your money could also lose its value due to inflation. This is because deposit account interest is at an all-time low of 0%, unlike in the 1970s when it was as high as 15%.

This is the perfect time to seek advice from a financial expert, who will help you analyse your long-term options, for rainy day funds, education funds, retirement savings or other investments that could prove beneficial for you. It's important to know all of your options so you make the best choice for your future.

While others might charge for a similar service, Cornmarket offers complimentary financial planning services to INMO members. You can book a free appointment at Tel: 01 4086277.

Table 1: Your goals

Goals	Time	Examples
Short-term	Up to one year	Holiday, emergency fund
Medium-term	One to five years	New car, house renovations
Long-term	Five years or more	Early retirement, travel, children's education

Table 2: Sarah and Catherine's annual income at retirement

	Catherine	Sarah
Planned early retirement age	60	60
Retirement salary	€60,000	€60,000
PRSI	Class A	Class A
Years of service	27	27
Joined the public sector	Before April 2004	After April 2004
Supplementary pension	Yes (where eligible)	No
Annual income	**€20,000**	**€10,000**

Ivan Ahern is a director at Cornmarket Group Financial Services Ltd

Survey reveals impact of eczema

Children with eczema losing sleep regularly – Irish Skin Foundation

CHILDREN with eczema miss one to two school days each month as a result of the condition, according to a new Irish Skin Foundation (ISF) survey.

The results of a survey – *Living with atopic eczema and eczema in Ireland* –by the Irish Skin Foundation (ISF) were launched in conjunction with World Atopic Eczema day on September 14. The survey was undertaken between September 2018 and March 2019 with the aim of gaining a better understanding of eczema, its prevalence and impact in Ireland.

The survey found that one in five children and one in 12 adults in Ireland have eczema, while 86% of surveyed parents and guardians reported that their children's sleep is regularly interrupted by symptoms of the condition.

ISF CEO David McMahon said that a better understanding of eczema was needed to combat the condition worldwide.

"The impact of eczema is still poorly understood, we want to find out more about how many people are living with chronic moderate or severe eczema in Ireland, how it affects sleep, work, school and psychology."

Speaking on the survey findings, Mr McMahon said: "Our work with families impacted by eczema, particularly at this time of the year as the school term starts back, focuses on supporting people to re-establish care routines that will strengthen the skin barrier. This is quite important in advance of the weather cooling and central heating being turned on again in the autumn, both of which can be a challenge for vulnerable skin and can lead to flares."

"The ISF has plenty of great simple tips, guidance and resources for anyone who wants to establish or re-establish a new skin barrier care routine. The charity also operates a free Helpline with access to specialist dermatology nurses who provide one-to-one guidance about a range of skin conditions and problems."

Establishing an emollient skin barrier and adhering to the 'treat, protect and cleanse' routine, according to Laura Dowling, pharmacist adviser for the Menarini Group's RELIFE project in Ireland, is key to the management of atopic eczema and dermatitis.

"When our skin loses moisture, the skin barrier is compromised and irritants and allergens pass through the skin more easily. As we become more hygienic in society, we are increasingly using 'cleaning' substances like shampoo, shower scrubs/gels and laundry detergents, which are stripping our skin of its natural moisture. We need to replace this moisture."

Resources

Coinciding with World Atopic Eczema Day, Global Skin announced the launch of 'AltogetherEczema', a new global online hub for people affected by chronic skin disorders. For this and related resources, visit **www.altogethereczema.org**

Louth hospitals mark World Sepsis Day

EVERY year since 2012, Our Lady of Lourdes Hospital Drogheda and Louth County Hospital, Dundalk mark World Sepsis Day on September 13.

The aim is to highlight the importance of prompt recognition of the signs of sepsis, thus improving patient outcomes.

A potentially life threatening condition, sepsis can occur when the body develops an infection that affects the vital organs. If not treated quickly, it can be fatal. There are around 15,000 cases in Ireland every year.

As part of the awareness campaign in both hospitals, there was a public awareness stand in Marshes Shopping Centre, Dundalk on September 5 and in Drogheda town centre on September 6.

Several landmark buildings were also lit up in pink, the international colour for sepsis awareness, including both hospitals in Dundalk and Drogheda from September 9-14 to raise awareness.

For staff, the day involved expert presentations, including a story from a patient. There were also display stands from various disciplines within the hospital, poster presentations and quizzes.

Steps to sepsis awareness and prevention improvement in Our Lady of Lourdes and Louth County hospitals include:

Pictured at World Sepsis Day at Louth Community Hospital were (l-r): *Siobhán McMahon, staff nurse, OLOL Drogheda; Mary Bedding, lead sepsis ADON, RCSI Hospital Group; Denise Flynn Walsh, CNM3, Louth County Hospital; Emma Ross, staff nurse, Louth County Hospital; and Emma Kirk, staff nurse, Louth County Hospital*

- Introduction of intradepartmental transfer form using ISBAR format
- ISBAR stickers to standardise communication when escalating patient care
- Regular audit to monitor progress
- A sepsis drawer in all clinical areas to ensure equipment for Sepsis 6 is available
- A sepsis newsletter to raise awareness of sepsis throughout hospitals
- The sepsis screening form launched in 2018 which included targeted education, sepsis awareness stands and dedicated information days on both hospital sites
- Education for staff on ISBAR communication tools, sepsis and screening forms
- Education on sepsis on World Sepsis Day
- Public sepsis awareness stands in hospitals and the local community.

– Siobhán McMahon, clinical facilitator for deteriorating older persons

New alliance aims to boost vaccine uptake

A NEW alliance aiming to boost the uptake of vaccines in Ireland was launched recently by Minister for Health Simon Harris. The Vaccine Alliance will comprise healthcare professionals, policymakers, patient advocates and representatives from groups affected by vaccine hesitancy.

The alliance will ensure that parents have accurate, evidence-based information about vaccinations.

A steering group made up of healthcare professionals and a range of organisations such as Barnardos, Science Foundation Ireland and the Union of Students of Ireland, will guide the work of the alliance.

Speaking at the launch, Minister Harris said: "Vaccination rates across the country are falling and diseases we had consigned to the history books are now making a comeback. We cannot afford to do nothing. We cannot allow the success of our childhood immunisation programme become its enemy."

Mr Harris said that the alliance will try to build on the success of the HPV vaccine programme, which has seen vaccination rates increase from 51% to 70% in just over two years.

The launch was attended by the parents of HPV campaigner, Laura Brennan, who died earlier this year having received a terminal cervical cancer diagnosis at the age of just 25.

Mr Harris announced that the Royal College of Physicians of Ireland has agreed to rename its medal for patient advocacy the 'Laura Brennan Advocacy Medal', in recognition of her work in increasing uptake of the HPV vaccine.

For more vaccination information, visit **www.hse.ie/eng/health/immunisation**

Children's palliative care conference

THE FOURTH International Children's Palliative Care Conference will take place at NUI Galway on November 21-22. The conference will focus on the care of children with complex palliative care needs. Dr Julie Hauer from Boston Children's Hospital will speak on the symptom management of children with severe neurological conditions. Consultant paediatrician Joanne Balfe will talk about cannabinoids, the location of care and the specific needs of adolescences and young adults. Bryan Nolan, communications specialist in end of life care, will discuss breaking bad news to families, while Dr Helen Kerr from Queen's University Belfast will discuss the transition of children with life limiting conditions into adult services. For further information, see **www.cpcconf.ie**

– Liz O'Donoghue, CNS in palliative care, CHI at Crumlin

Nursing seminar identifies resilience and leadership as key competencies

PERSONAL resilience, accountability and leadership were identified as key competencies that nurses require to succeed at a recent breakfast seminar involving nurses from public and private hospitals around Dublin. The seminar, sponsored by Roche Pharmaceuticals, focused on wellbeing, professional development, leadership and healthcare law.

Pictured at the seminar were (l-r): *Pat Divilly; Pierre-Alain Delley, general manager, Roche Ireland; Gearóid Hardy; Theresa Atkinson, hospital sales specialist, Roche; and Rosemary Wilson*

Accountability

Nurse and barrister Rosemary Wilson, who practises healthcare law in Ireland and Northern Ireland, presented at the seminar and highlighted the value of diligent record-keeping. She also spoke about the importance of accountability in nursing.

She said: "As nurses we are accountable to our regulatory bodies, our employers, our patients and to society. But besides all that, we are also accountable to ourselves."

Leadership

Also speaking at the conference, business coach and lecturer Gearóid Hardy highlighted leadership as a key area of focus for nurses. He discussed some of the issues that can arise in challenging work environments and how nurses are well placed to take the lead in addressing them.

Resilience

Fitness expert Pat Divilly presented on the importance of nurses/midwives looking after their own wellbeing as well as the wellbeing of their patients. He emphasised the correlation that exists between self care and work performance, and how personal resilience can be built up over time through exercise and recovery.

Also speaking at the conference, Roche Ireland general manager, Pierre-Alain Delley, said: "Roche is delighted to support nurses' careers by addressing some of the questions that they may have in terms of their personal career development.

"This event worked because the panel got to directly address their questions, and it also gave us an opportunity to better understand some of challenges facing nurses on a daily basis."

Bon Secours Cork conference focuses on importance of mindfulness

Pictured at the Bon Secours Cork conference, 'Building Resilience Through Mindfulness', in conjunction with UCC, were (l-r): *Siobhán Dowling, director of nursing, Bon Secours Tralee; Harry Canning, GM, Bon Secours Cork; Ber Mulcahy, director of nursing, Bon Secours Cork; and Fiona Murphy, director of nursing, Bon Secours Dublin*

Afternoon tea at the Richmond

Attendees at the Food Fleadh pictured outside The Richmond

AS PART of this year's Food Fleadh and Busker Festival in Smithfield and Stoneybatter, the INMO hosted a complimentary afternoon tea and tour on Friday, September 13 at the Richmond Education and Event Centre. The event was well attended by members, local businesses and friends of the INMO. It was thoroughly enjoyed by all.

October

Saturday 12
PHN Section meeting. Richmond Education and Event Centre. 11am

Saturday 12
Community RGN Section meeting. Richmond Education and Event Centre. 11am

Saturday 12
CNM CMM Section meeting, following the study day

Sunday 13
International Section gala night. Crowne Plaza Hotel, Blanchardstown, Dublin
Email: yemijeggy@yahoo.co.uk for further details

Thursday 17
All Ireland Midwifery Conference City Hotel, Armagh, See *page 54* for further details

Thursday 17
Student Allocation Liaison Officers meeting. INMO HQ. 12pm

Friday 18
Third Level Student Health Section meeting. Richmond Education and Event Centre. 11am

Wednesday 30
Directors of Nursing and Midwifery and Assistant Directors of Nursing and Midwifery Section members masterclass. Richmond Education and Event Centre. See *page 9* for further details

November

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

Thursday 21
OHN Section conference. Richmond Education and Event Centre. See *page 64* for further details

Wednesday 27
CPC Section meeting. Richmond Education and Event Centre

Wednesday 27
CPC Section meeting. Richmond Education and Event Centre

Saturday 30
ODN Section conference. Richmond Education and Event Centre. See *page 22* for further details

Saturday 30
PHN Section meeting. Richmond Education and Event Centre

Saturday 30
Community RGN Section meeting. Richmond Education and Event Centre

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

INMO Membership Fees 2019

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