€5.75 Vol 29 No 8 October 2021

WIN

Journal of the
Irish Nurses and
Midwives Organisation

World of Irish Nursing & Midwifery

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Aiming high

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Up to 4 sprays per hour may be used. Do not exceed 2 sprays per dosing episode and do not exceed 64 sprays (4 sprays per hour, over 16 hours) in any 24-hour period. **Step I: Weeks 1-6:** Use 1 or 2 sprays when cigarettes normally would have been smoked or if cravings emerge. If after a single spray cravings are not controlled within a few minutes, a second spray should be used. If 2 sprays are required, future doses may be delivered as 2 consecutive sprays. Most smokers will require 1-2 sprays every 30 minutes to 1 hour. **Step II: Weeks 7-9:** Start reducing the number of sprays per day. By the end of week 9 subjects should be using HALF the average number of sprays per day that was used in Step I. **Step III: Weeks 10-12:** Continue reducing the number of sprays per day so that subjects are not using more than 4 sprays per day during week 12. When subjects have reduced to 2-4 sprays per day, oromucosal spray use should be discontinued. To help stay smoke free after Step III, subjects may continue to use the oromucosal spray in situations when they are strongly tempted to smoke. One spray may be used in situations where there is an urge to smoke, with a second spray if one spray does not help within a few minutes. No more than four sprays per day should be used during this period. Regular use of the oromucosal spray beyond 6 months is generally not recommended. Some ex-smokers may need treatment with the oromucosal spray longer to avoid returning to smoking. Any remaining oromucosal spray should be retained to be used in the event of sudden cravings. *Paediatric population:* Do not administer this medicine to persons under 18 years of age. There is no experience of treating adolescents under the age of 18 with this medicine. Method of administration: After priming, point the spray nozzle as close to the open mouth as possible. Press firmly the top of the dispenser and release one spray into the mouth, avoiding the lips. Subjects should not inhale while spraying to avoid getting spray into the respiratory tract. For best results, do not swallow for a few seconds after spraying. Subjects should not eat or drink when administering the oromucosal spray. Behavioural therapy advice and support will normally improve the success rate. **Contraindications:** Hypersensitivity to nicotine or to any of the excipients. Children under the age of 18 years. Those who have never smoked. **Special warnings and precautions for use:** This medicine should not be used by non-smokers. The benefits of quitting smoking outweigh any risks associated with correctly administered nicotine replacement therapy (NRT). A risk-benefit assessment should be made by an appropriate healthcare professional for patients with the following conditions: *Cardiovascular disease: Dependent smokers with a recent myocardial infarction, unstable or worsening angina including Prinzmetal's angina, severe cardiac arrhythmias, recent cerebrovascular accident and/or who suffer with uncontrolled hypertension* should be encouraged to stop smoking with non-pharmacological interventions (such as counselling). If this fails, the oromucosal spray may be considered but as data on safety in this patient group are limited, initiation should only be under close medical supervision. *Diabetes Mellitus*. Patients with diabetes mellitus should be advised to monitor their blood sugar levels more closely than usual when smoking is stopped and NRT is initiated as reduction in nicotine induced catecholamine release can affect carbohydrate metabolism. *Allergic reactions*: Susceptibility to angioedema and urticaria. *Renal and hepatic impairment:* Use with caution in patients with moderate to severe hepatic impairment and/or severe renal impairment as the clearance of nicotine or its metabolites may be decreased with the potential for increased adverse effects. *Phaeochromocytoma and uncontrolled hyperthyroidism:* Use with caution in patients with uncontrolled hyperthyroidism or phaeochromocytoma as nicotine causes release of catecholamines. *Gastrointestinal Disease:* Nicotine may exacerbate symptoms in patients suffering from oesophagitis, gastric or peptic ulcers and NRT preparations should be used with caution in these conditions. Paediatric population: *Danger in children*: Doses of nicotine tolerated by smokers can produce severe toxicity in children that may be fatal. Products containing nicotine should not be left where they may be handled or ingested by children. *Transferred dependence:* Transferred dependence can occur but is both less harmful and easier to break than smoking dependence. *Stopping smoking:* Polycyclic aromatic hydrocarbons in tobacco smoke induce the metabolism of drugs metabolised by CYP 1A2 (and possibly by CYP 1A1). When a smoker stops smoking, this may result in slower metabolism and a consequent rise in blood levels of such drugs. This is of potential clinical importance for products with a narrow therapeutic window, e.g. theophylline, tacrine, clozapine and ropinirole. The plasma concentration of other medicinal products metabolised in part by CYP1A2 e.g. imipramine, olanzapine, clomipramine and fluvoxamine may also increase on cessation of smoking, although data to support this are lacking and the possible clinical significance of this effect for these drugs is unknown. Limited data indicate that the metabolism of flecainide and pentazocine may also be induced by smoking. *Excipients:* The oromucosal spray contains small amounts of ethanol (alcohol), less than 100 mg per dose (1 or 2 sprays). This medicinal product contains less than 1 mmol sodium (23 mg) per spray, i.e. essentially 'sodium- free'. This medicine contains 12 mg propylene glycol in each spray which is equivalent to 150 mg/mL. Due to the presence of butylated hydroxytoluene, Nicorette QuickMist may cause local skin reactions (e.g. contact dermatitis), or irritation to the eyes and mucous membranes. Care should be taken not to spray the eyes whilst administering the oromucosal spray.**Undesirable effects:** Effects of smoking cessation: Regardless of the means used, a variety of symptoms are known to be associated with quitting habitual tobacco use. These include emotional or cognitive effects such as dysphoria or depressed mood; insomnia; irritability, frustration or anger; anxiety; difficulty concentrating, and restlessness or impatience. There may also be physical effects such as decreased heart rate; increased appetite or weight gain, dizziness or presyncopal symptoms, cough, constipation, gingival bleeding or apthous ulceration, or nasopharyngitis. In addition, and of clinical significance, nicotine cravings may result in profound urges to smoke. This medicine may cause adverse reactions similar to those associated with nicotine given by other means and these are mainly dose-dependent. Allergic reactions such as angioedema, urticaria or anaphylaxis may occur in susceptible individuals. Local adverse effects of administration are similar to those seen with other orally delivered forms. During the first few days of treatment irritation in the mouth and throat may be experienced, and hiccups are particularly common. Tolerance is normal with continued use. Daily collection of data from trial subjects demonstrated that very commonly occurring adverse events were reported with onset in the first 2-3 weeks of use of the oromucosal spray, and declined thereafter. Adverse reactions with oromucosal nicotine formulations identified from clinical trials and during post-marketing experience are presented below. The frequency category has been estimated from clinical trials for the adverse reactions identified during post-marketing experience. Very common (≥1/10); common (≥1/100 to <1/10); uncommon (≥1/1 000 to <1/100); rare (≥1/10 000 to <1/1 000); very rare (<1/10 000); not known (cannot be estimated from the available data). **Immune system disorders** Common Hypersensitivity Not known Allergic reactions including angioedema and anaphylaxis **Psychiatric disorders** Uncommon Abnormal dream **Nervous system disorders** Very common Headache Common Dysgeusia, paraesthesia **Eye disorders** Not known Blurred vision, lacrimation increased **Cardiac disorders** Uncommon Palpitations, tachycardia Not known Atrial fibrillation **Vascular disorders** Uncommon Flushing, hypertension **Respiratory, thoracic and mediastinal disorders** Very common Hiccups, throat irritation Uncommon Bronchospasm, rhinorrea, dysphonia, dyspnoea, nasal congestion, oropharyngeal pain, sneezing, throat tightness **Gastrointestinal disorders** Very common Nausea Common Abdominal pain, dry mouth, diarrhoea, dyspepsia, flatulence, salivary hypersecretion, stomatitis, vomiting Uncommon Eructation, gingival bleeding, glossitis, oral mucosal blistering and exfoliation, paraesthesia oral Rare Dysphagia, hypoaesthesia oral, retching Not known Dry throat, gastrointestinal discomfort, lip pain **Skin and subcutaneous tissue disorders** Uncommon Hyperhidrosis, pruritus, rash, urticaria Not known Erythema **General disorders and administration site conditions** Common Burning sensation, fatigue Uncommon Asthenia, chest discomfort and pain, malaise. **MAH:** Johnson & Johnson (Ireland) Limited, Airton Road, Tallaght, Dublin 24, Ireland. **PA Number:** PA 330/37/13. **Date of revision of text:** PA 330/37/13: May 2019. Product not subject to medical prescription. Full prescribing information available upon request.

IE-NI-2000032

On the cover this month:
Sarah Torrans, student nurse at DCU and on placement at Beaumont Hospital, Dublin

Photo credit: Naomi Carroll
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FEATURES

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JOBS & TRAINING

WIN – World of Irish Nursing & Midwifery is distributed by controlled circulation to **more than 40,000** members of the INMO. It is published monthly (10 issues a year) and is registered at the GPO as a periodical. Annual Subscription: €155 incl. postage paid. Editorial Statement: *WIN* is produced by professional medical journalists working closely with individual nurses, midwives and officers on behalf of the INMO. Acceptance of an advertisement or article does not imply endorsement by the publishers or the Organisation.

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Breastfeeding: The best start

Health benefits for infants

Breast milk is the ideal food for newborns and infants. It gives them all the nutrients they need for healthy development. It is safe and contains antibodies that help protect infants from common childhood illnesses such as diarrhoea and pneumonia, the two primary causes of child mortality worldwide. Breast milk is readily available and affordable, which helps to ensure that infants get adequate nutrition.

Long-term benefits for children

Beyond the immediate benefits for children, breastfeeding contributes to a lifetime of good health. Adolescents and adults who were breastfed as babies are less likely to be overweight or obese. They are less likely to develop type 2 diabetes and perform better in intelligence tests.

Benefits for mothers

Breastfeeding also benefits mothers. It reduces risks of breast and ovarian cancer later in life, helps women return to their pre-pregnancy weight faster, and lowers rates of obesity.

Support for mothers is essential

Breastfeeding has to be learned and many women encounter difficulties at the beginning. Nipple pain, and fear that there is not enough milk to sustain the baby are common. Health facilities that support breastfeeding – by making trained breastfeeding counsellors available to new mothers – encourage higher rates of breastfeeding. To provide this support and improve care for mothers and newborns, there are 'baby-friendly' facilities in about 152 countries thanks to the WHO-UNICEF Baby-friendly Hospital initiative.

Work and breastfeeding

Many mothers who return to work abandon breastfeeding partially or completely because they do not have sufficient time, or a place to breastfeed, express and store their milk. Mothers need a safe, clean and private place in or near their workplace to continue breastfeeding. Enabling conditions at work, such as paid maternity leave, part-time work arrangements, on-site crèches, facilities for expressing and storing breast milk, and breastfeeding breaks, can help.

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For more information log onto www.breastfeeding.ie

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

(ISSN: 2009-4264)
Volume 29 Number 8
October 2021

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

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Lessons for Ireland from the US

THE future of affordable and accessible healthcare in Ireland remains in the balance. Sláintecare set a 10-year plan for achieving universal healthcare in Ireland. It was the beacon for real change in our health service. That early hope, positivity and excitement has now been replaced by disappointment, cynicism and frustration. Sláintecare has always been an ambitious plan. Even though it was developed with all party-political consensus, early indications were that government support was lukewarm.

At the outset a major recommendation was ignored – that the implementation office be based in the Taoiseach's department. That was a red flag, suggesting that this was going to be 'reform lite'. If the Taoiseach was not willing to lead it from his department, the rhetoric of reform may not be matched by reality.

I want to compare two very different health systems: those of the US and Ireland. While distinct, both face a common challenge – the need for major reform. I have worked as a nurse in both systems and from looking at the US experience, we can see lessons to be learned in Ireland.

The key question, common to both countries, is why would a plan to reform and improve our health service not be fully supported? Who would benefit from Sláintecare reform? We need to look at the current ability to bypass waiting lists, gain access to consultant-level care provided by private health insurance to fully understand this. We also need to consider how the tax changes needed to fund Sláintecare would be viewed by those who do not currently face access or waiting list problems. Those are often cohorts with strong political lobbying power.

Not unlike the issues debated and the Affordable Care Act (ACA, but sometimes called Obamacare) in the US, the debate reflected the difference between those who do not need the reforms and those who do. Research carried out in the US found that poor American families were primarily uninsured for reasons of cost or job loss. Those who were uninsured were more likely to die, less likely to have care outside of the emergency department and would delay care or go without it entirely. We often see a similar story in Ireland. Both reform programmes are different, but both aim to change problems disproportionately affecting the poorer in society and those who could not afford to have health insurance.

The ACA was signed into law by President Obama in 2010 – and upheld by a later Supreme Court ruling. The percentage of uninsured Americans dropped from 18% to 10% between 2010 and 2018. The legislative underpinning of the ACA has withstood attacks from right-wing Republicans including President Trump.

What this demonstrates is that the initial buy in is imperative to success. Like the NHS in the UK, universal healthcare is often controversial when proposed, but remarkably popular once implemented.

Sláintecare has a broad agenda of reform. It proposed to increase capacity, remove private beds from public hospitals, and to build three major standalone acute elective hospitals. It has also promised to increase inpatient beds and develop primary care and care delivery outside of the hospital setting to ensure better use of acute hospital beds. That is a broader agenda than Obamacare. But similar to the US, it takes on a powerful insurance industry and many entrenched interests. It aims to mandate conditions, quality of care and a human-rights approach to healthcare access.

In Ireland we must underpin Sláintecare reforms with legislation. For example, having a legislative requirement for a funded-workforce plan. That kind of change requires political will. It requires the return to the original all-party consensus and it requires big taxation changes to create the health fund to ensure change occurs. It also needs the courage of the Taoiseach of the day to back it by action – taking the implementation into their own office and showing real leadership and determination.

Phil Ní Sheaghdha
General Secretary, INMO

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If you have any queries in relation to the above, please contact:

Catherine Hopkins or Karen McCann, INMO Information Officers,
Tel: 01 664 0610 or 01 664 0619
email: catherine.hopkins@inmo.ie or karen.mccann@inmo.ie

A positive focus with the president

Karen McGowan, INMO president

Tough times ahead

AS WE head into the winter months all talk is around the winter plan. We all know that we are in for a tough time, plan or no plan. The health service is at a critical point and Covid-19 brings such uncertainty into the equation. The recent resignations from Sláintecare are regrettable but there is no smoke without fire. We need to see real commitment from government in relation to the future of Sláintecare. Despite all of this, members are going to work and in most areas they are having to work short. I urge you all to protect yourselves, sign the disclaimer, contact your IRE/IRO and get the support that is there for you as members of the INMO. On a related note, interest in health and safety rep courses is increasing, which is extremely positive.

Diverse role of an ANP in older adult care

THIS month I spoke with Oliver O'Halloran, advanced nurse practitioner (ANP) in older adults at Mid-West Community Healthcare. I was amazed that one ANP had such a diverse role practising across community and acute care. His knowledge, experience and passion for his role is inspiring.

Oliver O'Halloran, ANP in older adult care at Mid-West Community Healthcare

Mr O Halloran works with two different teams, the first being the older adults integrated care team, which is a specialist interdisciplinary consultant geriatrician-led team. This involves ANP intervention for frail older adults over the age of 75 in the community. The skill set required is a broader one, so it enables a full assessment of needs with complex co-morbidities and provision of ANP intervention. The second team is an older adult rehabilitation team. This involves the assessment of older adults who have been referred for in-patient rehabilitation consideration in a specialist unit. This role involves assessment of a patient's medical readiness for transfer and understanding the patient's rehabilitation potential, working closely with hospital and the specialist rehabilitation unit. Mr O'Halloran works closely with his older adult ANP colleagues within UL Hospitals Group. The older adult ANP team consists of an ANP older adult in dementia, syncope and stroke/TIA and an ANP older adult frailty.

He takes pride in the ANP team and the achievements of the syncope and stroke/TIA ANPs in setting up the first nurse-led service in the Republic of Ireland to insert implantable cardiac loop recorder devices. "This was a massive undertaking for them and they deserve the recognition for establishing this innovative nursing service," he told *WIN*.

Mr O'Halloran believes that the future is bright for ANP development in community and integrated care and explains that there will be three integrated care teams in Mid-West Community Healthcare based in Ennis, Thurles and Limerick, with a full HSCP team including clinical nurse specialist and caseload manager (CNM2), but most importantly there will be an ANP allocated to each team.

"In my 29 years as a nurse I have seen a sea change in the development of the profession which is unrecognisable from when I started nursing. It's such a positive thing". He explains that the development of older adult ANP practice requires the professional governance of a progressive director of nursing team, assisted by NMPDU professional officers and the continued clinical support and supervision of the consultant geriatrician team," he said.

Executive Council update

THE Executive Council met virtually once again this month. Future meetings were discussed and, in line with guidelines, we hope to resume in-person meetings from November. The work of the Executive Council has been carried out successfully throughout the pandemic via online platforms but there is no substitute for in-person discussions and debates. I look forward to meeting all existing and new members in due course.

The recent visit to the Labour Court with our compensation claim was discussed and at time of going to print we have not yet received a recommendation. Please keep note of emails from INMO for updates.

Nationally, there are major issues in relation to short staffing, redeployment and overcrowding. The Executive Council discussed our respective areas, specifically in relation to overcrowding and short staffing. In some areas members are progressing to protest stage and we considered how best to support members in these problem areas. A full report was also received from each of the IROs and IREs.

The next few months will see the ICTU biennial delegates conference in Belfast. The INMO will be submitting a motion on violence against healthcare workers. Future conferences via online format include the EFN and ICN conferences in October and November.

The psychological survey of members survey is now being analysed and we look forward to seeing the results. There are a number of other surveys being conducted on menopause, CRGN and RNID. Reports will be issued over the next month.

The next Executive Council meeting will take place on October 11 and 12.

If you would like to showcase your nurse-led initiative or role, please get in touch by email to: president@inmo.ie

Get in touch

You can contact me at INMO HQ at Tel: 01 6640 600 or by email to: president@inmo.ie

World news

Nurses and midwives in action around the world

Australia
- Melbourne nurses call on Premier for Covid-19 payment, citing 'dire' conditions
- 'Grave concerns': South Australia nurses working double shifts and unpaid overtime

Canada
- Canada was already desperately short of nurses before Covid-19. Now nurses say they're hanging on by a thread
- Wage premium for nurses hasn't solved staff shortage
- Canadian nurses to hold day of action

Italy
- Nurse suspensions and block on hiring risk service stoppages in hospitals

New Zealand
- 'It's a relief': Hospital midwives settle pay talks, NZNO nurses set to vote on new offer

Portugal
- Nurses display messages of support from Portuguese public in front of the Ministry of Health

South Korea
- Unionised nurses urge Seoul city to address staff shortage amid prolonged pandemic

UK
- Most NHS staff vote to oppose 3% pay rise as union warns workers 'fed up'
- RCN members brand 3% pay deal 'unacceptable', consultation reveals

US
- 'Most days I want to break down and cry': nurses share pandemic frustrations
- Some elective surgeries on hold as hospitals face staffing crisis

The Taoiseach must take responsibility for the full implementation of Sláintecare which has been left to stumble along for the past six years, writes **Dave Hughes**

Sláintecare hits the rocks with high level resignations

THE INMO, in its pre-budget submission, has called on Taoiseach Micheál Martin to take control and responsibility for the implementation of the Sláintecare health reform programme.

When launched, Sláintecare and its support by all political parties was acclaimed by the World Health Organization as a model for governments to move with consensus to universally accessible healthcare.

It was always indicated that Sláintecare would reside in the Department of the Taoiseach as a major strategic programme of national interest.

Allocating it to the Department of Health was like giving control back to the entity which most needed to change its ways. That the chair of Sláintecare, Prof Tom Keane, and the executive director, Laura Magahy, felt they had to resign may have been inevitable from the outset, given the delegation away from Taoiseach's department to Department of Health.

The subsequent resignation of Prof Geraldine McCarthy, of the UCC school of Nursing and Midwifery, from her role as chair to the South-Southwest Hospital group, meant that politically Sláintecare had hit the rocks. Whether it can be rescued will depend on political leadership.

So, what unfulfilled promise for 2021-2022 signalled to these highly reputable and committed leaders that they were on a fool's errand and had no choice but to resign?

The new Sláintecare Implementation Strategy and Action Plan 2021-2023 was published on May 11 and last updated on June 17, 2021. It identifies €1,235 billion additional spending in the 2021 budget dedicated to Sláintecare, €136 million of which is to be allocated to capital spending.

The strategic plan is a series of projects, with parts of each project identified to happen in each quarter of the year. Yet the plan itself was only published halfway through the year. This begs the question as to whether it is a plan or a checklist of actions already in progress with or without reference to their relevance to the Sláintecare programme.

The additional monies are earmarked against, for example, the implementation of the 2018 bed capacity review, enhanced community services, additional home help hours described as "social care expansion" and the implementation of outstanding expert reviews of which there are many, including the cancer strategy, the women's health taskforce, the maternity strategy, the safe staffing framework and the expert review report arising from the Covid-19 outbreaks in private nursing homes.

In resigning, Prof Keane cited that the requirements for implementing the unprecedented programme for change were seriously lacking.

Prof McCarthy in her resignation from a hospital group comprising 10 hospitals was more specific, she said: "When I commenced this role over six years ago, there was excitement and hope among clinicians and managers for a more devolved, modern and equitable health service. Despite the excellent care delivered at the frontline by committed staff, it is regrettable that much of the needed reform of the health service has not been delivered.

"This includes the establishment of regional health authorities with autonomy over decisions, budgets and capital spend. It also includes free GP services for all and elective hospitals to address waiting lists and ensure rapid and equitable access to services.

"I have waited for a long time for developments led by successive ministers for health and government. However, recent information and my own experiences tell me we are no nearer to the required reform than we were six years ago."

In its pre-budget submission 2022, the INMO has called for the required leadership to come from the very top of government. Sláintecare cannot be allowed to become the titanic of the first ever cross-party agreement on how to deliver universal, publicly available healthcare. We deserve better.

Dave Hughes is INMO deputy general secretary

See also INMO pre-budget submission 2022 on page 10

INMO Executive Council demands urgent action on Sláintecare

THREE high-level resignations over a lack of progress on Sláintecare health reforms are causing "huge concern" among nurses and midwives, the INMO Executive Council has warned.

The Executive Council said that the resignations required a "clear government recommitment at the level of Taoiseach" to the Sláintecare reform package.

The resignations came from Prof Tom Keane, chair of the Sláintecare Implementation Advisory Council; Laura Magahy, executive director, Sláintecare; and Prof Geraldine McCarthy, chair, South/South-west Hospital Group, who all cited a lack of reform of the health services as the reason for their resignations.

The INMO Executive Council also conveyed to government its alarm at the increased numbers of patients on trolleys following a day that saw 464 patients go without beds – the highest since the pandemic began and more than double what it was at the same time last year.

The union warned that the health service was rapidly returning to the "bad old days of overcrowding" and said it was further reason for the government to prioritise the Sláintecare health reforms.

The INMO has called on the Taoiseach to intervene to secure Sláintecare's future and has asked the Oireachtas Health Committee to urgently convene on this matter.

INMO president Karen McGowan said: "The health service is rapidly returning to the bad old days of overcrowding. Trolley figures are being permitted to grow and grow.

"Many of my colleagues across the country are feeling utterly unsupported in their workplace, with no sense that much-needed health service reforms are supported by government. The government need to seriously recommit to Sláintecare. We cannot lose the momentum for health service reform."

INMO general secretary Phil Ní Sheaghdha said: "The government needs to show they mean business on Sláintecare. These three resignations are a huge concern. It's time for direct intervention from the Taoiseach. We also need to see the Oireachtas Health Committee urgently reconvene.

"Sláintecare is a good plan – agreed by all parties. The high-level resignations indicate that government is not prioritising reform. After everything we have gone through with Covid, Ireland's healthcare team and patients deserve commitment to real change."

The INMO also joined with its fellow members of the ICTU Health Sector Group, which represents workers across the health sector, in a call for:

- The Oireachtas Health Committee to be reconvened to look into the resignations
- The Minister for Health to clearly renew his commitment to the Sláintecare project
- A commitment to transition funding for Sláintecare in the upcoming budget
- A return to the original principles of the Sláintecare plan, including basing the project office in the Department of the Taoiseach and the creation of regional authorities.

National Services Day honours frontline workers

THE INMO was honoured to represent nurses and midwives at the National Services Day ceremony last month at Collins Barracks, Dublin.

This event is held annually on the first Sunday of September to pay tribute to the work of frontline services, including nurses and midwives, the gardaí, fire and ambulance services, the coastguard and the civil defence.

This year the ceremony paid homage to frontline workers who lost their lives during the pandemic.

INMO president Karen McGowan and general secretary Phil Ní Sheaghdha attended the commemoration ceremony on behalf of the Organisation.

Ms McGowan said: "The sacrifice and ongoing contributions of nurses, midwives and all healthcare workers must never be forgotten. We stand with all those who have lost loved ones to Covid-19 and remember all those who lost their lives caring for others."

National Services Day:
Pictured at the commemoration ceremony with Dublin Lord Mayor Alison Gilliland (left) were INMO general secretary Phil Ní Sheaghdha and INMO president Karen McGowan (right)

As well as at Collins Barracks in Dublin, wreath-laying ceremonies were held around the country in Galway, Cork, Waterford, Wexford, Monaghan and Donegal to commemorate service workers who have passed away and for those who died during the Covid-19 pandemic.

A 'Parade of Light' took place on the streets of Dublin city early in the morning. A fleet of 60 vehicles from various frontline and voluntary services, including Dublin Fire Brigade, the Gardaí and the Civil Defence, took part in the parade.

INMO sets priorities for Budget 2022

Clear actions needed to cure ills affecting the health service

A KEY element of the INMO's pre-budget submission for 2022 is the dire need for a funded workforce plan for the health services. The union stressed the need for the government to commit to immediately grow the nursing and midwifery workforce by a minimum of 2,000 posts each year for the next three years.

In its submission to the Department of Public Expenditure and Reform, the INMO called for investment under the funded implementation of Sláintecare and the 2019 strike settlement deal, across the themes of protections for frontline workers, workforce planning – including recruitment and retention, and health service capacity.

The submission said that with a slow economic recovery on the horizon the focus of the 2022 budget must be on developing an inclusive, universal healthcare system incorporating global health security underpinned by a rights-based approach and an appropriate level of funding, with nurses and midwives playing an essential role.

The INMO called for significant action on the implementation of the Sláintecare report recommendations including the commencement of the multiannual transitional fund to support investment. It highlighted the blockages to strategies such as the Safe Staffing Framework and the National Maternity Strategy caused by allocating funding on an annual basis.

The INMO also called for the up-front investment required to run pilot programmes that will ultimately create significant cost savings to the health service. With specific regard to maternity care, the Organisation said that funding must be prioritised for full implementation of the Maternity Strategy, putting an end to the shortage of midwives and other health professionals to ensure the delivery of safe care across a fuller range of maternity services.

As part of the Sláintecare implementation, the INMO also called for strict adherence to 85% occupancy of acute hospitals and zero tolerance of hospital and emergency overcrowding, making reference to the steep rise in trolley and overcrowding figures across acute services. It also raised the requirement for funding and planning to ensure acute only hospitals are fast tracked and provide 24/7 acute care, as set out under Sláintecare.

Noting that 82% of long-term care is delivered via the private sector, the INMO also called for a single source of funding for care of older person services, with funding allocated to the next phase of the safe staffing framework to extend to these services.

2019 strike settlement

In terms of completing the implementation of the 2019 strike settlement, the INMO has called for correction of nursing and midwifery managers' pay, and new staff to be recruited directly to the enhanced practice scale.

Safe staffing

The submission also called on the government to honour the commitment to fully fund the rollout of the safe staffing framework over three years to meet the deadline for implementation by 2022. It stated that an allocation of €15 million a year is needed to support this rollout and completion of the nurse staffing framework in all acute hospitals for 2022-2025.

With regard to safe staffing and capacity, the INMO also highlighted the risk to recruitment and retention caused by burnout, excessive workload and conditions exacerbated by the Covid-19 pandemic.

Referring to INMO surveys conducted during 2020 and 2021, the INMO pointed out a worrying increase in the number of respondents stating their intention to leave the professions of nursing and midwifery, posing a further significant threat to the staffing levels across the health service.

As part of its call for recruitment and training, the INMO also proposed an increase of 250 undergraduate places each year as well as an increase in postgraduate places, with a particular need to match proposed essential increases in intensive care and high dependency unit beds with appropriate increases in qualified staff.

The union also called for funding for appropriate cover

for staff absences owing to Covid-19, long Covid and other illness, as well as statutory maternity and parental leave.

With regard to the Covid-19 pandemic, the INMO made clear that continued protection is still needed for nurses and midwives working on the frontline, including adequate levels of the most appropriate personal protective equipment, such as vital FFP3 masks needed to reduce the risk of infection to healthcare workers.

The INMO said there was clear evidence of extensive burnout and exhaustion caused by stress over health and safety, excessive workload, understaffing and inadequate resources, and called for measures to support nurses and midwives who were affected by Covid-19 or who required additional support, including occupational health and mental health supports.

The Organisation also called for measures to support the estimated 500-600 staff who will be affected by the post Covid syndrome or long Covid.

– Beibhinn Dunne

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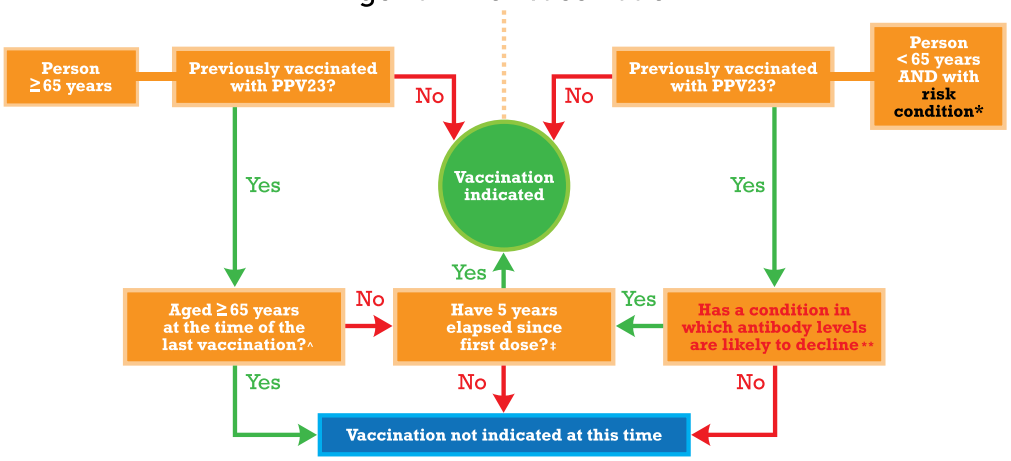
Pneumococcal disease is a very serious disease

Those with the following conditions should be vaccinated with PPV23[1]

Everybody aged 65 years and over Also those aged over 2 years with;

- Diabetes mellitus
- Chronic heart, respiratory or liver disease
- Chronic renal disease, nephrotic syndrome,renal transplant
- Sickle cell disease
- Those with missing or non functioning spleens
- Disorders of the immune system including cancer
- People receiving chemotherapy or other treatments that suppress the immune system
- Persons with HIV infection or AIDS
- Those who have received or are about to receive cochlear transplants

Pneumococcal Polysaccharide Vaccine (PPV23) Algorithm for Vaccination



* Asplenia or splenic dysfunction (splenectomy, sickle cell disease, coeliac syndrome); chronic renal, heart, lung, liver disease, diabetes mellitus, complement deficiency, immunosuppressive conditions; CSF leak, cochlear implant recipients or candidates for implants; children < 5 years with history of invasive disease.

^ Revaccination not indicated for any person who has received a dose of PPV23 at age ≥65 years.

‡ If vaccination has been given during chemotherapy or radiotherapy revaccination 3 months after treatment is indicated.

** Those with no spleen, with splenic dysfunction, immunosuppression including HIV infection, nephrotic syndrome, renal transplant or chronic renal disease.

Algorithm provided by National Immunisation Office[1]

Brought to you by PNEUMOVAX®23 Now in pre filled syringe presentation

(pneumococcal vaccine, polyvalent, MSD)

Supported by MSD

PNEUMOVAX® 23 solution for injection in pre-filled syringe. Pneumococcal Polysaccharide Vaccine.
ABRIDGED PRODUCT INFORMATION Refer to Summary of Product Characteristics before prescribing. **PRESENTATION** PNEUMOVAX 23 is supplied as a single Pre-filled syringe (0.5 mL) with 2 needles. Each dose contains 25 micrograms of each of 23 different polysaccharides of Streptococcus pneumoniae. **INDICATIONS** For active immunisation against pneumococcal disease in children aged from 2 years, adolescents and adults. Refer to SPC section 5.1 for information on protection against specific pneumococcal serotypes. **DOSAGE AND ADMINISTRATION** *The immunisation schedules for PNEUMOVAX 23 should be based on official recommendations. Primary vaccination:* Adults and children 2 years of age or older - one single dose of 0.5 millilitre by intramuscular or subcutaneous injection. Not recommended for use in children below 2 years of age. *Special dosing:* It is recommended that pneumococcal vaccine is given at least two weeks before elective splenectomy or the initiation of chemotherapy or other immunosuppressive treatment. Vaccination during chemotherapy or radiation therapy should be avoided and the vaccine should not be administered any sooner than three months after completion of such therapy. Persons with asymptomatic or symptomatic HIV infection should be vaccinated as soon as possible after diagnosis is confirmed. *Revaccination:* Healthy adults and children should not be revaccinated routinely. Revaccination at intervals of less than three years is not recommended because of an increased risk of adverse reactions. Revaccination may be considered for adults at increased risk of serious pneumococcal infection who were given pneumococcal vaccine more than five years earlier or for those known to have rapid decline in pneumococcal antibody levels. Revaccination after 3 years may be considered for selected populations (e.g. asplenics) who are known to be at high risk of fatal pneumococcal infections and for children from 2 to 10 years old at high risk of pneumococcal infection. **CONTRAINDICATIONS** Hypersensitivity to the active substance(s) or to any of the excipients. **PRECAUTIONS AND WARNINGS** As with any vaccine, adequate treatment provisions including epinephrine (adrenaline) should be available for immediate use should an acute anaphylactic reaction occur. Vaccination should be delayed in the presence of significant febrile illness, other active infection or when a systemic reaction would pose a significant risk, except where delay involves greater risk. The vaccine should never be injected intravascularly; precautions should be taken to make sure the needle does not enter a blood vessel. The vaccine should not be injected intradermally as injection by that route is associated with increased local reactions. If the vaccine is administered to patients who are immunosuppressed due to either an underlying condition or medical treatment (e.g. immunosuppressive therapy), the expected serum antibody response may not be obtained after a first or second dose, so such patients may not be as well protected against pneumococcal disease as immunocompetent individuals. Required prophylactic pneumococcal antibiotic therapy should not be stopped after vaccination. Patients at especially increased risk of serious pneumococcal infection (e.g., asplenics and those who have received immunosuppressive therapy), should be advised regarding the possible need for early antimicrobial treatment in the event of severe, sudden febrile illness. The vaccine may not be effective in preventing infection resulting from basilar skull fracture or from external communication with cerebrospinal fluid. As with any vaccine, vaccination with PNEUMOVAX 23 may not result in complete protection in all recipients. **INTERACTIONS** Pneumococcal vaccine can be administered simultaneously with influenza vaccine as long as different needles and injection sites are used. The concomitant use of PNEUMOVAX 23 and ZOSTAVAX resulted in reduced immunogenicity of ZOSTAVAX in a small clinical trial. However, data collected in a large observational study did not indicate increased risk for developing herpes zoster after concomitant administration of the two vaccines. **PREGNANCY AND LACTATION** The vaccine should not be used during pregnancy unless clearly necessary (the potential benefit must justify any potential risk to the fetus). It is unknown whether this vaccine is excreted in human milk. Caution should be exercised when it is administered to a nursing mother. The vaccine has not been evaluated in fertility studies. **SIDE EFFECTS** *Very common side effects:* Fever and injection site reactions such as pain, soreness, erythema, warmth, swelling and induration. Other reported side effects that may potentially be serious include thrombocytopenia in patients with stabilised idiopathic thrombocytopenic purpura, haemolytic anaemia in patients who have had other haematologic disorders, leukocytosis, anaphylactoid reactions, serum sickness, angioneurotic oedema, Guillain-Barré Syndrome, radiculoneuropathy, febrile convulsions and injection site cellulitis. For a complete list of undesirable effects please refer to the Summary of Product Characteristics. **PACKAGE QUANTITIES** Single pack containing one 0.5 mL dose pre-filled syringe with two separate needles. **Legal category:** POM. **Marketing authorisation number:** PA 1286/055/002. **Marketing Authorisation holder:** Merck Sharp & Dohme Ireland (Human Health) Limited, Red Oak North, South County Business Park, Leopardstown, Dublin 18, Ireland. **Date of revision:** November 2019. Further information is available on request from: MSD, Red Oak North, South County Business Park, Leopardstown, Dublin 18 D18 X5K7 or from www.medicines.ie. **Date of preparation:** July 2020. WS064

Adverse events should be reported. Reporting forms and information can be found at www.hpra.ie
Adverse events should also be reported to MSD (Tel: 01-299 8700)

Reference
1. http://www.hse.ie/eng/health/immunisation/pubinfo/adult/pneumo/

MSD Red Oak North, South County Business Park, Leopardstown, Dublin 18, D18X5K7 Ireland

IE-PNX-00025

INMO director of industrial relations Tony Fitzpatrick updates members

Unions set out case for pandemic recognition to Labour Court

ON September 13, 2021, the INMO and other health sector trade unions argued their case before the Labour Court for special recognition for the extraordinary efforts of healthcare workers during the Covid-19 pandemic.

At time of going to print we are awaiting the outcome and publication of the Labour Court recommendation. Please look out for an update by email in the next notice to members.

The INMO has argued since November 2020 that the HSE needs to provide special recognition in the form of compensation to healthcare workers. The Organisation lodged a claim in November 2020 for 10 days annual leave for nurses and midwives. Throughout the discussions with the HSE since then the union has stressed the requirement for special recognition based on the extraordinary efforts of nurses and midwives in responding to the global health pandemic.

As well as outlining the clear case for recognition to the Labour Court, the unions argued that the failure of the HSE and the government to provide such recognition was unacceptable. It was for this reason that the unions sought that the Labour Court would impose strict timelines on engagement with the HSE to bring negotiations on the recognition of healthcare workers to a conclusion.

The unions outlined the fact that more than 30,000 healthcare workers have been infected with Covid-19, with many thousands still suffering the effects of long Covid. In addition to running a normal health service, healthcare workers established new services such as contact tracing, the largest vaccination programme in the history of the state and they had experienced an unprecedented cyber-attack earlier this year.

The unions outlined that any realistic risk assessment in respect of the impact in working in such hazardous and stressful conditions would identify fatigue and burnout as serious risks. This would require an emergency procedure and plan to prevent significant mental and physical damage to individuals arising from such stressful working conditions.

The unions outlined that the Biological Agents Code of Practice 2020 for employers and employees in specific types of workplace applied. Under this, where workers may be exposed to biological agents or exposed to humans infected with a group 3 biological agent, new law applies. Covid-19 is a category 3 biological agent.

The unions argued that over the course of the current Covid-19 pandemic, healthcare workers involved in direct patient care, have been required to work in a hazardous and stressful environment. Indeed, many of these health care workers have worked beyond end of shift time regularly and were often unable to avail of their breaks.

Additionally, many such staff have had to work excessive hours wearing personal protective equipment (PPE) for extended periods. Many lives have been lost to the disease and the emotional pressure on staff as a result is exceptional, even in terms of health service norms.

The stress and fear of bringing Covid-19 home to relatives is an additional burden and, in many cases, the pressure balancing childcare or other caring responsibilities in a situation where normal state supports had ceased, were significant and in some cases irreconcilable.

The unprecedented working conditions have added to the impact of Covid-19 on those working in the health services. It is clearly time for the HSE to act and engage immediately with the unions with regards to appropriate recognition of healthcare workers' efforts during the pandemic.

The INMO and health sector unions continue to exert pressure on the employer and on the government to act on this issue. At time of going to print, the Labour Court Recommendation was expected.

INMO argues case for nurses and midwives to be included in any booster vaccination programme

THE INMO met with the HSE on the need for inclusion of healthcare workers in any Covid-19 vaccination booster campaign, in a similar way to the initial rollout of vaccinations in January 2021.

The National Immunisation Advisory Committee (NIAC) and the CMO have advised their intention to roll out a third dose for those in a particular clinical category defined as "with an underlying health condition". The details of the criteria for this have not yet been provided.

In addition, the HSE is planning to introduce a booster vaccination programme for those aged over 80 years as well as over 65-year-olds living in long-term care facilities.

At a meeting with the HSE on September 15, the INMO argued that if there is going to be a prioritisation with regards to boosters, it is necessary that frontline healthcare workers such as nurses and midwives would be categorised appropriately to ensure that they have access to it also. The INMO understands that the European Medicines Agency has not approved the use of booster doses as yet, however, it is the intention of the HSE with the advice of the CMO and NIAC to proceed with boosters as above.

The INMO acknowledges the vaccine inequity worldwide and has joined with nursing and healthcare unions around the world in calling for the waiving of Intellectual Property rules regarding Covid-19 vaccines. It is essential that there is an equitable vaccine rollout across the globe and intellectual property rights must not stand in the way of this.

on recent national issues under discussion

Nurses/midwives must remain vigilant about Covid-19 risks in the workplace

THE INMO has been applying significant pressure on the Health Protection Surveillance Centre (HPSC) and the HSE to ensure detailed figures are provided on the number of healthcare workers infected by Covid-19.

The interim report of the profile of Covid-19 cases among healthcare workers in Ireland from August 15 to September 11, 2021 prepared by the HPSC is showing a worrying upward trend.

The number of infections in healthcare workers in that period was 1,670; 46.8% of that figure is made up of nurses and healthcare assistants. Almost one in four (24.7%) of these healthcare workers work in an acute hospital; nursing home HCWs were the next most infected (19.6%).

It is vitally important that nurses and midwives continue to take all necessary precautions to protect themselves in the workplace.

It has been well established that the Delta variant is much more transmissible than previous variants of Covid-19. It is also accepted that Covid-19 is spread by airborne transmission and therefore, it is vitally important that all protections required are maintained in the workplace.

Each individual nurse and midwife should be vigilant about whether their workplace is safe and that they have a high enough standard of masks. The INMO has argued at recent meetings with the HSE that FFP3 masks should be issued as standard to all nurses and midwives working on the frontline.

The INMO has consistently argued that the precautionary principle should be applied, ie. that employers put in place the maximum level of protection pending full evidence and information with regards to Covid-19.

We have also sought detailed reports from the HSE on healthcare facilities and their suitability for ensuring that patients and staff are protected. It is necessary, in older sites particularly, that appropriate monitoring of carbon dioxide levels is put in place and assessments are made with regards to airflow.

If members have any concerns about their workplace, they should seek a risk assessment by health and safety representatives or contact their local INMO official.

Talks on compensation ongoing following closure of St Brigid's

DISCUSSIONS are continuing between the INMO and other unions with HSE-South (East) to resolve all outstanding claims, following the decision by the HSE to permanently close St Brigid's District Hospital in Carrick-on-Suir to inpatients in 2020 and to repurpose the building for community-based services.

The unions collectively served a number of claims on the HSE-South (East) and some progress on these issues was made, including:

- Agreement being reached with each member of staff on the relocation options available to them, having regard to their individual preference of new work location (all INMO members were facilitated with their chosen new work location)
- All appropriate mileage payments being made to members during their initial redeployment to other services in the region, arising from their co-operation with such redeployment due to Covid-19
- Compensation for ongoing loss of premium earnings being paid to each affected member, in line with the provisions of the Public Service Agreement, once redeployed from St Brigid's Hospital to their new work location

The remaining claims, which have not been conceded by the HSE, include the following, which will be progressed to the Workplace Relations Commission for resolution by the INMO and other unions involved:

- Compensation to members for their change in work location arising from the HSE decision to permanently close St Brigid's Hospital to inpatients
- Travel time from St Brigid's Hospital to the new work location of each member affected by the closure.

INMO IRO Liz Curran said: "Our members were shocked and saddened at the HSE's decision to close St Brigid's Hospital to inpatients last year. Every effort to have the HSE reverse this decision was made by the unions at that time, including a request to build a new 'fit-for-purpose' inpatient unit on the St Brigid's Hospital site. However, for a number of reasons, this was not possible and our members were redeployed to a number of other services to work.

"Progress on some of the claims was made for our members by the three unions involved, but the intervention of the Workplace Relations Commission looks increasingly likely at this point to resolve the outstanding claims made for our members, as outlined above."

Update

- **Saint John of God Community Services:** The INMO and other unions have been involved in discussions with Saint John of God Community Services and the HSE regarding a potential transfer of undertakings. In August, it was decided to defer the notice of termination of the service arrangement with the HSE to allow for the completion of a sustainability impact assessment process requested by the Department of Health.
- **CHO7 PHN paediatric qualification allowance:** The INMO has succeeded in its claim for payment of the paediatric qualification allowance to 11 PHNs in CHO 7. Prior to a scheduled WRC hearing, management confirmed that the allowance would be processed with retrospection to all members concerned.

– Lorraine Monaghan,

Haemovigilance officers seek parity

THE INMO is currently making representations at national level on behalf of haemovigilance officer members (CNM2 level) for parity with their medical scientist counterparts.

Senior nurses working as haemovigilance officers currently have lower pay, higher working hours and lower annual leave than their medical scientist counterparts, who are carrying out the same role and paid as senior medical scientists (with NFQ 9).

Conciliation at the Workplace Relations Commission took place in April and management subsequently made an offer to place members on the senior medical scientist scale (without NFQ9), which is a shorter scale with slightly higher pay than the CNM2 scale currently.

Lorraine Monaghan: *Disparity in pay, hours and annual leave for haemovigilance officers needs to be addressed*

The INMO pointed out that the CNM2 scale will surpass the proposed senior medical scientist scale (without NFQ9) early next year. In addition, management has not addressed the disparity in hours and annual leave.

The INMO and management is due to meet again on the matter before returning to the WRC.

There is a total of 56.04 WTE haemovigilance officers in the country; 40.72 WTE are a nursing grade and 15.3 WTE are senior medical scientist grade.

– Lorraine Monaghan, INMO assistant director of IR

ICU clinical audit nurses' claim in WRC

THE INMO claim seeking that ICU clinical audit nurse posts be regraded to CNM2 level was the subject of a conciliation conference at the Workplace Relations Commission on August 25.

Since lodging the claim, a number of posts throughout the county have been regraded from staff nurse to CNM2 level. Little progress was made at the WRC as management advised that they were only now collating information on the grading of ICU clinical audit nurses throughout the country.

A second conciliation conference at the WRC is scheduled for October 27.

– Lorraine Monaghan

Overcrowding reaches pandemic peak

INMO warns hospitals are at risk of becoming "infection hotspots"

THE INMO is warning that increasing levels of overcrowding mixed with poor ventilation will put hospitals at risk of becoming "infection hotspots". This warning came last month as the number of admitted patients on trolleys in Irish hospitals climbed above 400 in one day for the first time since the pandemic began.

The union is calling for maximum protection for frontline staff, including "audits and action" for ventilation in healthcare workplaces.

The consistently most overcrowded hospitals in Ireland are:

- University Hospital Limerick, where a total of 823 patients were cared for on trolleys in August
- Cork University Hospital, which had 738 patients on trolleys in August
- University Hospital Galway, with 563 admitted patients on trolleys in August.

INMO general secretary Phil Ní Sheaghdha said: "Overcrowded hospitals can act as infection hotspots for Covid. Vaccination has made a massive difference, but there are still big dangers for frontline healthcare workers.

"They are being regularly exposed to the virus and our members have reported long-term impacts. We need maximum protection for frontline staff.

"We need to see proper audits of every healthcare workplace to ensure that ventilation meets a high standard. We have a huge amount of data on how this virus spreads – now it is time to act on it."

The total number of admitted patients on trolleys across the country in August was 6,367, more than double the number in August 2020. For example on August 31, Cork University Hospital saw its highest number of trolleys since the start of the pandemic, with 63 patients waiting on trolleys.

INMO IRO for the hospital Liam Conway said: "The situation is out of control and extremely dangerous. The rate of overcrowding in CUH is now so high that we can't maintain the proper infection control measures needed to prevent the spread of Covid-19.

"There is an urgent need for additional beds and the appropriate staffing increases in ED and throughout hospital, but we also need more capacity in the community so people can be discharged at the right time and space is used properly."

Mr Conway continued: "This is very quickly approaching the record overcrowding we saw before the pandemic, and Covid is very much still an issue. Our members and their patients are being put at risk, and it cannot be allowed to continue."

INMO director of industrial relations Tony Fitzpatrick said: "This situation is completely unacceptable. Government plans for opening society back up need to include extra healthcare capacity and supports for our healthcare staff, who are burnt out and exhausted.

"Increasing pressure on our members now without proper measures to deal with the demands on the health service is going to drive nurses and midwives out of their professions and out of the country."

WRC talks on overruns in UHL theatres

SINCE 2016 the INMO has been seeking engagement with University Hospital Limerick regarding the unacceptable level of overruns occurring daily within the theatre department and the impact on members.

Numerous correspondence have been exchanged on this, with the HSE declining to attend at the Workplace Relations Commission for various reasons until September 7, 2021.

The INMO claim outlined at the conciliation hearing seeks that the scheduling of theatre lists on a daily basis is undertaken with proper cognisance of the available nursing resources as per the rosters, in particular the finish times and cessation of all overruns as far as is practical.

This is also required to mitigate the risk caused by the on-call team in this hospital not being available to undertake an emergency theatre list.

At the WRC conciliation, the HSE concurred with the INMO's view, however, said it was not in a position to provide any practical solutions. The hearing was adjourned for a number of weeks to allow the HSE to revert with proposals on the management of the overruns.

Mary Fogarty, INMO assistant director of IR

Staffing levels dispute in Skibbereen

NEGOTIATIONS are ongoing on the proposed new staffing levels for Skibbereen Community Nursing Unit following its redevelopment.

The INMO is currently engaging with hospital management and Cork/Kerry Community Healthcare general management on the issue. The union cited that additional nursing and HCAs are required for the unit to support the new layout of the building, which includes purpose-built units and bedroom areas to allow for single occupancy rooms.

– Liam Conway, INMO IRO

Access policy on hold nationally

MEMBERS across the Cork/Kerry region in public health nursing have highlighted concerns about the implementation, without consultation, of the National Access Policy – the referral pathway to the MDT and children's disability services. The INMO has secured an interim measure to protect members in terms of referral pathways within the region. Further engagement both at national and at local level is required before any implementation of the National Access Policy.

– Liam Conway, INMO IRO

CUH theatre on-call

FOLLOWING engagement with management at Cork University Hospital, the INMO has ensured the full implementation of the WRC theatre agreement for full 11 hours consecutive compensatory rest.

– Liam Conway, INMO IRO

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Coronavirus COVID-19 Public Health Advice

Whilst these events are currently planned as follows, the most current Public Health Advice will be fully adhered to and should the dates or the format in which the national conference is delivered change, we appreciate your understanding.

- **Public Health Nurses Section** — **Saturday, 16 October**
- **All Ireland Midwives Annual Conference** — **Thursday, 11 November**
- **Occupational Health Nurses Section** — **To be confirmed**
- **National Children's Nurses Section** — **Saturday, 20 November**

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Severe nurse deficit in Naas needs emergency response

FACED with in the region of 50 vacant frontline nursing posts at Naas General Hospital, the INMO called an emergency meeting of nurse managers at the hospital last month. This followed warnings from members about unsafe clinical environments and staffing levels.

Hospital management had failed to produce realistic proposals to address the staffing deficits on frontline rosters at a recent meeting with the INMO. The union had expected management to review services, consolidate rosters and stabilise clinical environments.

INMO IRO Joe Hoolan, said: "Our members should not have to ask management to provide a safe environment, and patients deserve to be cared for with safe staffing levels.

"It is not acceptable that management would propose to keep all services fully open while wards, specialist units and intensive care units are left short staffed."

Mr Hoolan stressed: "The INMO again call on hospital management to examine how to stabilise clinical areas, reduce the risk to staff and patients, and temporarily close non-essential services if necessary."

INMO urges St John's, Limerick to respond to serious nursing shortage

SERIOUS nursing deficits in St John's Hospital, Limerick led to a meeting with hospital management and local INMO activists on August 31.

The INMO clearly set out to management that a contingency plan was needed to enable the hospital's nursing staff to provide safe and appropriate clinical care to admitted patients.

The union sought several actions from management including:

- Payment of overtime to all nurses who agree to work additional shifts or hours, regardless of whether 39 hours a week have been worked
- Urgent contact is made with all graduate nurses seeking interest for staff nurse positions
- Transfers in from other hospitals to be curtailed until nurse staffing deficits are stabilised
- Clarity regarding ongoing surgery at the hospital with 20 beds maintained for same.

Management agreed to revert to the INMO on this matter and a meeting was pending at time of going to press.

Mary Fogarty, INMO assistant director of IR

Covid-leave premiums paid in CHO3

PREMIUM payments during members 'special leave with pay for Covid-19' under HR Circular 64/20 have been paid in the HSE CHO3 area.

The HSE human resources department advises that those due outstanding averaging of their premium payments for absences due to Covid-19 during the period March 2020 to May 2021 were paid at the end of August/beginning of September.

In addition, Brothers of Charity Services, Limerick has advised that all outstanding payments up to May 2021 (pay period 10) have been paid to eligible staff. The facility is now working on payments due for pay periods 11-17 inclusive, with a view to rectifying payments for these periods in the coming months.

The calculation of special leave with pay for Covid-19 should reflect an employee's average premium payments, subject to the employee satisfying specific conditions set out in Circular 64/20.

Enhanced nurse contract:

Meanwhile, HSE CHO3 area has confirmed that almost all applications received to switch to the enhanced practice contract have been processed. However, it advises that over 30 contracts issued have yet to be returned.

The INMO reminds all nurses and midwives who have been issued with their enhanced practice contract to return it as soon as possible so that they can move to the enhanced scale. If you have any queries about the contract you have received, contact the INMO Limerick office on 061 308999 or the INMO Information Office 01 6640610/19.

– Karen Liston, INMO IRE

Southern Region

- **Cope Foundation:** Management at the Cope Foundation has acknowledged the INMO's concerns about clinical governance. A discussion paper to map out how both a clinical/professional governance structure, led by the director of nursing and a general management operational structure, are to operate in tandem in this intellectual disability service will be presented. Engagement is ongoing on this matter.
- **St Vincent's Centre/Cope Foundation:** After a protracted period, two CNM1 members at St Vincent's Centre, Cope Foundation have received full retrospection of outstanding increments due to them, since the transfer to their new employment. In addition, following successful negotiation an enhanced goodwill gesture has been proposed by the HSE per member.
- **Saint John of God Services, Kerry:** The INMO has been successful in retaining the enhanced public holiday entitlement for a number of members working at Saint John of God Community Services, Kerry on a red-circled basis. Full retrospection of this unilaterally imposed change is being addressed by management.

– Mary Power, INMO assistant director of IR

Private hospitals confirm 1% pay increase

BOTH the Bon Secours Hospital Health System and the Mater Private Hospital have confirmed to the INMO that, in line with the Building Momentum Agreement, a 1% pay increase or an increase of €500 on annual salary will apply from October 1, 2021.

There is a requirement for engagement with the Bon Secours on an action plan but this will not delay payment for members, who should receive it on the due date.

– Albert Murphy, assistant director of IR

Short corners and long hours: Striking the right balance

Freda Hughes caught up with Sarah Torrans, an Irish Olympian who splits her time between representing Ireland in hockey and training as a student nurse in DCU and Beaumont Hospital, Dublin

WHEN Covid-19 hit in March last year, Sarah Torrans and her fellow Ireland national hockey teammates were forced to take a break from training as their preparations for the 2020 Olympic Games in Tokyo were put on hold. Eighteen months later and Ms Torrans is now an Olympian having represented her country at the postponed Games. Away from the pitch she is also a student nurse training on a sports scholarship in Dublin City University (DCU) and on placement in Beaumont Hospital, Dublin.

Although both Beaumont and DCU have been accommodating of her training schedule, Ms Torrans admitted that balancing hockey with her nursing commitments has been a challenge, but that she really enjoys both aspects of her life. She was allowed to take some time out from her degree for Olympic training and with the 2020 Games postponed until 2021, this allowed more time for preparation and led to her being selected for the team.

Juggling commitments

Ms Torrans told *WIN* that striking the right balance is really important to her.

"Most high-performance athletes will always acknowledge how important it is to have a balance in life so that you don't become entirely consumed by training. It's important to get that balance right and manage your time well. It can be difficult trying to fit in hockey training with shift work and long days," she said.

Ms Torrans and her team took a four-week break from training in March 2020 when the Covid-19 pandemic hit, after which they began a running programme and individual home gym sessions. The team was able to resume team training on a part-time basis in June 2020 and despite the disruptions and restrictions, she said the whole team remained focused on their goals and worked extremely hard.

The team have spent all their time together in a bubble for the past 18 months and have become very close as a squad. They invested a huge amount of effort and helped each other through the loneliness and strangeness of taking part in the Olympics during a global pandemic.

Ms Torrans is well used to balancing academic and sporting commitments, having had to juggle her hockey training schedule with school state exams. When she started college she told her tutor about her training schedule and that she would be away for a few weeks if the team were to qualify for the Olympics.

She explained that first and second year were easier to balance but that she had to split her academic schedule to

Main image: Sarah Torrans in action for Ireland against the Netherlands at the Olympic Games in Tokyo, July 2021; left: Ms Torrans poses with the Olympic rings in Tokyo; below: 'It takes a village' – the Ireland National Women's Hockey Team soak up the evening sun at the Olympic Village in Tokyo.
Main image Worldsportpics Frank Uijlenbroek/Naomi Carroll

> *"It has been amazing to represent my country at the Olympics. It hasn't fully sunk in yet"*

accommodate the Olympics this year.

"It has been amazing to represent my country at the Olympics. It hasn't fully sunk in yet. We had goals as a team and we didn't really achieve the results that we wanted, but I think in a few months' time we'll look back and give ourselves credit for it. The qualifying process is extremely difficult so it is actually a huge achievement for us to have qualified," she said.

Making the grade

Ms Torrans won her first cap for the Irish team in 2017. She was on the squad for the World Cup in 2018 as a reserve when the team took home the silver medal – an experience that gave her motivation to push forward.

Only 16 players are picked on an Olympic hockey squad – as opposed to 18 on a World Cup squad – so Ms Torrans was particularly proud to have been selected.

Ms Torrans said it took her a few days to get used to being in the Olympic Village and meeting her idols and sharing space with people she had watched on TV. She said it was hard not having family with her to share in the experience.

"It was our first Olympics so we didn't have anything to compare it with and just tried to enjoy it and take in the whole experience. My nursing background helps me to know what I can put my body through." She was also able to help support her team around being safe as regards Covid-19 at the beginning of the pandemic.

Her younger sister plays hockey for the Irish women's underage team and hopes to follow in older sister's footsteps.

Complementary disciplines

Having gone straight into nursing college after her Leaving Certificate, Ms Torrans has had a full but hectic life since entering third-level education. She said that both strands of her life complement each other and that skills learned in both disciplines are transferable to other aspects of her life.

"On the ward we're all one team working together. It's important to be able to delegate and know when to ask for support. It's important to know your strengths and know when you need to ask for help. It's important to act with confidence and responsibility and all of these skills are transferable from my sports training too.

"As competitive sports people, we know what our bodies go through and you can draw on this when working with patients who have sports injuries. We've all been through sports injuries on the team and when I see similar presentations in my patients from time to time it helps me to relate to them and understand their pain," she continued.

Future plans

Ms Torrans said she does not necessarily plan to specialise in sports medicine but would love to work as a theatre nurse, stating that she also enjoyed her time in the emergency department. Her mother is a pharmacist and she has always been interested in the pharmacology side of medicine.

She is currently training for the forthcoming World Cup qualifier in October, after which she will return to college and finish her degree. She is hugely grateful for the support from Beaumont and DCU, as well as from her friends and family. She said that the reality of representing her country has only really started to sink in and that it is an experience she will treasure for life.

"I mean business when I manage pain"

Freda Hughes spoke to pain nurse specialist Gwyneth Mahoko about her passion for her work

PASSIONATE about her role, clinical nurse specialist (CNS) in acute pain Gwyneth Mahoko, told *WIN* it was a fellow nurse who inspired her to pursue this particular career path.

"I did a placement with a clinical nurse specialist in acute pain back in 2006. She was a CNS in acute back pain. I thought she was a life changer. When she walked into the ward she made such an impact on her patients' wellbeing. I took my inspiration from that and I knew that it was pain management that I wanted to specialise in," said Ms Mahoko.

Training

Ms Mahoko qualified from the University of Stirling in Scotland as a general nurse in 2006. During her training she was on placement with a pain management specialist nurse and realised quickly that this was the area of nursing she would like to work in.

When she qualified she worked in various settings in order to gain experience. On moving to Ireland she first worked in care of the older person and then went on to work on medical and surgical wards in acute hospitals. This reinforced her desire to specialise in pain management so she began to look into where she could avail of specialised training in this area.

At that time, there was no defined pathway to working in acute pain available in Ireland so in 2012 she returned to Scotland and completed her master's degree in the University of Edinburgh and in 2018 took up her role as the first pain specialist CNS at Our Lady of Lourdes Hospital, Drogheda (OLOL).

Teamwork

Ms Mahoko's role as CNS in acute pain means working as part of a team along with anaesthetists, pain consultants and a pain registrar. Unfortunately in OLOL, the consultant and registrar roles are not fixed positions but are dependent on who is rostered.

Ms Mahoko reports to the CNM3 over theatre and the anaesthetist. Her role involves co-ordinating the pain services and ensuring the smooth running of the team. She also reports to the assistant director of nursing and the clinical nurse managers on the wards she attends. Although she is extremely humble about her role, she is aware of the impact it can make on positive patient outcomes and patient morale. She spoke about the need for more nurses working in this area.

"We don't have many specialist nurses in acute pain in Ireland. We are trying to recruit and raise an awareness of the need for and the importance of the role. We hope that in time there will be more of us working in acute hospitals nationwide," said Ms Mahoko.

Daily routine

On a day-to-day basis, Ms Mahoko attends the wards each morning and compiles a list of patients in need of her support. These patients often need patient-controlled analgesia (PCA), epidural or nerve blockers. OLOL is also a maternity hospital so she has a large cohort of new mothers who avail of her support.

"Lots of babies are born in our hospital every day and when epidural and spinal blocks are used I become involved. I would see these patients the following morning to make sure that their pain is well managed and to make sure that there are no issues following the epidural injections or spinal blocks," she explained.

A CNS in an acute hospital without maternity would usually only look after the general surgical patients, orthopaedics, abdominal surgeries, oncology patients etc, but the maternity aspect makes Ms Mahoko's role unique. She explained what the start of her typical day looks like.

"The first part of the day in the early morning, I go to the postnatal ward with the list of patients compiled from the post anaesthesia care unit. So this will include women who have had labour epidural or spinal block, and sometimes they might have delivered under general anaesthesia. Their pain levels might be high and they might need patient-controlled analgesia,

which is opioid based. I will also see people who have been in road traffic accidents, had workplace injuries or who have just had surgery. I carry out a pain assessment with them before deciding on the next steps in their care."

Patients

Pain management encompasses management of medication and treatment of pain, but it's also about managing how the patient copes with pain. During patient assessment they will be asked to quantify and describe their pain. Counselling may be offered if there are psychological issues surrounding the incident that caused the pain or surrounding the trajectory of the illness.

Most of Ms Mahoko's patients are post-operative or have come in through the emergency department after an accident. Although admitted through a surgeon or orthopaedic doctor these patients are often in severe pain so Ms Mahoko is called in to help optimise their pain management.

There is a lot more to her role after she finishes her rounds in the morning. As well as looking after patients she offers education and training to staff. Pain management sometimes incorporates high-tech pain management techniques and staff on the wards need to be trained up in these technologies.

Ms Mahoko also needs to know how to look after and maintain the various machines and technologies used in her specialty as well as supporting staff on the wards in this area. Service efficiency audits and patient satisfaction research also form an important part of her work.

Service need

There is no outpatients clinic for chronic pain in OLOL as yet and Ms Mahoko would love to see the service expanded to include such a clinic.

She explains that chronic pain and acute pain are treated differently. Acute pain can generally be treated with medications and injections, however chronic pain sufferers need a broader multidisciplinary approach. Ms Mahoko has highlighted the need for chronic pain services in her hospital and hospital management has acknowledged this. However, they would need a bigger team for this and currently don't have capacity.

"There is need for at least one more CNS in acute pain here. It's hard to know how hospitals can manage without a specialised pain team. I am delighted that my CNS post allows me to continue on the front-line. It is so important that I keep up with my general nursing skills as well as my advanced specialised skills and maintain clinical knowledge," she said.

Ms Mahoko added that the hospital facilitates study leave and ward managers will accommodate your needs when you are studying. Funding is sometimes available from the hospital for training too. She feels that funding for nurse and midwife education is essential along with a supportive workplace.

Education

She strongly advocates for investing in more clinical nurse specialists in pain management in Irish hospitals which she says she felt could be hugely beneficial to the health service and to patients directly.

Ms Mahoko, who oozes enthusiasm for her role, would like to see an acute pain CNS in every Irish hospital in the future and encourages nurses and midwives to explore the possibility of specialising in this area.

"It's all about education, education, education. It makes us more competent and it makes us more confident. When nurses are better educated there are better outcomes for the patients. I'm in the right job for all the right reasons. I mean business and I am assertive when I manage pain," she said.

Recognising the signs of human trafficking

Human trafficking is occurring here and now in Ireland and nurses and midwives are in a position to recognise potential victims if they know what to look out for, writes **Deborah Miranda**

ALL Marcia* wanted was a brighter future for her son and to support her parents as they grew older in South America. She came to Ireland to study English, but instead she was tricked by a friend and sold into prostitution. She was controlled all the time, kept under surveillance and under threat to herself and her family. Eventually she managed to escape and contacted the Gardaí. Marcia is one of the many potential victims of human trafficking detected in Ireland.

It is commonly believed that human trafficking only happens in countries 'far away' but the truth is that it is happening right here and now in Ireland. Between 2015 and 2020, 356 potential victims of trafficking were identified by the Irish authorities, but experts estimate that this figure could be much higher. Foreign trafficking victims identified in Ireland are from Africa, Asia, Eastern Europe and South America. Authorities and media have reported an increase in suspected victims from Nigeria, Romania, Indonesia, Brazil and Pakistan.

Human trafficking is recognised as a crime with transnational implications. In 2016, the International Labour Organization estimated that 40.3 million people are in situations of modern slavery and that the industry earns traffickers approximately US$150 billion per year. Human trafficking has widespread consequences both for the survivors and society. For the survivor, the trafficking process can involve sustained physical, sexual and psychological abuse as well as violence, deprivation, manipulation and exploitation.

The pandemic has exacerbated inequality and vulnerabilities. This has increased the risk for vulnerable persons as human traffickers and smugglers take advantage of pre-existing vulnerabilities, such as lack of a supportive family, poverty, little or no education and experiences of abuse. For these reasons it is crucial to raise public awareness and prompt civil society and frontline workers to be involved in the identification and referral of potential victims of trafficking to the appropriate authorities.

Trafficking versus smuggling

Trafficking and smuggling are often used as synonyms, however they have very different meanings. Migrant smuggling refers to the illegal transfer of a person across international borders. In this case, people are being transported willingly, some are fleeing violence or poverty. Most are paying someone to help them make the journey. The crime of migrant smuggling can also involve the creation or supply of a false identity document or the authorisation, by illegal means, of the stay of a non-national or non-resident.

Human trafficking, by contrast, is involuntary and traffickers use force, fraud or coercion for the purpose of exploitation for the benefit of a third party. The exploitation can be related to debt bondage, sexual exploitation, child labour, forced labour, forced marriage or the removal of organs. It is a form of modern slavery and can occur within a country or victims can be moved across borders. Migrant smuggling is a crime against the State, whereas human trafficking is a crime again against the person.

Sometimes, however, smuggling can turn into trafficking. There have been cases where a migrant has paid a people smuggler to help them enter a country only to find when they arrive that have become victims of violence and exploitation.

Some of the techniques used by traffickers to deceive their victims are abduction, the promise of a better life, debt bondage, threats to victims or their families, creating mistrust about the police, laws or other victims, and the threat of deportation.

As part of the International Organisation for Migration's (IOM) core work, the UN's migration agency aims to support governments and civil society to combat human trafficking through all aspects of counter-trafficking responses – prevention, protection and prosecution. This includes creating awareness among the general population as to what constitutes human trafficking, particularly given that there is

often confusion between human trafficking and smuggling.

Know the signs

Everyone has the potential to discover a human trafficking situation, especially those potentially coming into contact with victims, including frontline healthcare workers. While the victims may sometimes be kept behind locked doors, they are often hidden in plain sight working in restaurants, nail salons, on farms and in hotels.

An encounter in a healthcare setting may be the first opportunity a victim of trafficking has to engage with someone outside of their situation of exploitation. Knowing the indicators of human trafficking and some follow up questions will help you act on your gut feeling that something is wrong and report it, which can potentially save someone's life.

These are some key red flags that could alert you to a potential trafficking situation that should be reported:

- Living with employer
- Poor living conditions
- Multiple people in cramped space
- Inability to speak to individual alone or someone always speaking on behalf or translating for the individual
- Answers appear to be scripted or rehearsed
- Employer is holding identity documents
- Signs of physical abuse
- Submissive or fearful
- Repeat visits for STIs and/or treatment for multiple incidents of physical abuse or workplace accidents/injuries
- Unpaid or paid very little
- Under 18 and in prostitution.

It's important to remember that not all of these indicators have to be present for it to be human trafficking. Victims are often hidden in plain sight and it's important to be vigilant.

If you have concerns that someone may be a potential victim of trafficking, it can be challenging to build trust, especially during short visits, to allow a disclosure. Speaking with the potential victim alone, using an independent interpreter if needed, and reassurance of confidentiality is all key. Victims may be feeling guilt, shame and embarrassment over their situation so paying attention to body language, offering reassurance and trying to make them feel at ease are important.

Assuming you have the opportunity to speak with a potential victim privately and without jeopardising the victim's safety because the trafficker is watching, here are some sample questions to ask to follow up on the red flags you became alert to:

- Can you leave your job if you want to?
- Can you come and go as you please?
- Is anyone hurting you?
- Do you feel you would be hurt or threatened if you tried to leave?
- Has your family been threatened?
- Do you live with your employer?
- Where do you sleep and eat?
- Are you in debt to your employer?
- Do you have your passport/identification? Who has it?

What happens when a victim is found in Ireland?

The National Referral Mechanism in Ireland is a framework for identifying and referring potential victims of human trafficking and ensuring they receive the appropriate support.

- Step 1: Decision is made to identify person as a potential victim of trafficking
- Step 2: Recovery and reflection period
- Step 3:Temporary residence permission.

Between 2012 and 2020, the IOM in Ireland has assisted 92 victims of trafficking to return to their country of origin, or habitual residence. These victims were from a range of countries including from Europe, South America and Africa. Fifty-three people were trafficked for the purposes of labour exploitation and worked in a range of industries including car washes, meat factories, mushroom and flower farms, domestic work and a recycling plant. A further 22 were trafficked for sexual exploitation, seven for sham/arranged marriages and four for criminal purposes, including drug dealing.

If you suspect someone is a victim of trafficking, you can contact An Garda Síochána who are available to help.

You can report concerns by:

- Calling the Garda confidential telephone line: 1800 666 111
- Email: blueblindfold@garda.ie
- In an emergency please call 999/112.

For further information go to: **www.anyonetrafficked.com** or **www.blueblindfold.ie**

Deborah Miranda is senior communications assistant for the International Organization for Migration

**Name has been changed*

In 2019 the ICN launched a resource for nurses and midwives 'Human Trafficking, the basics of what nurses need to know' which was supported by the INMO and numerous international organisations. It can be viewed at: ***shorturl.at/giADS***

Fitness to practise: legal update

David Miskell examines recent changes to the NMBI's Fitness to Practise process

THE legislation that governs the Nursing and Midwifery Board of Ireland (NMBI) is the Nurses and Midwives Act 2011. This legislation sets out what the role of the NMBI is and how it carries out its work in the areas of registration, education standards, professional guidance and the management of complaints in relation to nurses and midwives.

The Regulated Professions (Health and Social Care) (Amendment) Act 2020 (the 2020 Act) was signed into law on October 14, 2020, sections 143 to 185 of which are applicable to the NMBI. As a result of this, changes to the 2011 Act have now come into effect. In this article, we will explore the main changes to the preliminary proceedings committee (PPC) stage of the fitness to practise process.

In essence, there are two stages to the fitness to practise process, the first of which involves the consideration of a complaint against a nurse or midwife by the PPC, which is a committee that considers the complaint and makes a recommendation as to whether or not a full inquiry into a nurse or midwife's fitness to practise should take place.

The PPC consists of 11 members, which includes nurses and midwives but has a majority lay membership. The role of the PPC is essentially to consider the complaint and the response by the registrant and thereafter to make a decision on referral of the matter for a full inquiry.

In addition, the committee has a number of additional powers and may direct the complainant to provide additional information or to verify existing information by means of a legal declaration. In cases where the complainant fails to provide this information, without a reasonable excuse, the committee may refuse to consider the complaint any further.

The committee may also direct the nurse or midwife subject to the complaint to provide specific information and they must comply with that direction. The PPC will then consider all the information it has gathered and make a determination as to whether or not there is a *prima facie*, or face value, case against the nurse or midwife for further action to be taken.

If it is decided that there is a case to answer, the matter is referred for a fitness to practise inquiry. Where the PPC determines that no further action should be taken in relation to a complaint, the committee brings this to the attention of the Board, which then, pursuant to section 59 of the Act, may accept that view and the matter is then closed, or they may direct that the matter should be subject to a fitness to practise inquiry, notwithstanding the view of the PPC.

Changes

The amendments to Part 7 of the Nurses and Midwives Act 2011 change the processes relating to the preliminary investigation of complaints related to the work of the PPC. The chief executive now has responsibility for the processing and investigation of complaints against a nurse or midwife. The chief executive will appoint an authorised officer, who will investigate the complaint and ultimately prepare a report on the complaint.

Authorised officers will have a number of investigatory powers, including the power to compel the production of information and records. The decision as to whether to refer a complaint forward for an inquiry will remain the responsibility of the PPC. This revised process should facilitate early disposal of frivolous or vexatious complaints and should also expedite the preliminary stage.

In addition, section 57A of the Act now provides an option for the PPC, instead of referring a matter forward for a fitness to practise inquiry, to ask a nurse or midwife to consent to certain measures and/or undertake to do certain things. This includes consenting to being warned in relation to the conduct in the form of a censure, undertaking not to repeat the conduct that is the subject of the complaint, demonstrate relevant competencies to the satisfaction of the Board, take such steps as may be specified by the Board, which may include taking a course of education or training or gaining clinical practical experience for the purpose of updating their skills and knowledge, or consenting to undergo medical treatment.

A number of other changes include, in some cases, a registrant who is the subject of a complaint may – with the agreement of the Board and when it is not contrary to the public interest – voluntarily be removed from the Register. If this happens, it will not be possible to return to the Register.

Section 55(2)(a) of the Act creates a statutory entitlement of the NMBI to request information in relation to a "material matter" from other regulatory bodies in Ireland or in another jurisdiction. A "material matter" is information relating to the imposition of conditions on registration, the suspension, withdrawal or removal of any registration, the refusal to grant registration, or conviction for a serious crime.

There is also a statutory entitlement to request information about a registrant's criminal records from An Garda Siochána, and to request copies of certificates of conviction and relevant court orders/judgments. An additional ground of complaint is introduced in Section 55(1) of the Act where a registrant has been prohibited or restricted from providing a type of health or social care in Ireland or in another jurisdiction.

Extensive representations have been made by Edward Mathews, INMO director of professional and regulatory services, on behalf of members throughout the legislative process. While many of the changes are welcomed they require ongoing monitoring and review in respect of how they are operated by the NMBI.

David Miskell is INMO professional and regulatory services officer

Covid-19 vaccine inequity:
A shameful story of greed

The EU's opposition to a plan to waive intellectual property rights relating to Covid-19 vaccines is a failing of its human rights obligations, writes **Sheila Fitzgerald**

NURSES, midwives and other healthcare professionals have faced huge challenges at work due to Covid-19, but the licensing of safe and effective vaccines was a game-changer for healthcare professionals as vaccination has lessened the risk of Covid-19 infection. Yet, the success of Ireland's vaccine programme should not cloud our vision of the situation in many parts of the world, especially in low-income countries, where many frontline healthcare staff and vulnerable people remain unvaccinated and already fragile healthcare systems are further stretched.

By the end of August 2021, the EU/EEA vaccination rate reached 67.3% of adults,[1] compared with a mere 2.5% of adults across Africa.[2] Last year, EU Commission president Ursula von der Leyen said that Covid-19 vaccines would become a "global common good" but 18 months on, this seems empty rhetoric. In fact, by September 2020, rich nations used advance purchase orders and outbid the rest of the world for the majority share of the global vaccine supply. Instead of vaccines being a global common good, national greed created vaccine apartheid.

COVAX was launched last year to support equitable distribution of Covid-19 vaccines. It modestly aimed to vaccinate 20% of people in poorer countries, but has consistently failed to meet its targets,[4] in part due to high-income countries repeatedly failing to keep donation promises.

Vaccine scarcity can be avoided if vaccine manufacturing capacity is expanded. Many pharmaceutical companies who develop vaccines, hold patents and other intellectual property rights over elements of the vaccine, allowing them to maintain a monopoly over production of the vaccines. This monopoly prevents any other company from producing that vaccine without a licence from the rights holder, resulting in much lower vaccine supply, that is inadequate to meet global needs. Clearly, the world has learned little from the HIV/Aids pandemic when many millions died unnecessarily because they were denied treatment due to the same monopoly system.

Pharmaceutical companies have had the opportunity since May 2020 to share patents and other intellectual property rights through the WHO Covid-19 Technology Access Pool (C-TAP). A second opportunity arose in June 2021 when the WHO announced it was working to establish the first mRNA technology hub in South Africa. To date no WHO-approved vaccine manufacturer has signed up to either.[3]

The failure of voluntary sharing measures such as the C-TAP and the mRNA technology transfer hub has increased pressure for mandatory measures. In October 2020, the Indian and South African governments made a landmark proposal to waive several sections of the World Trade Organisation TRIPS Agreement in relation to pharmaceutical products to address the Covid-19 pandemic. This waiver offers hope of ending global shortages of vaccines and other technologies to treat and prevent Covid-19, by expanding manufacturing capacity and saving many more lives.

In May 2021, in the US, President Biden made good on an election promise and backed the proposal. The EU, and Ireland as a member state, have adamantly opposed the waiver proposal.

This refusal to share the technology is made all the more untenable by the fact that millions of euros of public funding were invested in the development of Covid-19 vaccines, which de-risked the investment of the pharmaceutical industry. Private companies have already made tremendous profits, while nearly five billion people worldwide remain at risk of severe illness and death through a lack of access to vaccines.

Economically, estimates indicate that countries with less than 60% of their populations vaccinated by mid-2022 will register GDP losses totalling US $2.3 trillion in 2022-25. Timelines for recovery will be even longer in poorer countries, increasing poverty.[4]

In addition to all this suffering, leaving large proportions of the world unvaccinated will lead to unmitigated transmission, creating ideal circumstances for viral mutations and new variants which could threaten the effectiveness of vaccines everywhere and prolong the pandemic.

People will die in lower income countries, because they do not have access to vaccines and other technologies. We as healthcare workers owe it to our colleagues around the world to advocate for systemic change to rectify this situation. The EU's vehement opposition of the TRIPS waiver is a shameful failing in their human rights obligations of international co-operation and assistance, and is indifferent in the face of unnecessary death and suffering.

Sheila Fitzgerald is a retired assistant director of nursing and lecturer and an access to medicine activist

Further information on supporting vaccine equity from People's Vaccine Alliance Ireland https://peoplesvaccine.ie/ or Access to Medicines Ireland at:
www.accesstomedicines.ie

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Listening and learning

Freda Hughes spoke to Elaine Fallon, group lead for staff engagement and wellbeing at Saolta, about how we can learn from each other

THE Saolta hospital group covers a large geographical area, with more than 11,000 staff. Elaine Fallon's role involves travelling to various hospitals and facilities to carry out training, facilitation, coaching and feedback sessions.

Ms Fallon told *WIN* that since the pandemic she has noticed that management is more willing to listen to staff regarding their mental health concerns. Nevertheless, she would love to see more focus on staff engagement and wellbeing throughout the HSE and feels every hospital group should have an officer dedicated to this.

Ms Fallon completed a masters in leadership in 2012 which led her to her current career path. However, before this she trained as a nurse in her native Wolverhampton, working in coronary care and renal dialysis, before training as a midwife.

In 1996 she started work in Galway University Hospital as a staff midwife before moving to Portiuncula Hospital. She wanted to make a difference to what was happening on the frontline and began working in the Nursing, Midwifery Planning and Development Unit of the Midland Health Board and then moved to the National Leadership and Innovation Centre for Nursing and Midwifery in Dublin.

Ms Fallon also worked with the Quality and Patient Safety Directorate before moving to her role with Saolta.

"I feel passionately that we must involve nurses and midwives in the decisions made about services, and the delivery of those services, and also about patient care. You cannot have effective patient engagement without effective staff engagement, so it's no good putting all your resources into one without also considering the other," she said.

When she took on the role in 2019, Ms Fallon began working with groups of nurses and midwives asking what issues they'd faced and what solutions they thought could be implemented. She asked them to share their personal values and looked at how that those values could be aligned to both Saolta and the HSE's values. Those who shared their experiences were in a 'safe space' without fear of repercussions.

Elaine Fallon, Saolta group lead for staff engagement and wellbeing

> ***What you are doing is valuable and we cannot run the service without you***

"In 2019 staff were exhausted and depressed. Then Covid-19 hit and magnified that 1,000 times. They felt they were not being listened to and things just kept getting worse. If staff don't feel that their voice is recognised as valuable they quickly become disengaged and disenfranchised.

"Management need to be able to say, 'What you're doing is valuable. We cannot run the service without you. We're interested in your opinion'. When change happens without consultation it irritates staff. We need to show our frontline that we value them. If we say we're interested in what they've got to say, we need to follow up with action," she explained.

Ms Fallon introduced a number of useful initiatives including formal feedback mechanisms and a buddy system for newly qualified midwives and nurses and for new staff. She also implemented new coaching techniques for individuals and teams. This allows staff to get the best from themselves and helps them come together as a team while valuing their individual strengths.

She also brought in the concept of reverse mentoring. Standard mentoring involves a senior person mentoring someone junior by showing them the ropes, explaining the organisation's values and how that filters down to them.

Reverse mentoring involves placing somebody who is senior in the organisation with someone junior and encouraging the junior person to share something that the senior person needs to learn. This has worked well with student midwives on direct entry midwifery programmes who can share the changes in practice in clinical midwifery with their colleagues who have moved away from clinical practice.

Ms Fallon wants nurses and midwives to feel empowered and aims to have decision making and implementation become more streamlined and consultative within the Saolta group. She feels that change happens in small steps and encourages nurses and midwives who want to take on leadership roles or make changes in their workplaces to lay the foundations as they go, but to remain focused on their overall goal.

"Taking a strategic approach to change and making every effort to be inclusive, open and transparent encourages the whole team to share the journey. It's about being able to work on our own personal resilience and play to our strengths, but this means nothing if nurses and midwives' voices are not heard. Their expertise must be consulted and valued," she added.

Section focus

INMO Professional

Jean Carroll, Section Development Officer

Annette Kennedy to speak at PHN Section webinar this month

THE PHN Section has been working hard to provide relevant content for its upcoming webinar this month, which will hear from experts in postnatal depression, mother and baby units, positive ageing, mental health and menopause. The topics of skin conditions in children, the virtual ward, the ANP pathway and workplace safety will also be covered.

The section will welcome back our own Annette Kennedy, president of the ICN, who will speak about positive ageing, as well as policies to support older nurses at work. Ms Kennedy has served the past four years as ICN president, a position she took on after a lengthy career in nursing, which included almost 20 years in the INMO.

Ms Kennedy was responsible for establishing the Professional Development Centre – now INMO Professional – which laid the groundwork for the INMO being in a position to deliver our suite of member services.

The PHN Section is looking forward to hearing from Ms Kennedy, a global voice who understands the importance of nurses being heard and offered opportunities for advanced practice and leadership roles.

Also among the speakers will be Denise Gillespie, a qualified nurse, midwife and PHN, who will talk about the ANP pathway. Ms Gillespie worked as an area public health nurse in Donegal prior to moving to her current role as a registered ANP in child health and parenting in Co Donegal. She runs the pre-school children's behaviour support clinic in Donegal, which provides support to parents in the areas of sleep and behaviour.

Loretta Dignam, chief executive and founder of Ireland's Menopause Hub, will discuss the work she does as part of a diverse multidisciplinary team that includes physicians, a psychologist, a women's physiotherapist, an acupuncturist, a dietitian and a nutritionist. Ms Dignam will present on management of menopause in the workplace.

ICN president Annette Kennedy, who was formerly INMO director of professional development, will make a presentation on positive ageing at the upcoming PHN Section webinar

The Menopause Hub's mission is to empower women to optimise their health and vitality during their menopausal years so that they can continue to live their full life. Through her work with the Hub, Ms Dignam has helped organisations all over Ireland to educate their workforce and management about menopause and how to become a menopause-friendly workplace.

The section carried out a survey of its members to ascertain the most commonly requested topics, and the webinar's agenda has been formed around these results.

Date for the diary for orthopaedic nurses

THE INMO Orthopaedic Nurses Section will host an educational session on wound care at Cappagh Orthopaedic Hospital in Clontarf on Thursday, December 2, the same day as the section's bi-annual meeting.

The educational session will be facilitated by Julie Jordan O'Brien, who works in Beaumont Hospital, Dublin as a registered ANP in onco-plastic surgery.

Ms O'Brien has always had a keen interest in wound care and is an active council member of the European Wound Management Association (EWMA) and the Wound Management Association of Ireland (WMAI).

The importance of effective wound care in the orthopaedic setting cannot be underestimated. Wounds in complex patients and wounds that are managed poorly can lead to the development of a chronic wound, which may have a detrimental impact on both the patient and the health service.

Members of the section will be sent further details about this event via email, including on how they can access or attend the education session and meeting.

Online access to both the session and meeting will also be offered.

In brief...

All-Ireland Midwifery Conference

THE full programme for the All-Ireland Midwifery Conference in November has been set.

To book your place, visit **www.inmo.ie** or scan the QR code on *page 50*.

Topics will include mindfulness, the State of the World's Midwifery Report, workforce wellbeing surveys and women-centred models of care.

As well as a poster presentation, we have invited poets, artists and others to contribute to the day.

Children's Nurses Section webinar

THE National Children's Nurses Section will be holding its first webinar on World Children's Health Day, Saturday November 20.

A number of specialists will speak on such topics as self-harm in adolescents, paediatric sepsis, eating disorders, the psychological impact of Covid-19 and autism.

The webinar will also hear an update on the national strategy for the future of children's nursing in Ireland.

To book your place, see **www.inmoprofessional.ie** or call 01-6640641.

Get in touch

Contact: Jean Carroll
Section Development Officer
at HQ at Tel: 01 6640 600
or email: jean.carroll@inmo.ie

INMO Professional

INMO
Irish Nurses and Midwives Organisation
Working Together

LIVE ONLINE EVENT

Online Orientation programme to

Irish Healthcare System and Culture to International Nurses and Midwives

Friday, 8 October 2021

10am - 1pm

This short online programme is for nurses and midwives who have recently arrived or are coming to Ireland. It will cover information to support the transition to life in Ireland and the Irish Healthcare System and equip participants with a broad understanding of Ireland's work ethics and culture, further empower them to integrate with their professional colleagues and the system. If you know of anyone coming to work in Ireland in our healthcare system that would like information and support to transition to life in Ireland, please let them know

FREE TO ALL
Tell Your Friends

Programme Content:

- Familiarisation with Irish Culture, Geography and Society
- Introduction to Irish Health Care System and its operation
- Role of HSE & G.P, Public Vs Private Healthcare compared to sending country's Healthcare System
- Language and Communication at Work
- NMBI- Code of Professional Conduct & Practice Standards for Nurses and Midwives
- INMO Support and Services

(this programme is subject to change)

HOW TO BOOK:

Email **education@inmo.ie** with the following:
Name (name you will use to register as a nurse/midwife here),
Email, Mobile number and Work Location (if you know).
For any INMO members it is essential that you forward your INMO number.

www.inmoprofessional.ie

INMO Professional

Continuing professional development for nurses and midwives

INMO EDUCATION PROGRAMMES

In the pull-out this month…

Telephone Assessment and Advice Skills

Friday, October 15, 2021

This is a challenging time for nurses and midwives who are involved in providing telephone assessment and advice in emergency departments, general practice and other community settings. Such calls assess patients' needs and may provide advice for self-care, prompt the caller to seek immediate medical attention or refer the patient to another healthcare professional or agency. This short online programme will provide strategies and guidance on how best to communicate with each caller and how to handle calls in a professional and tactful manner so that you are mindful not only of what you say, but how you say it. Fee: €30 INMO members; €65 non-members.

Management of Chronic Disease in Primary Healthcare

Monday, October 18, 2021

This course will look at the self-management of chronic illnesses, how to assess chronically ill clients and develop self-management strategies. It will help participants to empower clients to understand and self-manage their conditions. The course will cover: chronic disease management (CDM) impacts on care provision in primary healthcare; evidence-based approaches to service delivery; skills to perform a detailed audit to identify current cohorts, guidelines and policies to set up CDM clinics; the role of the primary, secondary and tertiary care in the provision of CDM services; the prevention of secondary diseases and improving quality of life. Fee: €30 INMO members; €65 non-members.

Retirement Planning Webinar *(free for members)*

Thursday, October 28, 2021. 2pm-3.30pm

Planning for retirement is even more important today than it has ever been. There are many things to consider as you approach retirement. It's good to start by reviewing your finances to ensure that your future income will allow you to enjoy the lifestyle you want. INMO Professional has developed this webinar in partnership with Cornmarket Financial Services to help to support our members. It will cover the following: superannuation, AVCs, lump sum and investments. To join this webinar, places must be booked in advance. To book, please visit **www.inmoprofessional.ie** or email education@inmo.ie with your INMO number, email and the name you used to register with us.

Steve Pitman
Head of Education and Professional Development

INMO Professional continues to develop new education programmes for members covering a wide range of clinical and professional topics. We continue to explore new approaches and services that are both accessible and affordable. It has been more than a year since we moved our courses online in response to Covid-19 restrictions. This approach has been hugely popular with nurses and midwives, and has allowed us to deliver a wider range of courses that are available to INMO members across the country. This is in addition to the broad selection of free webinars that we have offered to members of INMO sections and on a variety of other topics.

As the end of the year approaches, we have been reflecting on what has worked well and new services that we can deliver for members. Due to the success of the online delivery of courses, we expect to continue with this approach into 2022, but we expect to be recommencing skills-based training in the first quarter of next year. We also hope to continue to expand our professional development and online education resources for members in 2022.

INMO Professional is conscious of the important role and contribution of migrant nurses and midwives to the Irish health service. To help support nurses and midwives who are preparing to work in Ireland or have been recruited recently, we have developed a pilot online introduction and orientation course. The course will cover professional and cultural aspects of working in Ireland, workplace rights and other useful information. This course runs on October 8. Further information is available on *page28* and at **www.inmoprofessional.ie**

Midwifery

The HSE National Women and Infant Programme has issued the *Revised National Clinical Guideline for Intrapartum Foetal Heart Rate Monitoring*, which is available at **www.hse.ie**

The Nursing and Midwifery Board of Ireland (NMBI) is currently in the process of updating the Midwives Practice Standards, which should also be available over the coming months.

Menopause in the workplace

The INMO, in collaboration with the Menopause Hub, has been conducting a survey of nurses' and midwives' experiences of menopause in the workplace. The survey will be open until October 8 *(see* **www.inmo.ie**). The results of this survey will be presented during the week of October 18 to coincide with World Menopause Day and will be published in an upcoming issue of *WIN*.

Digital health

The HSE Office of the *Nursing and Midwifery Services Director will be launching the All-Ireland Nursing and Midwifery Digital Health Capability Framework* in October. This is a guide for individuals and employers on the skills and knowledge required to deliver healthcare in a digital world. It ensures that the nursing and midwifery voice is heard as part of the development of the digital healthcare workplace. To enable the successful implementation of new technologies, it will be vital to support nurses and midwives to develop the necessary IT skills and ensure access to the required technology infrastructure and resources.

NMBI

The NMBI has extended the annual registration renewal window for 2022, in order to allow nurses and midwives more time to register. It will be possible to register from October 25, 2021 until January 31, 2022.

The Regulated Professions (Health and Social Care) Amendment Act 2020 came into effect on August 1,. and has resulted in changes to how the NMBI deals with complaints against nurses and midwives. The changes have allowed the NMBI to introduce a more efficient process and remove some of the administrative steps that have previously delayed the process. Further details on the changes can be found in the NMBI eZine or at **www.nmbi.ie**

The NMBI is also currently in the process of developing *Guidelines on Ethical Standards and Behaviours for Candidates (Student Nurses or Student Midwives)* on the NMBI candidate register. These should be available over the coming months.

Olympics

INMO Professional would like to extend its congratulations to Dublin City University nursing student Sarah Torrans, who represented Ireland as part of the women's national field hockey team at the Tokyo Olympics. You can read our full interview with her on *page 18*.

On-site Education

INMO Professional offers an extensive range of on-site programmes facilitated by expert practitioners. If you are interested in booking one, email marian.godley@inmo.ie or call 01 6640642.

Delivering courses and writing for *WIN*

We are eager to offer members the opportunity to work with us in delivering education courses. If you are an advanced nurse or midwife practitioner, a clinical nurse/midwife specialist or a nurse/midwife with expertise in clinical or management practice, we would like to hear from you by email: education@inmo.ie or Tel: 01 6640642.

We are also interested in hearing from members who would like to write professional and clinical articles for *WIN*. Please email steve.pitman@inmo.ie

INMO Professional

Online Education Programmes

Tel: 01 6640641/18
Email: education@inmo.ie

All of the following programmes are category 1 approved by the NMBI and allocated continuous education units
Fee: €30 members; €65 non-members
Time: 10am-1pm

Book three online education programmes and get the fourth free
www.inmoprofessional.ie

Keep your CPD up to date • Extensive range of programmes • NMBI category 1 approved • Digital certification provided

Oct 7 **Adult Asthma – Getting the Basics Right**

This short online programme is aimed at nurses and midwives who are working in clinical practice and who require basic knowledge and skills in order to care for people with asthma on a day-to-day basis. The programme will assist participants in gaining an understanding of the clinical evidence underpinning the diagnosis and ongoing care and management of the person with asthma, utilising current best practice.

Oct 8 **Orientation programme for International Nurses and Midwives**

This special online programme is for nurses and midwives who have recently arrived in Ireland see *page 28*. This programme is free so if you know of anyone who would like support in transitioning to life in Ireland, please let them know. Prior booking is essential.

Oct 11 **Infection Control: Link/Champion Guide to Standards**

This programme is aimed at nursing staff who are identified as infection control champions within an organisation or staff who are interested in infection prevention and control standards. The course utilises infection control's eight themes as a guide: identifying key areas in infection prevention, control and infection control resources in line with standards and use and review of equipment. This course will support staff in identifying their strengths and providing support with short, medium and long-term goals within the role of infection control champions in their clinical area.

Oct 11 **Introduction to Effective Library Search Skills**

This short online course is aimed at nurses and midwives who would like to develop valuable lifelong information-seeking skills to get the most up-to-date information for clinical practice, reflection or policy development. This course will assist participants who are undertaking academic programmes.

Oct 12 **Become More Assertive**

This short online programme is designed to help nurses and midwives develop their skills to be more assertive. It will help them to make decisions with conviction and deal with difficult situations.

Oct 13 **Improve Your Academic Writing and Research Skills**

This short online course is designed for nurses and midwives who are undertaking third-level academic programmes. It will assist participants in completing their written assignments. The objective of the course is to help prepare the student for academic study, which requires efficient literature searching, research critique and accurate referencing skills. On the day there will also be a question and answer session to help you with any of your queries.

Oct 14 **Delegation Principles and Practice**

This programme will explore the issues surrounding delegation and decision-making. Participants will learn the difference between clinical and managerial delegation and how delegation differs from assignment of a task. Guidance will be provided on the assessment of a delegate's experience and role and how best to match appropriate clinical supervision to a specific delegated function. The professional, legal and quality of care issues involved when deciding to delegate a function will also be explored.

Cancellation policy: For cancellations five days before the course due date, a full credit to transfer onto a course at a future date will be offered. For non-attendance, there is no refund or transfer. If a course is cancelled due to insufficient numbers, a full online refund will be issued.

Oct 14 **Best practice for Clinical Audit for Nurses and Midwives**

This programme equips nurses and midwives with the necessary skills to plan and implement a clinical audit in their practice and enable them to deliver evidence of improved performance for safer and better care for patients and improved quality service. Participants will be provided with an overview of clinical audit and be informed about each stage in the clinical audit cycle: topic selection, standards development, data collection, data analysis, reporting, implementing changes and re-audit. There will be an emphasis on continuous quality and safety improvement in healthcare.

Oct 15 **Telephone Assessment and Advice Skills for Nurses and Midwives**

This short new online programme is for nurses and midwives involved in providing telephone assessment and advice, in A&E, general practice and other community settings. Such calls assess patients' needs and may provide advice for self-care, prompt the caller to seek immediate medical attention or refer the patient to another healthcare professional or agency. This programme will provide strategies and guidance on how best to communicate with each caller in a professional and tactful manner.

Oct 15 **Overview of Nursing Assessment and Management of Stroke**

This short online programme will give participants an overview of nursing assessment and management of stroke during the Covid-19 pandemic. At the end of the training participants will be able to: identify and discuss the two types of strokes; identify and ascertain the various treatment options; understand best practice for the nursing care of people who have suffered an acute stroke, including secondary prevention; be aware of aetiology of stroke and rationale for specific diagnostic tests.

Oct 18 **An Introduction to the Management of Chronic Disease in Primary Healthcare**

This short introductory online course provides nurses/midwives who work in the primary healthcare setting with knowledge and skills to develop and apply the principles of self-management of chronic illnesses. In this programme you will discover the most common chronic diseases and learn how to assess clients with ongoing illness and to develop, implement and evaluate planned care and self-management strategies. This is an ideal professional development programme to gain essential skills to better support these patients and provide you with the knowledge and skills in doing so.

Oct 19 **Falls Reduction, Assessment and Review**

The purpose of this programme is to promote a consistent approach to falls reduction for older people through assessment, individualised care planning and post-falls review. It promotes excellence among nurses who provide care to the patients at risk of falls, informed by current evidence. The main aim is to assist nurses to identify those patients or residents who are at risk of falls and to reduce that risk by providing knowledge on falls reduction techniques, ultimately improving patient safety and minimising injuries in the older population.

Oct 19 **Fundamentals of Pain Management**

This short online pain management programme for nurses and midwives will promote critical thinking and a safe and systematic approach in the assessment and management of pain. It will demonstrate how to recognise and differentiate patient's pain more confidently, through understanding the concepts, meaning and classification of pain. Participants will learn skills in the early recognition and treatment of pain to help enhance patient comfort, well-being and recovery from illness, injury and surgery. At the end participants should be able to: describe the pathophysiology of nociceptive and neuropathic pain; select and describe the use of appropriate pain assessment tools for use with varying patient populations; discuss the main components of a pain-focused physical assessment; articulate a clear rationale for the safe use of specific pharmacological interventions for acute and chronic pain; describe the effective use of the analgesic ladder to treat acute and chronic pain.

Oct 20 **Understanding and Managing Burnout for Nurses and Midwives**

This programme is designed to explore the nature of burnout and work engagement. Burnout is an important issue for nurses and midwives and is related to a decrease in occupational wellbeing and an increase in absenteeism, turnover and illness. The prevention of burnout can be achieved by focusing on engagement, organisational assessment and the early detection of burnout. The key focus of this programme will be on the causes, definitions, measurement and interventions that can help create a more positive, fulfilling and engaging workplace.

When booking online courses please note:
Places must be booked in advance. You will need a reliable computer and internet access. Please ensure a correct email is provided when registering. Certificates for participation will be issued in digital form and sent by email. Do not hesitate to contact us at Tel: 01 6640641/18 or email: education@inmo.ie

Oct 20 **Tools for Safe Practice for Nurses and Midwives**

This programme provides safe practice tools to protect the nurse, midwife and patient within current healthcare settings. The programme is free to INMO members. Places must be booked online in advance of your attendance. See *page 40* for more information.

Oct 21 **Paediatric Asthma – Understanding the Basics**

This short online programme is aimed at nurses and midwives working in clinical practice who require basic knowledge and skills to care for children and their families with asthma on a day-to-day basis. The programme will assist participants in gaining an understanding of the clinical evidence underpinning the diagnosis and ongoing care and management of the child with asthma utilising current best practice.

Oct 21 **Type 1 Diabetes Management for Nurses and Midwives**

This programme will provide nurses and midwives with knowledge and skills regarding type 1 diabetes. The literature would suggest that diabetes, chronic disease management and the self-care that is associated with it brings high incidence rates of depression, anxiety and negative thoughts. The use of different strategies, self-management, treatment options, insulin pump therapy and CGM will be looked at to improve patient self-management. The exploration of these strategies and management of type 1 diabetes is a necessary component to help nurses and midwives to formulate plans to combat issues that clients face.

Oct 27 **Competency-based Interview Preparation for Nurses and Midwives**

This online programme will help participants to prepare for a competency-based interview that enables candidates to show how they would demonstrate certain behaviours and skills in the workplace by answering questions about how they have reacted to, dealt with and handled previous workplace situations. It will explore preparation, presentation and performance during the interview and will briefly focus on CV preparation.

Oct 28 **Retirement Planning Webinar**

Planning for retirement is even more important today than it has ever been. There are many factors to consider as you approach retirement. It is good to start by reviewing your finances to ensure your future income will allow you to enjoy the lifestyle you want. This webinar will cover: superannuation, AVCs, lump sum and investments. This event is free to members. Prior booking is essential. Time: 2pm-3.30pm.

Oct 28 **The 'Know How' of Inhaler Technique**

This short, two-hour online programme for nurses and midwives will address issues around inhaler technique. The programme will introduce the participant to current best practice in relation to inhaler technique and assist in the understanding of the role of inhaled medication with the correct use of inhalation devices (fee for members: €20).

Oct 28 **Diabetes CBT and General Wellbeing**

The literature would suggest that diabetes, chronic disease management and the self-care that is associated with it brings high incidence rates of depression, anxiety and negative thoughts. The use of different strategies, Cognitive Behaviour Therapy (CBT) and clinical trials look at the area of wellbeing and theories and models to help clients and healthcare providers try and formulate plans to look at these issues. This programme will explore techniques and interventions that can be used to help clients acknowledge issues that arise from having diabetes.

Nov 1 **Introduction to Management and Leadership for Nurses and Midwives**

The aim of this short course is to identify managerial and leadership competencies for frontline managers and to explore how these are applied in practice. The course will include management theory, effective leadership and teamwork, as well as delegation and clinical supervision; understanding the nature and approaches to leadership; leading nursing and midwifery in your workplace; understanding yourself; leading others; professionalism, regulation and fitness to practice.

Nov 2 **Tools for Safe Practice for Nurses and Midwives**

This programme provides safe practice tools to protect the nurse, midwife and patient within current healthcare settings. The programme is free to INMO members. Places must be booked online in advance of your attendance.

Nov 3 **Infection Prevention and Control During Covid-19 Pandemic in residential care settings**

Infection prevention and control is essential to prevent the spread of Covid-19. This short online course for nurses working in residential care settings will outline evidence-based and national guidance on infection prevention and control in residential care settings during the Covid-19 pandemic. Understanding infection control will provide the participant with the tools to prevent Covid-19 from spreading.

Nov 4 **Introduction to Oncology: Terminology and Patient Pathways**

This short three-hour session will give participants an increased understanding of the language of oncology in order to improve fluency with patients and colleagues, increased insight into the oncology journey and stages the patient is at which will improve overall patient care and outcomes. There will also be an opportunity to ask questions.

Nov 8 **Understanding Epilepsy for Nurses and Midwives**

This short course will provide a good foundation and increase participants' knowledge when caring for patients with epilepsy. Nurses who are not specialists in epilepsy can play a central role in providing optimal care, education, and support to their patients with epilepsy given the proper tools. This course will provide a foundation on which to build increasing knowledge of epilepsy and care of the patient.

Nov 9 **Medication Management Best Practice 2021 – Guidance for Nurses and Midwives**

This programme supports nurses and midwives in providing safe, evidence-based practice in the area of medication management thus preventing medication errors and near misses. The programme will cover key topics such as: the key principles of medication management, the medication management cycle, management of controlled drugs and medication safety. Participants will have the opportunity to update their knowledge in line with the most up-to-date Nursing and Midwifery Board of Ireland Guidance for Registered Nurses and Midwives Administration (2020) and Health Information and Quality Authority requirements for medication management.

Nov 9 **Introduction to Effective Library Search Skills**

This course is aimed at nurses and midwives who would like to develop their searching skills to effectively find the most relevant information for clinical practice, reflection and policy development. This course will also be of benefit to those who are undertaking, or about to commence, post-registration academic programmes.

Nov 11 **Introduction to Chemotherapy**

Chemotherapy simplified: this introductory session will equip you with the main principles of chemotherapy, its side effects and how to feel safe and confident handling these drugs. In return you will feel empowered to deliver improved care to your patients. This session will cover pharmacology of chemotherapy; chemotherapy side-effects and chemotherapy regimes and safe handling of cytotoxics. As good communication skills with patients and families are crucial in chemotherapy, this programme will keep your skills up to date.

Nov 16 **Improve Your Academic Writing and Research Skills**

This course is designed for nurses and midwives in third-level education. It will assist participants in completing their written assignments. The objective of the course is to help prepare the student for academic study, which requires efficient literature searching, research critique and accurate referencing skills. On the day there will also be a question and answer session to help you with any of your queries.

Nov 16 **Safer Better Care – 8 Themes – Public Health and Community-based Nursing**

This short online programme aims to update nurses/midwives who work in the community setting on the eight themes of the 2012 HIQA Safer Better Care framework. These themes are: person-centred care and support; effective services; safe services; health and wellbeing; leadership, governance and management; use of resources; responsive workforce and use of information. This programme will examine the ethos within the role of these nurses, customer service, advocacy and procedures and the role of the team.

Nov 17 Introduction to Wound Management for Nurses and Midwives

Topics covered in this course will include wound healing, wound bed preparation, treatment options and dressing selections. Participants will learn about the anatomy and physiology of wound management, the factors influencing wound healing, the differences between acute and chronic wounds, implementation of a holistic assessment of individuals with wounds and different types of dressing and their application.

Nov 18 PEG Feeding – Caring for Adults and Paediatrics who have a PEG Tube

This introductory programme is aimed at all nurses working within the hospital and community setting caring for adults and paediatrics who have a percutaneous endoscopic gastrostomy (PEG) tube. It will address the clinical indications and requirements for PEG feeding in the home and hospital setting. It will provide guidance on medication administration and nutrition with a focus on hospital policies and government guidance. It will also discuss the complications of PEG feeding that can occur and how these can be clinically managed.

Nov 23 **Understanding and Developing Care Plans for Nurses and Midwives**

This programme provides nurses and midwives with the most up-to-date information regarding policy and standards. It will enhance their understanding of nursing care plans, reflecting on the past, present and future use of care planning and its importance in the workplace. It will focus on the need for comprehensive assessment, including risk assessment and care planning. Participants will be provided with practical tips on how to prepare for and carry out a comprehensive assessment, enabling them to develop a person-centred care plan.

Nov 24 **Navigating Your Way Through Conflict**

This short online programme will help participants develop the insight and skills necessary to navigate conflict situations and reach satisfactory solutions. Workplaces can be the perfect breeding ground for conflict. As well as our skills, we bring our individual needs, ambitions, personalities, perspectives, backgrounds and vulnerabilities with us to work. It is hardly surprising, therefore, that conflict can arise as we interact with others. While some conflict can be healthy, unresolved conflict can lead to negative outcomes for our wellbeing.

Nov 24 **Introduction to Positive Behaviour Support**

Positive behaviour support is an evidence based-approach to supporting individuals that can present with behaviours that challenge. This workshop introduces participants to the model of positive behaviour support and outlines the benefits and considerations in its utilisation from a practical and applied standpoint. Fee €60 INMO members; €130 non-members. Time: 9.15am-4.45pm.

Nov 25 **Tracheostomy Care Study Day**

This programme introduces a holistic and inter-disciplinary approach to the management of the adult patient with a tracheostomy. Participants will be given the necessary knowledge, skills and confidence to assess, manage and evaluate the nursing care of a patient with tracheostomy.

Nov 30 **Medication Management in Diabetes Type 2**

This programme aims to enhance and develop the knowledge and skills required by healthcare professionals to educate and support the self management of people with diabetes. Topics will include the classification and diagnosis of type 2 diabetes, glucose targets and current pharmacological approaches to glycaemic management, challenges to medication management and practical skills required to support education and diabetes self-management.

Nov 30 **Introduction to Leg Ulcer Management**

This short online course will advise participants on leg ulcer management. Topics covered on the day include; pathophysiology, assessment and management of leg ulcers. Upon completion, participants will: have an understanding of the theory and concepts of the different causes of leg ulcerations; have gained a deeper understanding of the pathophysiology of leg ulceration; be aware of different non-invasive assessment for leg ulcerations; understand the importance of compression for venous leg ulcerations.

Dec 1 **Clinical Governance for Senior Nurse Managers (Acute/Residential Healthcare Settings)**

This short online programme is aimed at the most relevant to senior nurse managers within the acute or residential healthcare settings to help them understand and be confident in building their skills and having a keen knowledge of clinical governance. Clinical Governance is the system through which healthcare organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which clinical excellence will flourish.

Dec 2 **Recognition and Management of Sepsis**

This online session will focus on early recognition and management of Sepsis. Case studies will be included to create an interactive learning platform to engage participants throughout the session. Outcomes: discuss and provide background for development of sepsis; identify the early recognition of signs of sepsis; discuss implementations of sepsis guidelines through fluid and antimicrobial stewardship; apply and integrate evidence based guidelines into patient care planning.

Dec 7 **Introduction to Treating and Preventing Pressure Ulcers**

This short online programme will advise participants on pressure ulcer prevention. Topics covered on the day include; causes of pressure ulcers, risk assessment and prevention of pressure ulcers. Learning outcomes: discuss the causes of pressure ulcers; identify the factors that place a person at risk of developing pressure ulcers; have an understanding of the key principles of preventing ulcers and be able to take action to prevent pressure ulcers in the clinical environment; have an understanding of pressure ulcer classifications and grading; have an understanding of the key principles of the SSKIN Bundle (surface, skin infectioin, keep moving, incontinence and nutrition) and how to implement it in the clinical environment.

Dec 9 **Competency-based Interview Preparation**

This programme assists participants to prepare for a competency-based interview, which is based on the premise that past experience can predict future behaviour. This is an increasingly common style of interviewing that enables candidates to show how they would demonstrate certain behaviours and skills in the workplace by answering questions about how they have reacted to, and dealt with, previous workplace situations. The programme will provide an overview of CV development and will outline the steps in the interview process. Role play will be used to ensure that participants are able to communicate their knowledge and experience effectively for any future interviews.

Dec 15 **The Sociology of Health**

This course is an introduction to sociology of health and illness. It examines the meaning and relationship of health, disease, illness and sickness. The impact of social inequality will also be explored, along with other topics such as the sick role and the role of healthcare professionals.

INMO Professional

Climate change literature

This month the library team recommends articles looking at the impact that environmental changes have on nurses and midwives

Climate change perspectives

- Kalogirou MR et al. Nurses' perspectives on climate change, health and nursing practice. J Clin Nurs 2021; 29(23/24), pp. 4759–4768
- Anåker A, Spante M, Elf M. Nursing students' perception of climate change and sustainability actions – A mismatched discourse: A qualitative, descriptive exploratory study. Nurse Educ Today 2021
- Adrian A. Climate and health. J Perioper Nurs 2020; Vol 33(1), pp. 9–11

Environmental practice

- Cook, C., Demorest, S. L. and Schenk, E. Nurses and Climate Action. Am J Nurs 2019; 119(4), pp. 54–60
- Scullion J. Sustainability 3: how nurses can reduce the environmental impact of inhalers. Nursing Times 2020; 116(9), pp. 38–40
- Kalogirou MR et al. How the hospital context influences nurses' environmentally responsible practice: A focused ethnography. J Adv Nurs 2021; 77(9), pp. 3,806-3,819
- Lira T et al. Finnish nurses' perceptions of the health impacts of climate change and their preparation to address those impacts. Nursing Forum 2021; 56(2), pp. 365-371
- Schenk EC. Addressing Climate Change: We Can't Afford Not To. Nursing Economics 2019; 37(1), pp. 6-8
- Nicholas PK, Breakey S. Climate Change, Climate Justice, and Environmental Health: Implications for the Nursing Profession. J Nurs Scholarsh 2017; 49(6), pp. 606–616

Role of the Nurse

- Loodin J. Nurses have a key role in action against climate change. Kai Tiaki Nursing New Zealand 2019; 25(10), pp. 3
- Last R. Greener Respiratory Healthcare: A Call To Action. Practice Nurse 2021; 51(1), pp. 17–21
- Kolbuk ME et al. Mitigating the Effects of Climate Change on Health and Health Care: The Role of the Emergency Nurse. Journal of Emergency Nursing 2021; 47(4), pp. 621–626
- Brenndorfer M. Nurses are crucial in the fight against climate change: Nurses understand the impact of the environment on individual and population health. That understanding is crucial to ensuring health justice in interventions to mitigate climate change. Kai Tiaki Nursing New Zealand 2020; 26(9), pp. 22–23
- Schenk EC et al. Nurses Promoting Inclusive, Safe, Resilient and Sustainable Communities: Taking Action on Covid-19, Systemic Racism and Climate Change. Am J Nurs 2020; 121(7), pp. 66–69

Library services

The library has a number of services to support your practice and educational requirements, including literature searching, document supply, reference desk assistance and searching consultations. To find out more, call 016640614 or email: library@inmo.ie

Impact on patients

- Jackson Allen P. Climate change: a review of potential health consequences. Primary Health Care 2015; 25(7), pp. 34–40
- Wright L. Allergies, asthma and climate change. Contemporary Pediatrics 2020; 38(7), pp. 20–22
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Online – Introduction to Effective Library Search Skills

Next course date: Monday, October 11

Fee: €30 INMO members; €65 non-members

This course is aimed at nurses and midwives who would like to develop their searching skills to effectively find the most relevant information for clinical practice, reflection and policy development. This course will also be of benefit to those who are undertaking, or about to commence, post-registration academic programmes.

INMO Professional

RCM i-learn

THE ROYAL COLLEGE OF MIDWIVES

Epidurals in labour

This module aims to improve midwives' confidence in caring for women who choose to birth using epidural analgesia

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

Why is this topic important?

Pain relief is important for women in labour. Pharmacological methods of pain relief include breathing in nitrous oxide, injection of opioids and local analgesia with an epidural for a central nerve block.

Epidurals are widely used for pain relief in labour and involve an injection of a local anaesthetic into the lower region of the back close to the nerves that transmit pain. Women may choose epidural for labour (EFL) for a number of reasons and sometimes an epidural may be advocated for or indicated for medical or obstetric reasons, eg. cardiac disease or a perceived high-risk labour where urgent transfer to operative delivery is envisaged.

It is important that healthcare professionals are fully informed about possible contraindications and that the woman is fully informed about the advantages and disadvantages as well as the side effects and complications.

The role of the midwife

Epidural analgesia can be an effective form of pain relief for labour and is a choice for many woman today. Midwives have a key role in the caring of women for epidural. This spans from the antenatal period, where education on labour analgesia options is a vital tool for ensuring women are able to give informed consent during labour, to the prompt identification of major complications and the swift action to remedy them and the practical care of women who have restricted ambulation.

Preparing for epidural anaesthesia

While it is the responsibility of the anaesthetist to obtain informed consent prior to administering an epidural, midwives must also ensure informed consent is obtained.

A significant section of the module covers the varying considerations that must be attended to when looking after a woman with epidural analgesia. This includes regular observations and assessments, what to look out for and how they could deviate from the norm and examples of other aspects of care that require attention such as personal hygiene and hydration.

The module also explores skin and bladder care in more detail. Pressure area damage is a common side-effect of epidural analgesia and requires midwives to be vigilant in preventing it. Bladder care is also considered in more depth as regular bladder emptying plays a vital role in effective labour care.

Learning outcomes

On completion of this module you will understand:

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

RCM i-learn access for INMO midwife members

Free access is available to all midwife members of the INMO. If you are interested in learning more about the modules outlined or in completing a learning module, visit **www.inmoprofessional.ie/RCMAccess** or email the INMO library at library@inmo.ie for further information

Mental health awareness week

WITH mental health awareness week 2021 just around the corner, Cornmarket is delighted to bring INMO members a bespoke collection of mental health and wellbeing programmes – all free as a part of *Let's Talk About It*, a mental health collective for INMO members. Available for a limited period of time, these resources are designed to create better mental health awareness within the nursing and midwifery professions and also equip you with the tools you need to support your own mental health and wellbeing.

Let's get behind this together

It's OK not to be okay | Mental Health Ally Training for healthcare professions
October 13, 2-3PM

What is mental health? Is it simply feeling 'good' all the time, or can we also hold space for feeling 'bad'? This training focuses on building awareness of mental health as it exists on a continuum, noticing your current mental health status, and understanding how to support others by reducing the stigma around mental ill health. It will also provide nurses and midwives with strategies to help support individuals experiencing difficulties.

This course will cover:

- Mental health continuum and reducing stigma
- Noticing thoughts, emotions and behaviours
- Skills to support your own mental health
- What it means to be a mental health ally
- How to support a colleague who may be struggling

To book your place, visit: **Cornmarket.ie/lets-talk-about-it/ally**

Can't make it? Register and we'll send you a recording following the course

Group life skills

With Aware – six-week programme commencing October 18 at 7:30PM

Based on the principles of cognitive behavioural therapy (CBT), the Life Skills programme is designed to help people learn more about how we think and how this can influence our actions in helpful or unhelpful ways.

With easy-to-follow worksheets and expert guidance from a trained facilitator at each session, you can learn:

- How to better manage the stress of everyday life
- Recognise and manage unhelpful thoughts
- Learn new ways of thinking
- Begin the journey to a healthier and more confident life.

There is no charge for this course, but spaces are limited. To book your place, visit: **Cornmarket.ie/lets-talk-about-it/support-services**

Pre-recorded bespoke webinars

Earlier this year, Cornmarket asked some of their INMO customers to help shape *Let's Talk About It* by completing a short survey. Over 1,000 members responded,[1] confirming what topics they wanted to see. Watch a webinar at a time that suits you best by visiting: **Cornmarket.ie/lets-talk-about-it/webinar**

Reference
1. Cornmarket's Shape the Initiative Survey, March 2021, based on 1,134 responses from INMO Income Protection Scheme Members Let's Talk About It, a mental health collective for INMO members, is brought you by INMO and Cornmarket

Spotlight on: Leadership

Midwifery leadership in focus – the need for a chief midwifery officer

MIDWIVES play a central role in maternal healthcare and across the spectrum of sexual, reproductive, maternal, newborn and adolescent healthcare. Midwives are experts in their field; they are highly knowledgeable, skilled and their presence has been shown to reduce maternal deaths by as much as 80%.[1] Working across acute and community settings, midwives deliver compassionate care, advocacy, and empowerment to women, children and families.

According to the World Health Organization (WHO), midwives are vital to the delivery of maternal and reproductive healthcare: "the need for every woman to have skilled care in pregnancy, childbirth and the immediate postnatal period…midwives are the most appropriate primary healthcare provider".[2]

Traditionally leadership was associated with the more formal senior positions in maternity services. However, increased emphasis has been placed on leadership skills for frontline midwives. It is critically important for all midwives to understand leadership principles and how it applies to their role.

Clinical leadership is central to the midwife's role. The National Maternity Strategy (2016) states that "strong and effective" clinical leadership is imperative for the model of care to deliver safe, high quality maternity services across all settings in Ireland.[3] In the UK, the National Maternity Review (2016) found that a lack of clinical leadership led to poor outcomes for women.

Midwives have proved their leadership capacity by leading care excellence. Locally, regionally and nationally, midwives in Ireland provide evidence of the importance of midwifery leadership and its impact on services across different settings. Covid-19 has significantly impacted services and in a recent interview with midwife leaders in *WIN*,[4] the directors of midwifery of several hospitals provided further testimony to the skills and expertise in delivering high quality care in unprecedented times.

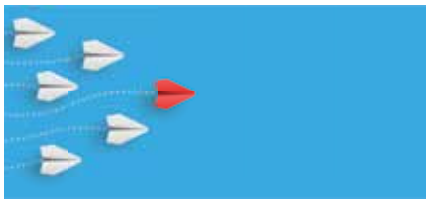
Midwife-led care is proven to deliver excellent quality continuity of care and outcomes for women. Studies have shown benefits, including better health outcomes and cost-effectiveness.[5] A study in Ireland found continued positive outcomes and cost effectiveness of care led by midwives.[6] However, the lack of clarity and implementation of the National Maternity Strategy, which supports midwifery-led care development, has halted further progress in this area.

Investing in and strengthening midwifery leadership is high on the agenda of all international and national representative organisations. The recent *State of the World's Midwifery* Report identifies leadership as an important issue for midwives. It notes that there are limited opportunities for midwives to hold leadership positions.[7]

The Royal College of Midwives in a manifesto entitled *Strengthening midwifery leadership: a manifesto for better maternity care*, presents a pathway to improvements in maternity services underpinned by building strong midwifery leadership. The manifesto outlines seven steps required to strengthen midwifery leadership in all areas of midwifery, from senior leadership positions, education and research to specialist and consultant positions.

The UK is one of a small number of countries that has established the position of chief midwife officer to date, a key role for reinforcing and strengthening leadership. Rolling out the position globally is a key objective for the International Confederation of Midwives (ICM) and other midwifery organisations.

As part of the eighth WHO-ICN-ICM Triad Meeting in 2020, the ICM held a forum advocating for developing the position in member states.



There are many reasons why the chief midwife officer post should be established, not least the delivery of high quality, evidence-based sexual, reproductive and maternal health services and providing strength to the voices of women and their families. The position is also an essential strategic leadership and influencing role, critical to policy direction and development. It is a key component in recognising midwifery as a separate profession and advocating for all midwives at national level on important issues, including regulation, workforce and career pathways.

Niamh Adams is head of library services and Steve Pitman is head of professional development, both with the INMO

Launched in 2021, the Nursing Now Challenge brings forward the Nightingale Challenge mandate, which focuses on developing leadership opportunities for nurses and midwives globally. Visit ***www.nursingnowireland.ie***

If you are interested in writing or contributing to this series of leadership articles, please get contact Steve Pitman by email: steve.pitman@inmo.ie.

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SCAN ME

Minding your mental health

There is a broad range of mental health support available to those who need it, writes **Catherine O'Connor**

THIS month sees World Mental Health Day taking place on October 10. Being a student nurse or midwife can be challenging at the best of times, let alone in the middle of a pandemic. It is important that we take the time to evaluate how our mental health is being affected by circumstances. While we are frequently told about the importance of 'minding our mental health', it's worth examining what exactly mental health encompasses, as it is not simply the absence of mental illness.

The WHO defines mental health as being "a state of wellbeing in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community".

There are a variety of ways that we can develop good habits to protect our mental health. In 2018, the HSE developed a campaign that focuses on the 'Little Things' that we can do to mind our mental health. Some of these things include ensuring to get enough sleep, reducing alcohol consumption, eating regular nutritious meals, and keeping active by exercising for at least 30 minutes per day, five days a week. Limiting social media exposure and moderating or eliminating caffeine, tobacco, and drug intake has also been linked with improved mental health.

Studies have also shown the importance our environment has on our mental health – walking in nature or even sitting in a room with a view or with indoor plants has been linked with an enhanced sense of wellbeing. Some studies indicate that there can be benefits to gratitude journalling, particularly when used in conjunction with other stress management techniques.

One of the most important ways that we can mind our mental health is by connecting with other people. Speaking to someone you trust about what you're going through can prove to be invaluable in terms of receiving help and staying well. It can be difficult to know where to start when first opening up to someone about your mental health and the thought of it can be daunting. Try to say how you're feeling, be honest and to use words that feel comfortable to you.

There may be times where you feel you want support but don't feel able to speak to friends or family. The *Table* above lists organisations you may find useful to engage with at some point. INMO members have access to a 24-hour counselling helpline service (Tel: 1850 670 407 /01 8818047) that provides confidential counselling including, where appropriate, onward referral to relevant voluntary and/or professional services (at the caller's expense). For further details, please see: **inmo.ie/membership_benefits**. Members also have access to 'Let's Talk About It' an initiative with Cornmarket, featuring recorded webinars, podcasts and more, see: **cornmarket.ie/lets-talk-about-it**

In college, link lecturers, student union welfare officers and student counselling services can offer support. There are also supports in clinical placement sites, for example you can share concerns about the pressure of placement with your CPCs.

As internship students are employees, they have access to the employee assistance and counselling service; more details available at: **hse.ie/eng/staff/workplace-health-and-wellbeing-unit/employee-assistance-and-counselling-service**

Catherine O'Connor is the INMO's Student and New Graduate Officer, email: catherine.oconnor@inmo.ie

Table: Organisations offering support or information

Organisation	Website	Contact details	Service provided
Samaritans Ireland	**samaritans.org/ireland/samaritans-ireland/**	Tel: 116123 (free) Email: jo@samaritans.ie	24/7 Listening service and emotional support for people experiencing distress
Aware	**aware.ie**	Tel:1800 80484 (free) Email: supportmail@aware.ie	Support and information for people experiencing stress, depression, bipolar disorder and mood related conditions
Pieta House	**pieta.ie**	Tel:1800247247 (free) Text HELP to 51444	Free therapy to those engaging in self-harm, experiencing suicidal ideation, or bereaved by suicide.
Jigsaw	**jigsaw.ie**	Tel: 01 4727010 Email: info@jigsaw.ie	Support and information for people ages 12-25
Spun Out	**spunout.ie**	Text SPUNOUT to: 086 1800280	Provide information on health and wellbeing for people ages 16-25
BodyWhys	**bodywhys.ie**	Tel: 01 2107906 Email: alex@bodywhys.ie	Support and information for people affected by eating disorders
LGBT Ireland	**lgbt.ie**	Tel: 1890 929539 Email info@lgbt.ie	Support and information for members of the LGBT+ community
Women's Aid	**womensaid.ie**	Tel: 1800341 900 (free)	Advice and practical support for women and children experiencing physical, emotional and/or sexual abuse.
HSE	**yourmentalhealth.ie**	Text YMH to 50808 Tel: 1850 241850	Information and advice on mental health

Irish Nurses and Midwives Organisation
Cumann Altraí agus Ban Cabhrach na hÉireann

Help us to update your INMO membership contact details

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** INMO number:	NMBI number:
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Surname:	
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Study address:	
Employment grade (eg. CNM1, etc)	
If you are PHN or Community RGN Name of Local Health Office: Name of Community Care area:	
INMO Section:	
INMO Branch:	
Student: (Please tick appropriate) Yes ☐ No ☐	
Telephone Home:	Work:
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Please note that this mobile number will only be used by INMO for important updates and will not be given to any other party at any time. If you have any queries, please call the membership department Tel: 01 6640600

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The above details are correct as of:

Date: Signature:

Irish Nurses and Midwives Organisation,
The Whitworth Building, North Brunswick Street, Dublin 7, Ireland
Tel: 01 6640600 **Fax:** 016610466 **Email:** inmo@inmo.ie

Q and A Bulletin Board

With INMO director of industrial relations Tony Fitzpatrick

Parental leave

Q. I recently applied for parental leave, but my employer has refused this request and I have explained that I have an entitlement to take parental leave. What are my entitlements in respect of the granting of this leave?

Parental leave is a statutory entitlement based on the provisions of the Parental Leave Acts. There is a requirement on employees to give their employer at least six weeks' written notice of their intention to take parental leave and also to request the manner in which that leave is sought. Some employees seek to take a block of time (26 weeks or separate blocks of a minimum of six continuous weeks), others seek to have the time taken as a day a week or a number of hours per week. However, the decision as to how the period of parental leave should be taken has to be agreed with the employer. A confirmation document specifying the date of commencement of the leave, its duration and the manner in which it is to be taken has to be prepared and signed by both the employee and the employer, at least four weeks before the leave is due to commence. Once the confirmation document has been signed, specifying the date of commencement of the leave, its duration and the manner in which it is to be taken, both parties can agree to change the arrangement and a new confirmation document can be written up. Postponement of the leave cannot take place if the leave is confirmed. However, if the document is not signed the employer can postpone the leave up to six months, but notice (not less than four weeks before your leave) is required.

Enchanced senior staff nurse/midwife increment

Q. I have 17 years' service as a staff nurse. Will I be eligible for the senior staff nurse increment?

All senior enhanced nurses/midwives who have 17 years' post-qualification service are eligible for payment of the senior enhanced nurse/midwife increment. The reference date for determination of service and payment is November 1 each year. All service, inclusive of part-time/job sharing service, is reckonable. Currently the salary scale for senior enhanced practice staff nurse/midwife is €51,344.

- Service constitutes all genuine nursing experience in Ireland and abroad
- The reference date for determination of service and payment is November 1 each year, you must apply in advance of that date
- Application forms may be obtained from your HR department.

Superannuation

Q. I have recently sought information in respect of my pension as I am due to retire shortly. The superannuation department has advised me that the nine days that I partook in the national nurses' dispute are being deducted as part of my service record. I thought this had been negotiated and that we would not lose these dates for pension purposes. Can you please clarify this?

You are correct. The INMO argued that this time should be considered service and the matter was heard by the Labour Court in 2006 and the Court issued a recommendation on November 9, 2006 in respect of this matter. The Court recommended that any period of absence, without pay, due to the industrial action from October 19-27, 1999, would be reckonable for pension purposes. The Labour Court recommended that the service would be reckonable subject to the payment of the appropriate superannuation contributions in respect of the days being reckoned. Superannuation contributions would be calculated based on pensionable remuneration at the date of retirement. The only exception to this would be nurses and midwives who already exceeded the maximum reckonable service permitted under the superannuation scheme. The HSE issued a circular following this Labour Court recommendation in 2007. The circular (013-2007) sets out the terms on which this particular issue is to be dealt with. This period, in accordance with the Labour Court recommendation, can now be considered as time worked and the superannuation that would have been due, had it been worked, is to be calculated at the rate of remuneration that applied for the nurse/midwife at that time.

INMO Professional

Irish Nurses and Midwives Organisation
Working Together

Public Health Nurses Section WEBINAR

Saturday, 16 October 2021

From 10am - 2pm

Theme 1: **Post natal depression**

Theme 2: **Menopause - Positive ageing – Minding your mental health**

Theme 3: **Paediatric Skin Conditions in the Community**

Theme 4: **ANP Pathway & Virtual ward**

Theme 5: **Health Safety Wellbeing**

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Quality & Safety

A column by Maureen Flynn

Put your name on the 'Q Ireland Network Map'

WE KNOW that a significant number of nurses and midwives are interested in quality and patient safety and quality improvement. An excellent way to nurture and sustain that interest is to connect with other people who are involved in similar work, to hear about their success stories, and to learn about their challenges.

This week's column highlights how nurses and midwives can make new connections with people working in Quality and Patient Safety in Ireland by accessing a new online network map.

The map is for those involved in healthcare quality improvement in Ireland. It aims to visualise and build the connections of people who are involved in healthcare quality improvement anywhere in Ireland.

It was developed by a group of people with an interest in quality improvement who co-designed and tested the mapping processes with members of the HSE Quality and Patient Safety Directorate. The Health Foundations, Q Community provided technical support and guidance.

Joining the Network Map

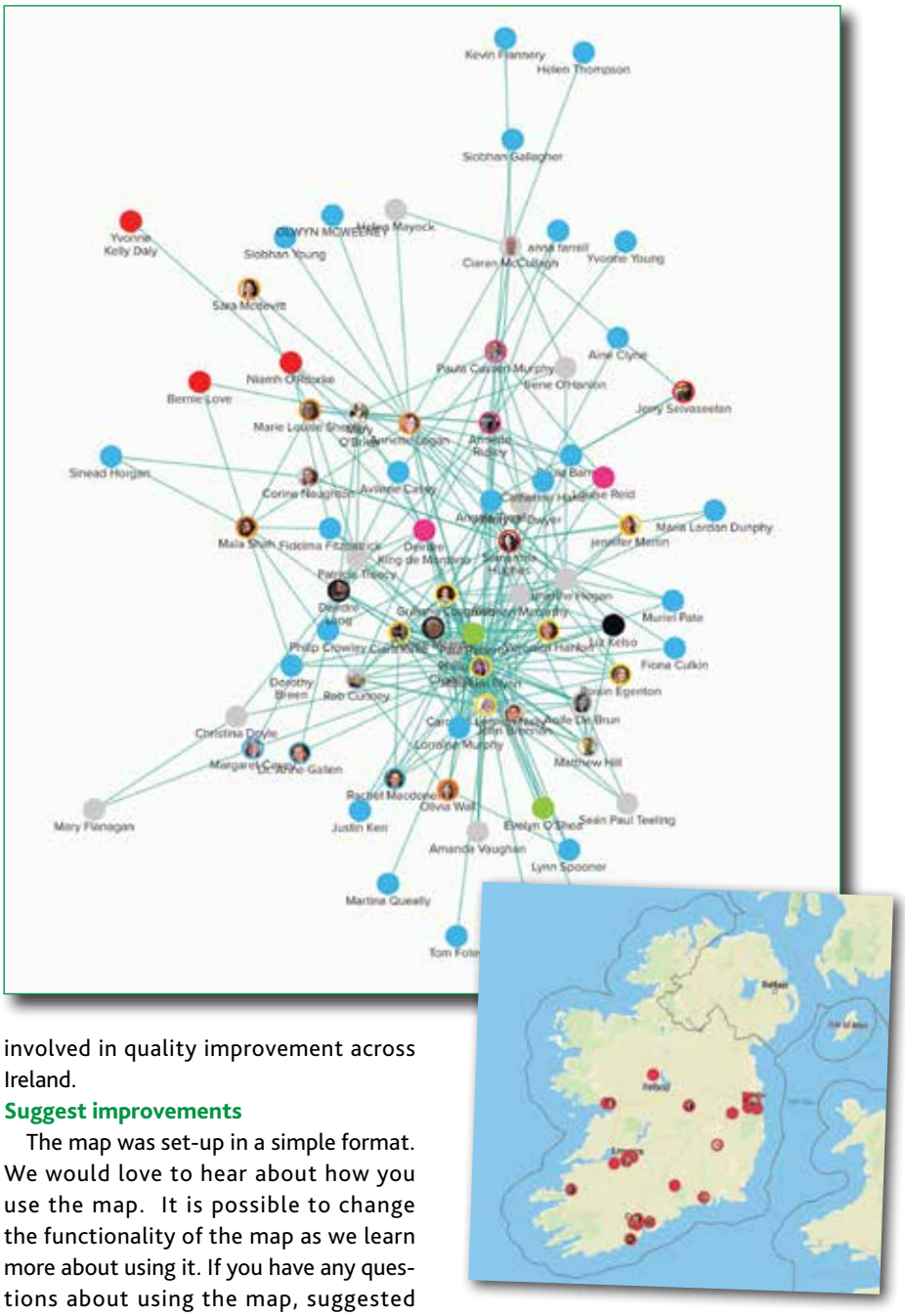
The network map is open to nurses and midwives with an interest in quality improvement. Joining is easy – you simply opt-in to join the map by entering your details (name and email address). Participation on the map is entirely voluntary and is based on your specific and informed consent. You can withdraw your name from the map at any time by deleting your data.

Follow Q Ireland Network Map to see all members of the network and their connections within the network (*see main image*). The map is searchable: **bit.ly/3lxLaAG**

To view the Geo Network Map follow the Q Ireland Network Geomap to see where all members of the network are based geographically on a map of Ireland (*see small image*). The map is searchable.

Navigating the map

You can use the map to search for people you already know, to make new connections, and to collaborate with other people involved in quality improvement across Ireland.



Suggest improvements

The map was set-up in a simple format. We would love to hear about how you use the map. It is possible to change the functionality of the map as we learn more about using it. If you have any questions about using the map, suggested improvements, or experience any issues in using it - please send an email to: caroline.lennonnally@hse.ie or matthew.hill@health.org.uk

Maureen Flynn is the director of nursing ONMSD, QI Connections lead, HSE Quality and Patient Safety Directorate

Acknowledgement: Thank you to Matthew Hill and the team at Q for helping us to learn about network mapping and to Q members in Ireland who assisted in the co-design. A particular thank you to my colleagues Caroline Lennon Nally, Anne Marie Heffernan, and Noemi Palacios for sharing information and assistance in preparing this column

The power of positive psychology

Investment in wellbeing improves our health and leads to optimal results in our personal and professional lives, writes **Sophie Dooley**

THE World Health Organization (WHO) defines health as "a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity".[1] Positive psychology sets itself the task of determining scientifically validated ways of pursuing and achieving happiness. In one article, Satterfield states: "In contrast, the primary purpose of positive psychology is to measure, understand and then build human strengths and civic virtues, including hope, wisdom, creativity, courage, spirituality, responsibility, perseverance and satisfaction".[2]

Positive psychology is a conscious move from treating pathology and mental illnesses. Its aim is to complement traditional psychology by seeking more balance. Its focus is on optimal human flourishing, which requires connection to what is going on inside oneself.

Healthcare professionals have an amazing ability to adapt to challenges. Agility is called on regularly in the healthcare profession when adapting to change and challenges during a normal working day, adapting quickly to traumatic experiences. The healthcare professions are open to change and new lessons, eager and enthusiastic to improve constantly by leveraging strengths and skills to deliver and meet the needs of this constantly evolving industry.

Covid-19

The emergence of Covid-19 required that health professionals change and adapt quickly. However, while change can be challenging, it was accelerated by the pace at which change needed to occur to meet the demands that the pandemic presented. This meant the endless delivery of professional care during an extremely difficult period. This created an environment where chronic stress and burnout could develop.

This constant demand of energy and expectation to deliver in high-performing teams may result in mental and physical exhaustion. There was no preparation for this challenge and there has been little or no time for rest or recovery. Barker and Nussbaum's study on fatigue, performance and the work environment among nurses demonstrates that "fatigue is a factor that has been linked to poor performance decrements in healthcare workers".[3]

Gaining some perspective

Maybe it is time to examine and gain an understanding of all that has happened and allow for time to stop and check in with yourself. INMO president Karen McGowan advocated for this in the April 2021 issue of *WIN*: "Let's help ourselves to be as well as we can during these challenging times."[4]

Martin Seligman, the founder of positive psychology – the study of human flourishing and optimal functioning – states that "positive health describes a state beyond the mere absence of disease and is definable and measurable".[5] Why wait until we are unhappy to focus on happiness or wait until we are ill to make wellbeing a priority? Wellbeing is not limitless and needs to be topped up. We constantly need to fill up our emotional stores as they empty. Wellbeing requires as much attention as all the other aspects of our health.

Positive psychology focuses on positive emotions, engagement, relationships, meaning and accomplishments, which are the building blocks of wellbeing.[6] A substantial body of research tells us that interventions focusing on positive states and traits can be used to evoke positive emotions. A number of studies by Sin and Lyubomirsky measure the effectiveness of such interventions through a meta-analysis of 51 interventions among 4,266 individuals. This allows us to understand how we can be autonomous and responsible for enhancing our own wellbeing by focusing on activities that increase our happiness. Sin and Lyubomirsky conclude by stating that "the field of positive psychology is young, yet much has already been accomplished that practitioners can effectively integrate into their daily practices. As our meta-analysis confirms, positive psychology interventions can materially improve the wellbeing of many".[7]

The importance of positive emotions

Self-care can be a simple positive experience; it is unique to everyone. Firstly, it is important to check in with ourselves by examining habits that may not be serving us well that may have developed during the rush to the next task. Were there activities unintentionally omitted during our race to meet all the demands on us, such as exercise, downtime, fun or play? Ackermann states that "play is at the heart of emotional wellbeing and mental health".[8] Play and fun are not just for children; they are vital parts of human development and help with building up our wellbeing stores.

Frederickson's research shows us the positive benefits of evoking and building positive emotions. She states that "key to our proposal that positive emotions trigger upward spirals is the proposition that positive emotions broaden attention and cognition".[9] Interestingly, the study goes further to explore how positive emotions can build on our psychological resilience and wellbeing. So from a health promotion perspective, by adopting healthier habits, starting out small and possibly examining our quality of sleep, diet and exercise, we can implement changes that could have a positive influence on our overall wellbeing. By gaining clear perspective we can recharge and rethink, allowing ourselves an opportunity to tap into our innate resources of resilience. Taking back your power around decision-making both personally and professionally will help you on the path to becoming your best self.

Starting with yourself

Maybe it is time to take a bow and acknowledge the ground you have covered, the great decisions you have made and the positive outcomes you have achieved during an extremely challenging time. Maybe it is time to acknowledge the unfailing resilience and perseverance you showed in the face of adversity, viewing

the struggles with a sense of kindness and compassion for yourself and your team and recognising the importance of peer and team support and how it regularly raised its head when required.

One of the most valuable resources people have is one another. Without collaboration our growth is limited. We should acknowledge the humour and positive small moments along the way that carry us through dark times. If we build on our own wellbeing it can have a ripple effect on our relationship with family, friends, work and our community. Engaging in activities that generate positive emotions contributes towards wellbeing.

Nurses must put themselves first. Leadership starts with oneself; how we are with ourselves influences our relationship with others. When we are engaged fully with ourselves and those around us, our performance improves. This is evident in the work of Fred Luthans, who is an expert in positive leadership. In a paper he co-wrote *Psychological capital: an evidence-based positive approach*, the authors focus on hope, efficacy, resilience and optimism (HERO) and share their evidence that this has a powerful impact on attitudes, behaviour, wellbeing and performance.[10]

Becoming your best self

Health literacy and psychological wellness are the keys to performance. We can survive and even thrive in uncertain times when we acknowledge and look after our needs. With a focus on creating and implementing changes in our lifestyle and health, we are contributing to the UN Sustainable Developmental Goals (SDGs). Pradhan et al[11] discuss the aim of the SDGs 2030 agenda in their study *Earth's future*, which is "to transform our world by tackling multiple challenges humankind is facing to ensure wellbeing, economic prosperity and environmental protection".

Investing in wellbeing not only strengthens healthcare professionals, but contributes towards the health system and the economy. Shifting the focus to optimising our own wellbeing through the lens of self-care and compassion will improve relationships, positive emotions and performance, leading to optimal results both in our personal and professional lives.

Sophie Dooley is a former nurse who is now studying positive psychology/coaching in University College Cork

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Top of the class

A team from Kerry describes how school public health nurses are helping Ireland to meet the UN's Sustainable Development Goals

IN SEPTEMBER 2015, the UN's Sustainable Development Goals (SDG) were launched as the new framework for supporting the planet to 2030. They position nurses and midwives as essential partners who in turn work in partnership with people throughout our planet.

This article highlights the role of school nurses as they lead the implementation of SDG 3 in primary schools. An example of how the school nurse confronts the challenge of maintaining a healthy weight in childhood is outlined as part of implementing SDG 3.

In describing the context, the Irish Houses of the Oireachtas Committee on the Future of Healthcare Sláintecare Report incorporated the World Health Organization concept of universal healthcare as the basis of the reform of the Irish health service. Universal healthcare is centred within a primary healthcare framework[1] and includes the provision of population focused, promotive, preventative, primary, curative, rehabilitative health and social care that is affordable, timely, quality driven, effective and integrated across services.[2]

This article explains how school public health nurses express the concept of universal healthcare in implementing the SDGs as part of their roles and responsibilities. Children are the future and school nurses make sure that all of our children face their best futures by advocating for healthy lives and promoting health achieved through a four-step social and health driven screening process.

Step 1: In planning to meet the children we first seek consent from parents. The aim is to find out if the parents themselves have any developmental concerns with their own child. The following are examples of common concerns expressed by parents of young school children:

- *"I always have to repeat myself when I am talking with him. I wonder if he is hearing me?"*
- *"She goes very close or turns sideways when watching the television, I wonder if her sight is okay?"*
- *"He is still wearing pull-ups at night, I wonder if he has a problem or is this normal for five-year-olds?"*
- *"She cannot pronounce 'n' or 'l' yet, is this common?"*
- *"He never relaxes, he is always on the go and cries and shouts a lot, I am worn out, is this normal?"*
- *"She stumbles a lot, I just thought she was clumsy, now I am wondering could there be another reason?"*

Step 2: Each parental response is carefully reviewed by the nurse and before meeting the child at school further discussion takes place with the parents when concerns are expressed. Though we strive to provide our service in bilingual English or Irish contexts sometimes an interpreter may be required where parents are new to the English language.

Step 3: In liaising with the junior infant teacher both nurse and teacher work within the context of parental consent and adhere to data protection legislation.

Step 4: There is always great excitement in the class the day the school nurse is visiting. Children anticipate listening and seeing games, using colourful pegs and letters, they share details about their food preferences and they even compare their own heights with friends in the class.

In maximising the success of the hearing test the level of quietness within the room is measured using an audiometer where a measure of less than 40 hertz is required in maximising the hearing test. Then a three metre measure is identified before commencing the Logmar vision tests. The Leicester height measure and Secca 900 weight measure is used to calculate growth in the school children.

The children attend screening in pods of two or three as determined by their teacher and we make sure that each child is warmly welcomed, valued, respected and carefully assessed.

Afterwards, findings are discussed with parents and the teacher, and either confirm suspicions or present a surprise where difficulties had not been previously noted. Where required and with consent from parents follow-up referrals are made to members of the multidisciplinary and integrated teams, such as audiometry, audiology, the community medical doctor, speech and language therapists, physiotherapy, occupational therapy, dietitians or nutrition services, disability or family support services. Each of these professional and integrated services continue the implementation of SDG 3 as they advocate for healthy lives and promote health.

One example of how the school nurse continues to advocate for and promote health is in confronting the increasing challenges with maintaining a healthy body weight in children. Childhood overweight is defined as a body mass index in the 85th to the 94th percentile, whereas obesity is defined

within the 95th percentile or higher.[3]

Though parents frequently share that maintaining a healthy body weight can be a challenge, internalisation of responsibility for achieving and maintaining a healthy weight is noted as a feature of parents' reluctance in the uptake of an offer of referral to dietitian and nutritional support services for their child.

Undoubtedly, childhood overweight and obesity is multifaceted and complex, including socioeconomic and cultural influences, and no parent or nurse wants to label or create a social barrier for a child in relation to weight.

School nurses engage with teachers and principals in embracing a whole school approach where all children are targeted in promoting healthy weight management. Examples of this intervention planning include heightening awareness of healthy lunches, supporting referral to breakfast clubs where such facilities exist for children who might benefit from this resource, focus on reducing sedentary behaviour and promoting physical activity throughout the school day. However, children who are identified as obese in the junior infant class may benefit from intensive family-based support and the nurse uses sensitive, respectful and where possible culturally competent communication with parents when exploring pathways in endeavouring to achieve the best outcome for the child and the family.[4]

Conclusion

We have shown how our school nurse service provides health promotion and illness prevention within the context of universal health care and primary healthcare[5] and we partner in implementing SDG 3 as we engage in:

- Primary prevention through health promotion on issues such as, among others, maintaining a healthy weight
- Secondary prevention such as hearing, vision, fine and gross motor skills, growth screening and vaccinations in primary and also vaccinations in secondary schools
- Tertiary prevention in referring and following-up on children who are identified with reduced hearing, vision or challenging motor, enuresis, growth or behaviour concerns.

School nurses use sensitivity in interpersonal communication skills as well as professional observation techniques, knowledge, skills and competence in engaging and acting as a liaison between parents, teachers and the wider statutory and voluntary community services.

School public health nurses work in an integrated way towards supporting and maintaining health, identifying challenges and optimising care pathways for children who require support in maximising their potential to live healthy, happy and fulfilled lives. School public health nurses are a fundamental partner in implementing the UN Sustainable Development Goals for 2030.

Dolores Moriarty, Agnes Lucey, Claire Gibson, Margaret Dillane, Marian Lucey, Mary Kelly O Connor, Majella Kearney and Gerardina Harnett are school public health nurses in Co Kerry

Acknowledgement: This project was supported by the CHO7 director of public health nursing Helen Sweeney

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Post-Covid swallowing disorders

Recent research has shown that non-intubated patients are also at risk of being affected by dysphagia after Covid-19 infection

COVID-19 caused by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) has led to a pandemic of unprecedented damage, resulting in hospitalisations and intensive care unit (ICU) admissions worldwide.

Patients affected by Covid-19 are assumed to be at high risk of developing swallowing disorders. Until recently however, data on the characteristics and incidence of dysphagia associated with Covid-19 have been scarce, especially in relation to non-intubated patients. With this in mind, researchers in Italy decided to investigate the onset of swallowing disorders in patients with laboratory-confirmed Covid-19 infection who had not been treated with invasive ventilation. They aimed to evaluate how the virus affected swallowing function regardless of orotracheal intubation.

They noted that swallowing disorders have been described in patients treated with endotracheal intubation after a relatively long stay in an ICU but that it is still unclear whether their subsequent dysphagia was caused by intubation, by the Covid virus itself or by both.

The researchers evaluated 41 patients admitted to the Covid department of their hospital at the point when they had already passed the acute phase of the disease and were asymptomatic but still positive for SARS-CoV-2 RNA.

They examined patients' clinical history and performed the volume-viscosity swallow test. Each patient also answered the swallowing disturbance questionnaire (SDQ). After six months, the researchers then performed a follow-up in patients with swallowing disorders.

It was found that eight of 41 patients (20%) presented with dysphagia symptoms during hospitalisation and two of them still presented an SDQ high score and swallowing disorders with liquid consistency after six months.

The researchers therefore concluded that non-intubated patients can experience various grades of swallowing impairment that probably directly related to pulmonary respiratory function alterations and other viral effects.

According to the researchers, while these symptoms show natural tendency to spontaneous resolution, their impact should not be underestimated, since it could adversely affect patients' recovery from Covid-19 and worsen health outcomes.

The findings were reported in the *European Archives of Oto-Rhino-Laryngology*.

DOI:10.1007/s00405-021-07062-3

A further study also reported dysphagia in a non-intubated Covid patient. A case study recently published in *Nutrition in Clinical Practice* warned that practitioners caring for patients with Covid-19 should be aware that dysphagia, which is associated with increased mortality in older adults, may occur even in the absence of intubation.

The authors observed that dysphagia is one of the complications of intubation in ICU patients,noting that the inflammatory state of Covid-19, combined with malnutrition and low mobility during hospitalisation, may predispose patients to secondary sarcopenia and sarcopenic dysphagia, presenting a major challenge for those caring for patients with Covid-19. However their case study focuses on sarcopenic dysphagia following Covid-19 infection in a non-intubated 85-year-old male. This patient was re-admitted to hospital for post-Covid-19 cough and difficulty in swallowing three days after his discharge following a six-week hospitalisation.

During his treatment, the patient had received remdesivir, favipiravir, dexamethasone and low-molecular-weight heparin for severe Covid-19 pneumonia, but he was not intubated and never required ICU care. Throughout his hospital stay the patient had been confined to a bed as he had dyspnoea on exertion. Physical therapy had not been initiated. Because of his loss of appetite, he had been able to consume approximately 25% of his estimated daily energy and protein requirements. He had not been evaluated for malnutrition or dysphagia. An oral nutrition supplement had not been initiated, and he claimed to have lost more than 3kg body weight.

On examination, he was afebrile with a blood pressure of 117/78mmHg and a pulse rate of 90bpm. Oxygen saturation was 96% on four litres of oxygen through a nasal cannula. He described difficulty swallowing liquid and solid bolus, which was not present prior to his hospitalisation for Covid-19. There was no sign of olfactory dysfunction. Gag reflex was present bilaterally. His EAT-10 eating assessment tool score on admission was 40/40 (EAT-10 is a screening tool for dysphagia and a score of ≥ 3 is considered abnormal). The patient had a BMI of 21.6kg/m^2. His mini nutritional assessment score was 6/30, which was consistent with malnutrition.

The patient was diagnosed with oropharyngeal sarcopenic dysphagia and subsequent aspiration pneumonia after recovery from Covid-19, induced by prolonged immobilisation and malnutrition due to hospitalisation. Initially, enteral nutrition was started through a nasogastric feeding tube. A high-protein formula was initiated, and the infusion rate was gradually increased to reach 30kcal and 1.5-1.8g protein per kilo body weight daily to achieve the desired protein-energy targets.

A dysphagia rehabilitation programme including tongue-hold swallow, tongue base and shaker exercises was provided until discharge. Percutaneous endoscopic gastrostomy (PEG) tube placement was performed one week after his admission when he was no longer on supplemental oxygen. On the next day, he was started on enteral feeds through the PEG tube and discharged home with a reassessment scheduled for two months later.

At the follow-up visit he was observed to have gained 4kg and had a handgrip strength of 28kg. His penetration-aspiration scale score was two with water and three with yogurt. Oral feeding was introduced along with enteral feeding via the PEG tube. The PEG tube was removed when the patient resumed adequate oral intake.

The authors concluded that assessment of malnutrition and sarcopenia may be overlooked and those caring for patients with Covid-19 should be aware that dysphagia may occur even in the absence of intubation. They recommended that the assessment of swallowing function is part of a clinical routine in older Covid patients with malnutrition or sarcopenia.

DOI.org/10.1002/ncp.10731

– Alison Moore

Pain in the older person with dementia

Pain and dementia are common in patients across many healthcare settings. An understanding of the types of pain they may experience will aid in its effective assessment, writes **Alexandra Kelly**

IT IS well established that the prevalence of both dementia and pain increases with age. One in 14 people over the age of 65 have dementia[1] and 50% of those aged over 65 suffer from chronic pain.[2] The age of Ireland's population has been increasing since the 1980s and from 2011 to 2016, the number of adults over the age of 65 increased by 19.1%.[3,4] Research conducted in 2016 found that nearly 22% of encounters in general practice were with an adult over 70 years of age.[5]

Nurses in many practice settings are likely to encounter individuals of advancing age who are suffering from both dementia and pain. Your ability to work with your patient and their family or carers to perform an effective pain assessment is essential, as this is the first step in its effective management.[6]

The objective of this article is to provide nurses with concise, evidence-based information regarding the common features of pain in the older person with dementia and its effective assessment. It is outside the scope of this article to address the management of pain in this population.

What is pain?

Pain is sometimes defined as "whatever the experiencing person says it is, existing whenever the experiencing person says it does".[7] This definition illuminates the subjective nature of pain; in other words, there is no objective test that can definitively establish whether a person is experiencing pain, or that can measure the severity of that pain.[8] You are therefore relying on your patient to provide you with the necessary information to perform a pain assessment. However, if an individual struggles to understand your questions, does not have the language to accurately communicate the sensations that they are experiencing, and does not have the abstract reasoning required to appreciate the effect that these sensations are having on their quality of life, pain becomes much more challenging to assess and treat.

People suffering from dementia typically have difficulty with memory, thinking and language,[9] which are required to conceptualise and express pain. In addition, the older person may suffer from sensory impairment such as hearing and/or vision changes, which can impede effective communication. Unfortunately, pain in the older person with dementia commonly goes undetected for these reasons.[10]

Pain may also be defined as "an unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage".[11] Here, it is stressed that in addition to the unpleasant physical sensations that arise as a result of pain, there are always emotional implications for the person. Older people who suffer from pain are more likely to experience loneliness and social isolation,[12] depression and anxiety and interference with activities of daily living such as impaired sleep and mobilisation.[13]

In order to assess pain, it is essential to have an understanding of the different types of pain your patient may experience. A visual breakdown of the types and aetiologies of pain outlined below can be seen in *Figure 1*. A patient may experience one type of pain, or a combination of types. One of the simplest ways of classifying pain is by duration. Acute pain is related to a specific injury that lasts for a limited time,[14] such as pain from a fracture following a fall.

Chronic pain persists beyond three months.[15] This may be associated with long-term conditions such as diabetic neuropathy.

Pain may also be classified according to its site of origin. Nociceptive pain arises from non-neural tissue[16] (any tissue that is not part of the nervous system). Nociceptive pain may be further classified as somatic (arising from such structures as bone, muscle, ligament or skin) or visceral (arising from deep organs such as the bowel, uterus or bladder).

Acute nociceptive pain which is somatic in origin will arise following a fracture or a skin laceration. Patients with constipation may suffer from acute nociceptive pain which is visceral in origin, as the bowel stretches due to faecal loading or colic. An example of chronic nociceptive pain which is somatic in origin is the pain associated with osteoarthritis. In this condition, thinning cartilage causes changes in the underlying bone.[17]

An example of chronic nociceptive pain which is visceral in origin is the pain associated with endometriosis, whereby growth of endometrial cells outside the uterine lining causes inflammation and scarring in the pelvic and abdominal organs and

abdominal wall.[18] Neuropathic pain occurs as a result of a problem with the nervous system itself[16] and may arise in the peripheral and/or central nervous system.

An example of acute neuropathic pain may be found in patients with shingles. In its initial presentation, reactivation of the varicella zoster virus in the peripheral nervous system causes blistering of skin and pain in the associated area.[19] However, pain may persist long after the skin rash has healed. Some patients who have been diagnosed with shingles subsequently develop postherpetic neuralgia, a chronic neuropathic pain condition. It is important to remember that each type of pain can exist without tissue damage, and that tissue damage can exist without pain.[16]

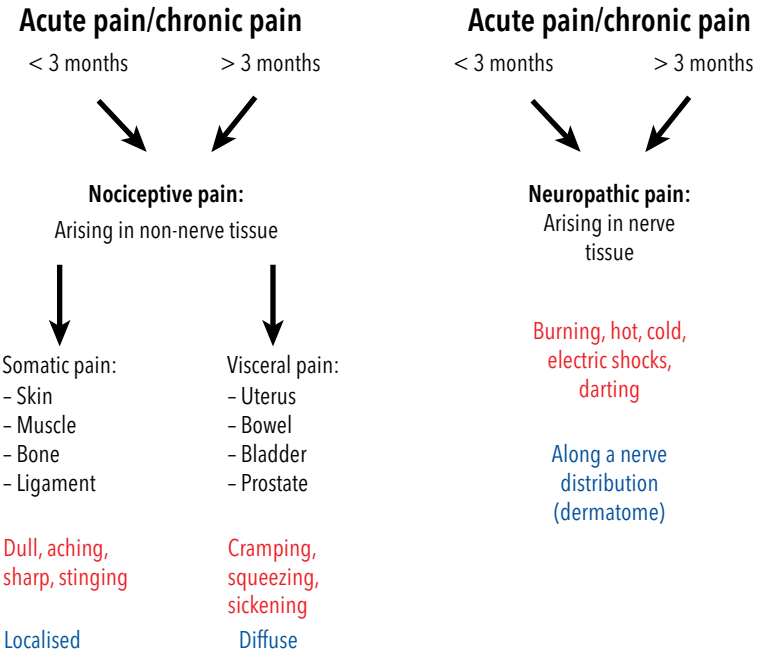
Holistic approaches to pain in the older person

When assessing pain, it is important to consider not only the physical sensations experienced by the person, but also social, spiritual and psychological aspects.[20] These will vary between younger and older people. For example, with regard to the physical processing of pain in the older person, there is some evidence to suggest that changes in the nervous system over time result in a higher pain threshold.[21] For this reason, often clinicians assume that older people feel less pain than their younger counterparts.[22] However, the body's intrinsic mechanisms for pain control (such as the natural release of endorphins in response to a painful event) are also impaired,[21] which can lead to increased pain intensity.

Social differences may contribute to bias and misconceptions on your part and on the part of your patient, which can affect pain assessment. For example, stoicism is common in older people.[23] While this is seen as an individual coping strategy rather than a negative trait, it may lead to under-reporting of pain.

You and your patient may also make assumptions about what the other is thinking and feeling. For example, your patient may assume that you know how much pain they are in, while you may be assuming that they will tell you if they have pain. Actively probing for pain is important in order to avoid this communication gap.[24] Differences in language can also impede pain assessment. Often the older person will deny pain, but confirm that they are experiencing "soreness" or "hurt" when asked. For this reason, it is helpful to use a variety of different words to describe sensations when probing for pain.[12]

Figure 1: Types of pain



The spiritual component of pain is concerned with philosophy; in other words, the meaning that the person attributes to pain. For example, the older person may interpret pain as punishment or atonement for previous behaviours.[13] They may assume that pain means advancing disease, and consequently may fear discussing this with you. Conversely, the older person may interpret pain as a normal feature of advancing age and assume that relief is not a possibility.[13]

Your patient may be concerned that a discussion about pain would serve as a distraction from their priority of treatment for the underlying condition.

Open conversation about pain can help to identify and address such preconceptions. The psychological aspect of pain may be concerned with its common emotional effects such as sadness or fear, or associated psychopathology such as depression or anxiety. It is also concerned with learning and knowledge development. Both you and your patient have spent a lifetime learning about pain. Beginning in early childhood, every previous pain experience builds on the last, leading up to the assessment that you will perform together. A positive experience will have an impact on each subsequent experience of pain assessment for both of you.

Evidence-based framework to assess pain

Given that the older person with dementia is at particular risk for under-recognition and under-treatment of pain,[25] it is wise for your assessment to follow a systematic approach. The American Society for Pain Management Nursing provides an evidence-based framework for guiding pain assessment in the patient unable to self-report pain.[26] This method of assessment follows a hierarchical approach, which prioritises self-report where possible. The framework can be seen in *Figure 2* and is applied to pain assessment in the older person with dementia below.

Hierarchy of pain assessment techniques

Be aware of potential causes of pain

As your patient may be unable to tell you that they have pain, it is important to be aware of any potential causes of pain. As mentioned above, chronic pain is common in the older person, with the most frequent sites being the knees, hips and back.[23] Certain positions or activities may exacerbate their chronic pain. You should also consider the possibility of acute pain in the context of their presenting complaint. For example, if your patient has had a recent fall, recent surgery, has been diagnosed with an infection such as in the urinary or respiratory tract, or has another acute condition such as constipation, they may experience pain as a result. Furthermore, acute pain may cause a period of exacerbation (or 'flare') of underlying chronic pain.

Medical history may reveal other potential sources of pain such as cancer, diabetic

neuropathy or multiple sclerosis. Pain may also be associated with procedures that you undertake as you care for your patient, such as attending dressing changes or phlebotomy.

Attempt self-report

You should attempt to obtain a self-report of pain with every patient. This is the most accurate assessment strategy[12] and safeguards the person's autonomy in care.[27] Assessment of present pain may be more reliable, as it may be difficult for the person to recall past painful experiences.[21] While the severity of the person's dementia will have an impact on the strategies used to assess pain, many older people with dementia can use pain assessment tools if they are facilitated to do so.[8]

To assess pain intensity, usually a simple verbal rating scale such as mild – moderate – severe will be preferred.[21] The numerical rating scale 0-10 may also be used[12] or pictorial scales such as the Wong-Baker FACES scale.[28] It can be useful to show the scale to the patient, as this helps with abstract reasoning. The same scale should be used consistently when one is identified as appropriate for a particular patient,[8] so their preference should be documented in their file. In order to assess pain location, the person may be able to point to the area of their body where they are experiencing pain.[29]

Different motions may be used depending on which type of pain the person is experiencing. For example, somatic pain is usually well localised and may be indicated by a pointed finger, whereas visceral pain is usually diffuse, indicated by a sweeping motion of the hand.

In order to assess pain quality, you can simply ask the patient what their pain feels like. Offering a few descriptors such as "dull, aching, sharp or burning" can help to prompt the person. The person's chosen descriptors will aid you in diagnosing their pain type (*see Figure 1*). If the patient can not speak, they may be able to nod or squeeze your hand in response to your questions. Perhaps most importantly, the person must be given adequate time to talk about their pain in order to maximise the possibility of obtaining a self-report.[12]

Observe patient behaviours

If the person is unable to self-report pain, assessment depends on the observation of pain-related behaviours. Importantly, while this kind of assessment may suggest that your patient has pain, it does not tell you how severe the pain is. It is also important to consider that pain behaviours may also overlap with fear-related behaviours.[25]

Figure 2: Enhanced hierarchy of pain assessment

1. Use the hierarchy of pain assessment techniques:
   - *a.* Be aware of potential causes of pain
   - *b.* Attempt self-report
   - *c.* Observe patient behaviours
   - *d.* Solicit proxy reporting of pain
   - *e.* Attempt analgesic trial
2. Utilise behavioural pain assessment tools
3. Minimise emphasis on vital signs
4. Assess regularly, reassess post-intervention and document

Behaviours commonly associated with pain include changes to facial expression, interpersonal interactions and activity patterns, and negative verbalisations such as groaning.[13] Behaviours should be assessed at rest and on movement. Tools to standardise measurement of pain behaviours are mentioned below.

Proxy reporting

In the process of assessing pain-related behaviours, it is important to be familiar with the patient's routine activities. When you meet an older person with dementia for the first time, involving family members and caregivers will help you to detect changes from their baseline. Depending on the clinical setting, it may be sensible to teach a proxy reporter about the different types of pain behaviours that may be observed. However, these reports should be used as one part of your pain assessment, and should not be relied upon as a sole method of assessment.[25]

Analgesic trial

The type of analgesia used for a trial will depend on the patient. You may start with a non-pharmacologic treatment (such as ice or a heat pack), or a non-opioid drug such as paracetamol or ibuprofen.[25] A mild opioid may be considered if there is no change in behaviour; thereafter doses can be adjusted slowly. However, if neuropathic pain is suspected, the person may require analgesia specifically for this type of pain, such as gabapentin.

It is essential to consider the patient's medical history, gastrointestinal, renal and hepatic function, and to be aware of potential polypharmacy and drug interactions. Sources of more detailed guidance on the pharmacologic management of pain can be found in the references section *(on request)*.

Behavioural pain assessment tools

There are a number of behavioural pain assessment tools available for use. The Report of the second National Dementia Audit of Ireland[10] recommends either the Abbey Pain Scale[30] or the Pain in Advanced Dementia (PAINAD) Scale.[31] The Abbey Pain Scale takes one minute, whereas PAINAD requires a five-minute observation period. Use of either tool helps to ensure consistency between assessments.[25] Ideally assessments should be performed at rest and on movement.

Vital signs

If your patient has changes in vital signs, this should only be taken as a prompt to complete a more detailed pain assessment.[25] Vital sign changes do not indicate the presence of pain, nor does an absence of vital sign changes confirm that the person has no pain.[32]

As your pain assessment gives information about a single point in time, it is essential to reassess pain frequently. Reassessment provides important information regarding the effectiveness of your interventions to treat pain. Documentation of numerous assessments allows caregivers to glean more detailed information about pain, such as its temporal features and the overall impact of pain on the person's quality of life.

Conclusion

Pain and dementia are common among patients in many healthcare settings. An understanding of the types of pain your patient may experience will aid in its effective assessment. Holistic approaches to assessment are essential, and should take the physical, social, spiritual and psychological aspects of pain into account.

A systematic approach to pain assessment in the older person with dementia will improve the validity of your assessment. Pain assessment should follow a hierarchical approach, with priority given to obtaining a self report of pain where possible. Observation of pain behaviours can be standardised through the use of an evidence-based assessment tool. Family and caregivers should be included in the assessment process. Pain should be assessed and reassessed frequently, with documentation of results to enhance quality in pain assessment and its subsequent management.

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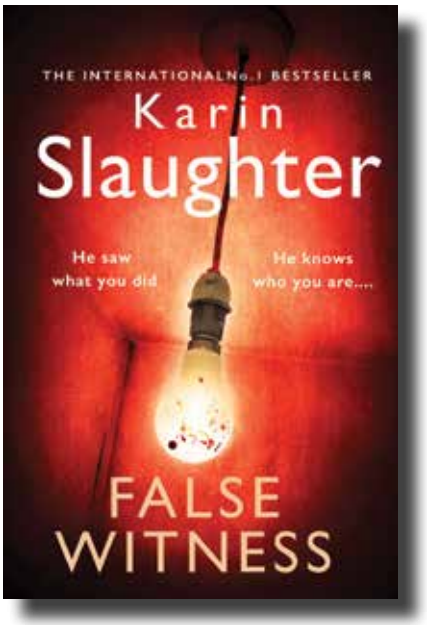
References on request by email to nursing@medmedia.ie (Quote: Kelly A:WIN 2021; 28(8): 52-54)

A complex, page-turning thriller

In her latest book *False Witness*, author Karin Slaughter continues her trademark of setting an exhilarating thriller against an exposé of contemporary social and political issues. Unusually for Slaughter, this novel is set in a very definable period of time as she documents the affects of the Covid-19 pandemic, highlighting how everyday life has changed with the pervasive need for masks, handwashing and sanitiser, as well as the enormous death toll, job losses, the damage done to the most vulnerable in society and the unwillingness of politicians to provide the resources they need.

Against this backdrop we meet the main protagonist Leigh Coulton. Leigh has worked hard to build what looks like a normal life. She has a good job as a lawyer and a teenage daughter doing well in school; even her divorce is relatively civilised. However we soon learn that Leigh's ordinary life masks a childhood that was far from average. She carries the secret of a devastating act of violence that only her sister Calli knows about.



Slaughter highlights the ongoing opioid crisis in the US through her very sympathetic portrayal of Leigh's younger sister – 37-year-old heroin addict Calliope. Calli, as she is known, broke her neck as a child gymnast and has suffered from constant neck and back pain ever since, with her only relief found at the end of a needle.

Prior to her injury, while babysitting, Calli was groomed and regularly sexually abused by 10-year-old Trevor's father, a violent paedophile, named Buddy Waleski. Leigh's many attempts to help Calli get clean have been fruitless and she now lives in anonymity in low rent motels, working just enough to fund her addiction.

Leigh is told she has been requested by name to handle a high-profile case that could make or break her career, when she is asked to defend a wealthy man accused of rape. When she meets the accused man she realises that it's no coincidence that he has chosen her as his attorney. She knows him, and he knows her, but more alarmingly, it soon emerges that he knows her secret and will use it to make her bend the law in his defence. If Leigh can't get him acquitted, she'll lose more than the case. The only person who can help her is Calli – the last person she wants to ask for help...

False Witness is a well crafted page turner and a recommended read.

– Alison Moore

False Witness is published by Harper Collins.
ISBN: 9780062858092

CROSSWORD Competition

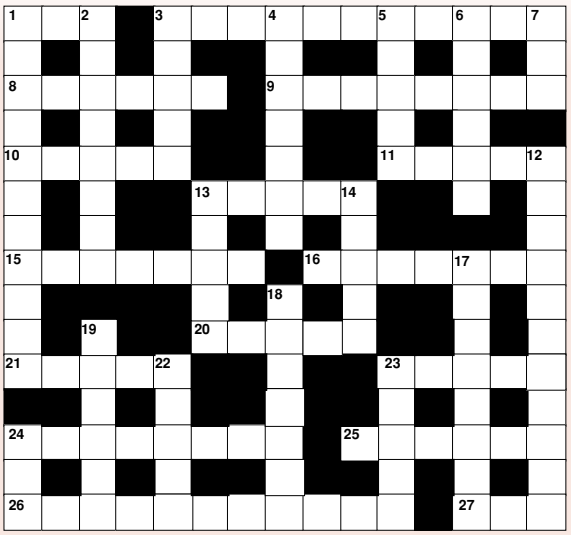
WIN a €50 gift voucher

Across

1 Total (3)
3 It could be the girly shop he depicted with these symbols (11)
8 The name of this weather phenomenon is Spanish for 'the boy-child' (2,4)
9 Elevated in rank; advocated an idea (8)
10 Great push (5)
11 Jewelled headgear (5)
13 Wired up? That's spooky! (5)
15 Will someone change religion and have a successful rugby kick? (7)
16 Fictional knight created by Sir Walter Scott (7)
20 I want to be confused with Shania (5)
21 Bring in a piece of legislation (5)
23 Leaps (5)
24 Promontory (8)
25 This chap is engaged (6)
26 Wastrel (11)
27 Took a seat (3)

Down

1 Scoops teeth up with some medical equipment (11)
2 Type of orange or Chinese dialect (8)
3 & 23d The elbow, for example, could join the Gin Movement! (5,5)
4 Persuaded to volunteer by use of cord noise (5,2)
5 Restriction (5)
6 This style of shorthand would make Tim nap, perhaps (6)
7 Unhappy (3)
12 An item of laundered linen is the object of every goalkeeper! (1,5,5)
13 German sausage (5)
14 County in the South-West of England (5)
17 Some horn develops from these natural substances (8)
18 Bullfighter (7)
19 Impair, cause harm to (6)
22 Covered with squares (5)
23 See 3 down
24 Possesses? Ha ha! (3)



September crossword solution

Across: 1 Fibreglass 6 Toss 10 Knead 11 Brigadier 12 Startle 15 Dante 17 Many 18 Omit 19 Krill 21 Hydrate 23 Vague 24 Scam 25 Sows 26 Laois 28 Scoured 33 Spinal tap 34 Eased 35 Eggs 36 Therapists

Down: 1 Fake 2 Breathing 3 Elder 4 Label 5 Said 7 Orion 8 Street lamp 9 Van Dyke 13 Troy 14 Empress 16 Convalesce 20 Increases 21 Hessian 22 Toto 27 Owing 29 Caper 30 Use up 31 Utah 32 Odes

The winner of the September crossword is: Helen Crawford Portmarnock, Co Dublin

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: Tuesday, October 19, 2021
If preferred you can post your entry to: Crossword Competition, WIN, MedMedia Publications, 17 Adelaide Street, Dun Laoghaire, Co Dublin, A96E096

Name:
Address:

Breast milk proven to enhance heart performance in premature babies

NEW research from the RCSI University of Medicine and Health Sciences demonstrates the beneficial effects of breast milk consumption on cardiovascular health and early cardiovascular development in premature infants, with preterm babies who are fed on breast milk found to have greater heart function than those who have higher intake of formula milk.

Conducted in collaboration with researchers from Oxford University and other leading universities in the US and Canada and published in *JAMA Network Open*, the study of 80 preterm infants shows that those with higher exposure to their mother's milk had enhanced cardiac function at the age of one year, with values almost on par with those of healthy, full-term infants.

Babies who are born preterm are at increased risk of cardiovascular disorders as adults, including ischaemic heart disease, heart failure and systemic and pulmonary hypertension. They are also more likely to die as a result of cardiovascular disease.

The hearts of young people born early are known to have unique traits such as reduced biventricular volume, shorter length, lower systolic and diastolic function, and a disproportionate increase in muscle mass. This results in impaired heart function, which is significantly lower than that of healthy infants who are born at term. This study shows that breast milk consumption in the first months after birth is associated with a normalisation of some of these traits

Premature infants who were exposed to a high proportion of their mother's own milk during the first few week after delivery had greater left and right heart function and structure with lower lung pressures and enhanced right heart response to stress at one year of age compared to preterm infants who had a higher intake of formula, with all measures approaching those seen in term-born healthy children.

These findings were apparent before discharge from the hospital and persisted up to one year of age.

The lead author of the study, Prof Afif El-Khuffash, clinical professor of paediatrics at the RCSI and consultant neonatologist at the Rotunda Hospital, Dublin said: "This study provides the first evidence of an association between early postnatal nutrition in preterm-born infants and heart function over the first year of age, and adds to the already known benefits of breast milk for infants born prematurely.

"Preterm infants have abnormal heart function. However, those fed their mother's milk demonstrate recovery of their heart function to levels comparable to healthy term born infants. Preterm infants fed formula do not demonstrate this recovery."

Older adults showed resilience during lockdowns

MANY of Ireland's ageing citizens demonstrated high levels of adaptability to public health measures during the Covid-19 lockdowns, despite the majority reporting heightened feelings of loneliness and social isolation, according to a new report by The Irish Longitudinal Study on Ageing (TILDA).

The report – *In Their Own Words: The Voices of Older Irish People in the Covid-19 Pandemic* – recorded the first-hand experiences of 4,000 people aged 60 and over in Ireland.

According to the report, 20% indicated a capacity to cope or demonstrated resilience, while 20% referred to increased social isolation or loneliness, which were the most commonly reported feelings.

The study's lead author, Dr Mark Ward, senior research fellow with TILDA, said: "TILDA's report not only reveals lessons to be learned for the future but offers important insights from the unique experiences and perspectives of older adults impacted by the Covid-19 emergency".

ICN slams 'unacceptable' hoarding of Covid vaccines by western countries

THE International Council of Nurses (ICN) says the slow rollout of vaccines across Africa and other parts of the developing world is continuing to put nurses at risk.

Responding to claims that western countries are hoarding what could amount to one billion unused vaccines by the end of the year, ICN chief executive Howard Catton called for urgent action.

Mr Catton said: "Nurses and other health workers are at the sharp end and are both directly and personally suffering the consequences of the unacceptably slow roll-out of vaccines in Africa where only 2% of the population are vaccinated.

"Western nations are hoarding unused vaccines, which is a major contributing factor to the snail's pace of the roll-out. Every day that nurses go to work unvaccinated, they are putting their lives on the line. We are talking about a predominantly female workforce that is also in fear of passing on the virus to their families. Worryingly, there are also increased reports of nurses suffering from abuse from antivaxxers."

Mr Catton said it was a positive development that the G20 health ministers meeting in Rome has agreed to create a pact to ensure fairer vaccine distribution but added that words without action were not enough.

"Good intentions alone will not ensure that a vaccine is jabbed into the arm of a nurse in a developing country and – despite talk of sharing – the rollout is not going fast enough or hard enough," he said.

"It is uncertain whether we will meet the important World Health Organization targets for global vaccinations and that is why ICN supports the call for an emergency G7 vaccine summit to address the issue of vaccine rollout and instigate a plan of action.

"We need to see a shift in the dial in vaccinations in Africa and elsewhere before the G20 Leaders' Summit at the end of October, because if not, many more of our nurses, healthcare colleagues and their patients will die needlessly," he added.

ICN chief calls on governments to invest in advanced nursing roles

ANPs praised for their focus on the future needs of global healthcare

SPEAKING on the final day of the International Council of Nurses (ICN) Advanced Practice Nursing Conference, which was held in September, ICN chief executive Howard Catton called on world governments to invest in advanced nursing roles in order to maximise effectiveness of healthcare systems in a post-pandemic world.

The three-day conference, which was addressed by Canadian premier Justin Trudeau, saw more than 1,000 advanced practice nurses from around the world meet virtually.

In his closing address to the conference, Mr Catton congratulated nurses working in advanced roles for focusing on the future health needs of the planet and global health.

"That positive focus is right for now, despite some of the events we see unfurling around the world and the fragile and perilous state that our world appears to be in. We know that Covid-19 has taken an enormous toll on the nursing workforce globally, and the ICN has run a commentary on its impact on nurses around the world," he said.

"We have also had the renewed warnings around climate change and the threat it poses to the health of our planet. When I look at these issues, what is clear is nurses are right at the centre of the response to natural and manmade disasters.

"Nurses ensure not just that care is delivered but that there is increased access to care, and that it is safe, equitable and sustainable, and also that the values that care are based on, are ones which put people at the centre. As a consequence, we are seeing a change in the way that people and the world's leaders see and evaluate nurses and the nursing contribution.

"The pictures that have been beamed into our living rooms have shown the care, courage and expert skills of nurses everywhere. People have also seen that the nursing contribution is not just important for our health and wellbeing, but also for our economic prosperity and for our individual freedoms. As a result, we have seen changes in the attitude of the public towards nursing.

"Many people who had old-fashioned traditional views of nursing have been challenged because they have seen the modern-day realities of nursing, and they have seen our health is so intimately linked to the safety, security and peacefulness of the communities and societies that we live in," said Mr Catton.

ICN remembers colleagues lost to Covid-19

THE International Council of Nurses (ICN) marked World Humanitarian Day on August 19 by remembering colleagues who have lost their lives during humanitarian service and during the pandemic.

This year's event also highlighted the human cost of the climate crisis and called on world leaders to take immediate climate action to protect the world's most vulnerable people, who have been worst affected by the effects of climate change.

ICN president Annette Kennedy said: "Nurses are making a powerful contribution to mitigate climate change and support people and communities around the world to adapt to its impacts.

"Nurses' collaborations and partnerships with humanitarian organisations will become even more important as the adverse health impacts from disasters will be complex and long-term."

'Blood clotting may be the root cause of long Covid syndrome' – RCSI research

PATIENTS with long Covid syndrome continue to have higher measures of blood clotting beyond the course of their infection, according to new research conducted in the Royal College of Surgeons in Ireland (RCSI) University of Medicine and Health Sciences.

Published recently in the *Journal of Thrombosis and Haemostasis*, the study found that the increased blood clotting was observed predominantly in patients who were hospitalised with Covid-19, but that the problem was also present in those who recovered from the virus at home.

The researchers examined 50 patients with symptoms of long Covid syndrome to better understand if abnormal blood clotting is involved. What they noted was that higher clotting was directly related to other symptoms of long Covid syndrome, such as reduced physical fitness and fatigue.

Even though markers of inflammation had all returned to normal levels, this increased clotting potential was still present in long Covid patients, according to the research.

The study's lead author Dr Helen Fogarty, PhD student at the Irish Centre for Vascular Biology in the RCSI School of Pharmacy and Biomolecular Sciences, said: "Because clotting markers were elevated while inflammation markers had returned to normal, our results suggest that the clotting system may be involved in the root cause of long Covid syndrome."

Prof James O'Donnell, director of the Irish Centre for Vascular Biology and consultant haematologist, St James's Hospital, said: "Understanding the root cause of a disease is the first step toward developing effective treatments.

"Millions of people are already dealing with the symptoms of long Covid syndrome, and more people will develop long Covid as the infections among the unvaccinated population continue to occur.

"It is imperative that we continue to study this condition and develop effective treatments for it," Prof O'Donnell added.

All of the meetings and conferences listed below will take place online

October

Tuesday 5
Student Allocation Liaison Officers (SALO) meeting. 12pm via Microsoft Teams

Saturday 16
PHN Section webinar

Monday 18
National Children's Nurses Section meeting. 11am via Zoom

Tuesday 19
Care of the Older Person Section meeting. 2pm via Zoom

November

Thursday 11
All-Ireland Midwifery conference – online. Bookings: **www.inmoprofessional.ie** or scan QR code

Wednesday 17
Clinical Placement Co-ordinators Section meeting. 11am via Zoom

Saturday 20
PHN Section meeting. 11am via Zoom

Saturday 20
National Children's Nurses Section conference. 11am online

Thursday 25
ADON Section meeting. 2pm

December

Thursday 2
Orthopaedic Nurses Section meeting and education session on wound management. Cappagh Orthopaedic Hospital and online. See *page 27* for further details

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

Condolences

- We were shocked and saddened to hear of the death of nurse Cathrona Herron O'Grady from Sligo. Cathrona was a nurse in St John's Community Hospital, Sligo since 1998 but in recent years worked with St John's Rehab Unit. We offer our deepest condolences to her husband and sons, her parents, brothers and sisters and all who loved her. *Ar dheis de go raibh a h-anam*.
- We extend our deepest condolences to the family and friends of Elizabeth (Betty) O'Connor. Betty was CNM1 in the Mater Private Hospital in Cork. She will be missed by her husband John, her children and grandchildren and all her colleagues and friends in the INMO.
- The INMO offers its sincere condolences to the family of Deirdre O'Donoghue, who passed away recently in the Mater Private Hospital, Dublin. 'Dee' worked in the ICU in the Midland Regional Hospital Mullingar for more than 20 years. She will be sadly missed by her husband John, son Ryan and daughter Naoise, her extended family and all her colleagues. May she rest in peace.
- We send our sincere condolences to the family and friends of nurse Mary Hayes. Mary was a staff nurse at Cork University Hospital and a member of the INMO Cork HSE Branch. She will be sadly missed by her colleagues and peers.
- The INMO Limerick Branch and the INMO Limerick Office extend deepest sympathy to Gerri Ryan, CNM2 in Croom on the recent passing of her father Donie Ryan. May he rest in peace.

INMO Membership Fees 2021

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 members	No Fee

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For further information, please visit **www.sfh.ie/career-opportunities**

Irish Cancer Society Nurses

The Irish Cancer Society are seeking registered nurses who can provide a minimum of two nights per week and have some palliative experience. Training will be provided.

- Job description on **www.cancer.ie**
- Email CV to **recruitment@irishcancer.ie**
- Informal enquiries to 01-231 0524 or **mferns@irishcancer.ie**

Irish Cancer Society

Irish Nurses Rest Association

A committee of management representing the Guild of Catholic Nurses of Ireland, the INMO, the Association of Irish Nurse Managers and Director of Public Health Nursing exists to administer the funds of the Irish Nurses Rest Association. It's open for applications from nurses in need of convalescence or a holiday for a limited period who are unable to defray expenses they may incur or for the provision of grants to defray other expenses incurred in purchase of a wheelchair/other medical aids.

Please send applications to:
Ms Margaret Philbin, Rotunda Hospital, Dublin 1.
email: mphilbin@rotunda.ie

Don't forget to mention *WIN* when replying to advertisements

• **Next issue:** November 2021 • **Ad booking deadline:** Monday, October 18
• **Tel:** 01 271 0218 • **Email:** leon.ellison@medmedia.ie

VACANCY – Director of Care, Co Wicklow

St Patrick's Missionary Society, Kiltegan Co Wicklow is a facility for retired missionary priests. It includes a 25 bedded dedicated care unit and provides assisted living in Kiltegan (40 residents), Dublin (10 residents), Cork (3 residents) and Knock (2 residents). We are now seeking a suitable candidate for the exciting new position of Director of Care. The successful candidate will provide a high level of clinical proficiency, management and direction to the dedicated team in Kiltegan to ensure the highest standards of person-centred care are achieved for residents both in the care unit and in assisted living.

Requirements:
- Qualified RGN with at least 3 years' management experience in the last 6 years in care of the older person
- Post registration management qualification in health, or a related field
- Excellent Leadership, Organisational and Communication skills
- Proven track record in Healthcare Clinical Management
- Sound decision making ability and results driven
- Ability to work well with others and promote a positive team environment

Core Aptitudes:
- Excellent communication and interpersonal skills
- Ability to manage and promote change
- Experience of risk management
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- Quality and service improvement

Benefits: Excellent remuneration package, permanent wholetime position, pension contribution, mobile phone and laptop, subsidised meals.

Queries regarding the specifics of the position should be made to **sandra.neville@spms.ie**

To apply, email your CV and cover letter to Fiona McHenry, HR Manager, at **hrmanager@spms.ie by Friday, October 8 at 5.30pm.**

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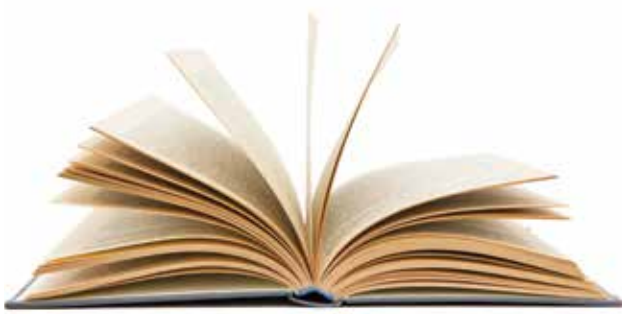
TO APPLY Contact **Susan Murphy**, Nursing HR Business Partner, on **021 4542807** ext 2137,
Email **bscnursegraduationprogramme@bonsecours.ie** or visit **www.bonsecours.ie/cork**
Bon Secours Health System is an equal opportunities employer

Read a good book recently? Write a review for *WIN*

Every month we publish a book review written by one of the *WIN* team or by an INMO member. It doesn't have to be nursing/midwifery related, but if you have read something that you found helpful to your practice, please consider writing a review for an upcoming issue of *WIN*.

Submit your review to nursing@medmedia.ie

Word count: 400



ICN CONGRESS 2021, November 2-4

Full sponsorship for four INMO members

The INMO is offering full sponsorship for four members to attend the virtual ICN Congress from November 2-4. In response to Covid-19 public health issues and travel restrictions, this year's Congress, in partnership with the Emirates Nursing Association, will be held virtually. Using the theme 'Nursing Around the World', the ICN will pass the nursing baton across the different regions in a series of live and interactive events that will give members the opportunity to showcase their expertise and innovations throughout the world.

The Congress will bring together 2020, the International Year of the Nurse and Midwife, and 2021, the International Year of Health and Care Workers, to celebrate the work of nurses internationally, highlight the challenging conditions they and other healthcare workers often face, and advocate for increased investments in the nursing and midwifery workforce.

The INMO will be represented at the ICN Congress by the president Karen McGowan and general secretary Phil Ní Sheaghdha. In keeping with past practice, the Executive Council normally provides some financial assistance, subject to criteria for members who may wish to travel to this worldwide gathering of nurses. However, as this year's event is taking place virtually, the Executive Council would like to pay the registration fees of four INMO members to attend this event.

Members who are interested in attending should send an email containing not more than 200 words on why they would like to attend to the general secretary's office at **gspaoffice@inmo.ie** before 12pm on **Monday, October 11, 2021**. Further information can be found at **www.icncongress2021.org**

Experiencing difficulties paying?

For cyber security reasons, in the interests of protecting the integrity of individual banking credentials, new restrictions have been imposed on payment systems. The INMO will no longer be able to accept payments over the phone. Payments can be made by:

- Monthly salary deduction, using the deduction at source form available from INMO (Not all work locations offer this facility so an alternative would be by monthly standing bankers order through your bank)
- Monthly standing bankers order, using form available from the INMO
- Cheque payable to INMO
- Postal order payable to INMO
- Bank draft payable to INMO
- Online via our website (using your unique quick payment code available from the INMO).

If paying online, your bank security will require that the billing details on the card you are using are the same as those used to register membership with INMO.

We apologise for any inconvenience, but heightened awareness of cyber security is in all of our interests. We must implement the highest standard of protection for our members.

INMO Professional

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Irish Nurses and Midwives Organisation
Working Together

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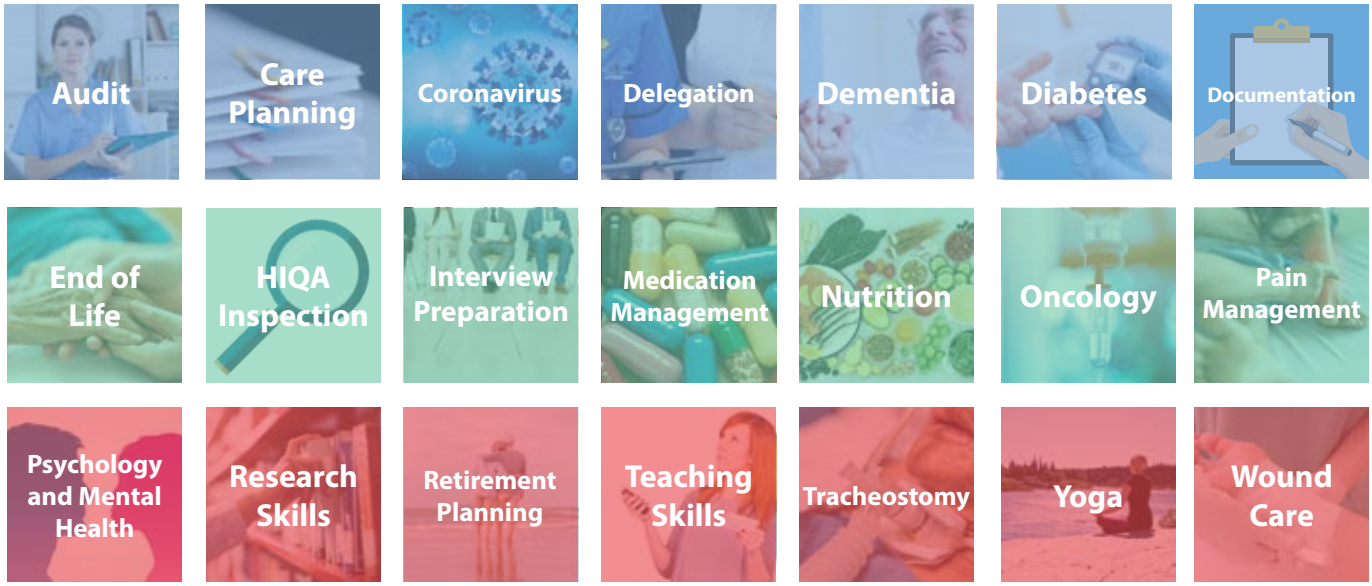

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