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WIN

INMO

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Irish Nurses and
Midwives Organisation

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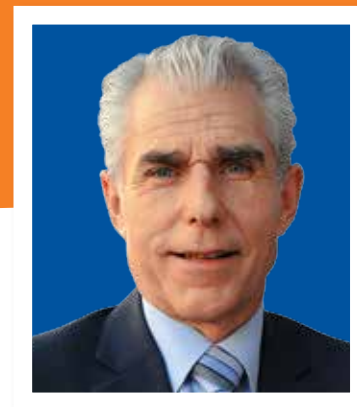


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Caring through conflict



THE Irish Nurses and Midwives Organisation was proud to host this year's general assembly of Global Nurses United (GNU) held in Dublin on September 22-23. The GNU is a relatively new body which comprises a growing number of nursing unions from across the world who come together to support our individual and collective endeavours to enhance the pay, conditions and influence of nurses in health services across the globe. The proceedings of the two-day conference are covered in detail on pages 20-23.

A key contribution to the GNU assembly was an address by Prof Leonard Rubenstein, a worldwide expert in this area, who detailed the reality of what is happening to nurses and other healthcare workers in conflict and war zones. His address came only three days after the latest atrocity in Syria, which saw 20 care workers killed when a convoy of aid was callously attacked. This led the outgoing secretary general of the UN, Ban Ki-moon, in his closing address, to ask the question: "how low can these acts of depravity go before the world reacts?"

This atrocity is, in reality, the latest in a growing trend of attacks, many of them unreported and denied, on health workers, health services and already injured people in conflict zones.

As a result of this, many brave nurses, simply doing what their profession calls them to do, have been injured and killed as they seek, without any reference to where the individual comes from, to provide care and professionalism to anyone who is injured in the conflict. Everyone at the GNU conference acclaimed their admiration, respect and solidarity for these unsung heroes in conflict zones.

In his address, Prof Rubenstein challenged all of us to agree specific acts that we could take, in our own countries, to highlight the increase in attacks on healthcare workers and, specifically, the increasing callous disregard for the Geneva Convention, which gives protection to those who are trying to care for others.

The INMO fully supports the call by

Prof Rubenstein for nursing organisations to immediately engage with their governments and to challenge them to raise these atrocities in fora such as the European Parliament, the UN and the International Labour Organisation. It is only when governments feel the weight of their respective citizens that they will act to bring to justice those who would engage in war crimes by attacking those who are only there to care for the injured, wounded and dying.

From an Irish perspective, the call of Prof Rubenstein has all the more relevance based on the recent history of this country. At the GNU conference we also heard a presentation from our colleagues in the Royal College of Nursing about nursing through the troubles over the 30 years in Northern Ireland. Their contribution to the conference was moving, sobering and enlightening, and convinced all of us, who live in this country who were listening, that we must never return to that type of conflict.

Following the GNU congress, the INMO Executive Council will review what we can do, even as a nursing union in a small country, to highlight the disregard for nurses and healthcare workers in conflict zones.

It is true that the INMO has very challenging issues to tackle, on behalf of our members, in the coming weeks and months. All members will hear much more about the actions, the Executive Council is proposing to address these challenges within the next few weeks.

However, we have the capability to look beyond our immediate horizon and, together with our sister nursing unions in the GNU, demand greater protection for those who are caring for everyone in conflict situations.

Liam Doran
General Secretary, INMO

Your priorities with the president

Martina Harkin-Kelly, INMO president



Dear members,

FIRSTLY, on behalf of all, it is with deep sadness that I give my sincere condolences to the bereaved Coll and Hawe families in Ballyjamesduff on the tragic events that befell them at the start of the school year, may they rest in peace. Our hearts also go out to the Kenny family from Clonmel in Tipperary on the tragic death of Nicola Kenny, who died while on her way to Temple Street Hospital to visit her newborn baby Lily Rose. RIP.

Public Service Pay Commission

PAY restoration was a key element of my speech at our ADC in Killarney. In July, Paschal Donohoe, the Minister for Public Expenditure and Reform set the ball rolling on the new Public Service Pay Commission, which will examine pay levels across the public service in advance of the next set of talks between the government and the public service trade unions. The Minister stressed from the outset that the Commission would be "advisory in nature". It is likely that, despite the LRA not expiring until September 2018, the next agreement will be agreed ahead of schedule with economic factors prevailing. Watch this space!

National Women's Council of Ireland AGM

CLARE Treacy and I attended the National Women's Council of Ireland's AGM in Dublin on September 9. There was a packed agenda, with officer and board elections and robust debates on 16 motions. Sincere congratulations to Sheila Dixon, former president of the INMO, on her election as deputy chair at the meeting. As the INMO delegate I spoke on two motions – the first related to the continued support for the criminalisation of the demand for prostitution, which was passed. The second motion, which also passed, dealt with the need for health service reform, in the context of multi-annual funding and access based on need not ability to pay.



INMO president Martina Harkin Kelly addressing the NWCI AGM on two INMO motions

Global Solidarity Summer School 2016

I ATTENDED this year's Global Solidarity Summer School in Letterkenny on September 2-3. The event theme was 'Global challenges and opportunities – local and global responses'. Minister of State for International Development, Joe McHugh, gave the opening address, in which he outlined his portfolio remit and acknowledged the role of multilateral involvement in achieving results on such issues as climate change and the refugee crisis.

Nursing and midwifery quality care metrics

I PARTICIPATED in the inaugural governance group meeting of the nursing and midwifery quality care metrics (QCM) in Dr Steeven's Hospital on August 31. QCM is a robust standardised suite of measurements based on the Donabedian Principle (1988) of getting the process right via interventions. Mary Wynne, Office of the Nursing and Midwifery Services director, is the commissioner and chair of the project. Anne Gallen, director of Nursing Midwifery Planning and Development Units Ballyshannon, is the national QCM lead. The group comprises a broad stakeholder base involving academic consultants, Irish Association of Directors of Nursing and Midwifery Ireland reps, director of nursing reps, HSE quality care improvement division, information communication technology reps, unions and Patient Voices.

Over the next year, the governance group will agree a national framework for the development of an evidence-based suite of standardised nursing and midwifery QCMs. For further information, see www.hse.ie and search 'nursing and midwifery metrics'.

Quote of the month

"Three groups spend other people's money: children, thieves and politicians, all three need supervision"
– Dick Armev

Report from the Executive Council

THE Executive Council met on September 12-13 last. Two new members, Tom Caulfield and Marie O'Brien, were welcomed. However, it is with sadness that I announced the resignation of Deirdre Munro, who will be missed, not least for her intuitive awareness regarding nursing and midwifery challenges. Deirdre, from myself as president and all of your colleagues on Executive Council, we wish you every success with your career.

The meeting agenda focused on the substantive issues of recruitment/retention, pay restoration and hours. The Executive Council is resolute that the current nursing/midwifery crisis must be addressed with urgency with a planned campaign. Despite the INMO's success at the end of 2015 in securing the restoration of incremental credit for fourth year interns, the government refuses to restore the incremental credit for those who graduated between 2011 and 2015.

A forewarning of our planned campaign was the protest outside Leinster House planned for September 27. Rest assured that I am determined as president to ensure strong leadership in what will be a fight back by all nurses and midwives.

Our next Executive Council meeting is on October 3-4, 2016. Don't forget to forward your ideas, advice and thoughts on how to plan for the Health Summit.

Get in touch

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

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

Trolley crisis worsens outside Dublin

A MIXED outcome was revealed by the latest INMO trolley/ward watch figures for the month of August, with a decrease in trolley figures in Dublin hospitals but a dramatic increase in hospitals outside of Dublin.

While there was an overall reduction of 6% in trolley numbers in August this year compared to August 2015, with a 41% reduction in Dublin hospitals, there was a 14% increase in admitted patients waiting on trolleys in hospitals outside of Dublin

During August, the emergency departments with the

highest levels of overcrowding were: University Hospital Limerick (610); Cork University Hospital (473); South Tipperary General Hospital (470); University Hospital Galway (400); and Our Lady of Lourdes Hospital, Drogheda (391).

The number of delayed discharges (patients who have completed their acute care) had increased to 640 at the time the latest trolley/ward watch figures were released.

In addition to these delayed discharges, hospitals are continuing to report an inability, despite repeated efforts, to recruit and retain nursing staff.

The shortage of nursing staff, which is at crisis levels, will inevitably result in the closure of hospital beds during the autumn and winter period, thus exacerbating ED overcrowding and the number of patients on trolleys.

INMO general secretary, Liam Doran said: "These figures confirm that further actions, in addition to all steps taken to date, are required in order to alleviate trolley overcrowding as we now enter the autumn/winter period.

"The reduction in Dublin hospitals is welcome and must be maintained into the

future. However, the significant deterioration in a number of hospitals outside of Dublin is totally unacceptable and should be viewed as critical by the Department of Health/HSE.

"At the Workplace Relations Commission, the Department of Health/HSE reaffirmed their commitment to implement all aspects of the National ED Agreement, including the filling of all vacant posts, as a matter of absolute priority. This commitment, at national level, must now be matched with actual recruitment in every emergency department across the country."

Table 1. INMO trolley and ward watch analysis (August 2006 - August 2016)

| Hospital | Aug 2006 | Aug 2007 | Aug 2008 | Aug 2009 | Aug 2010 | Aug 2011 | Aug 2012 | Aug 2012 | Aug 2014 | Aug 2015 | Aug 2016 |
|---|--------------|--------------|--------------|--------------|--------------|--------------|--------------|--------------|--------------|--------------|--------------|
| Beaumont Hospital | 232 | 408 | 713 | 520 | 504 | 596 | 304 | 508 | 490 | 678 | 335 |
| Connolly Hospital, Blanchardstown | 162 | 259 | 255 | 152 | 359 | 354 | 386 | 464 | 271 | 364 | 138 |
| Mater Misericordiae University Hospital | 197 | 315 | 487 | 385 | 354 | 333 | 328 | 82 | 285 | 218 | 316 |
| Naas General Hospital | 206 | 68 | 122 | 199 | 292 | 221 | 65 | 40 | 230 | 273 | 95 |
| St Columcille's Hospital | 39 | 42 | 48 | 145 | 96 | 126 | 171 | 47 | n/a | n/a | n/a |
| St James's Hospital | 8 | 41 | 120 | 174 | 31 | 77 | 60 | 104 | 165 | 101 | 108 |
| St Vincent's University Hospital | 385 | 545 | 271 | 354 | 509 | 587 | 432 | 74 | 191 | 335 | 284 |
| Tallaght Hospital | 227 | 399 | 319 | 237 | 457 | 335 | 47 | 357 | 188 | 395 | 121 |
| Eastern | 1,456 | 2,077 | 2,335 | 2,166 | 2,602 | 2,629 | 1,793 | 1,676 | 1,820 | 2,364 | 1,397 |
| Bantry General Hospital | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | 0 | 7 | 15 |
| Cavan General Hospital | 216 | 141 | 263 | 177 | 168 | 382 | 142 | 228 | 42 | 84 | 27 |
| Cork University Hospital | 319 | 189 | 329 | 272 | 453 | 418 | 151 | 261 | 115 | 399 | 473 |
| Letterkenny General Hospital | 330 | 59 | 24 | 35 | 36 | 70 | 32 | 7 | 152 | 235 | 128 |
| Louth County Hospital | 34 | 4 | 0 | 12 | n/a | n/a | n/a | n/a | n/a | n/a | n/a |
| Mayo General Hospital | 131 | 97 | 28 | 64 | 126 | 8 | 109 | 15 | 10 | 105 | 175 |
| Mercy University Hospital, Cork | 90 | 108 | 69 | 38 | 117 | 44 | 137 | 122 | 130 | 98 | 243 |
| Mid Western Regional Hospital, Ennis | 94 | 9 | 17 | 23 | 26 | 20 | 24 | 0 | n/a | 5 | 20 |
| Midland Regional Hospital, Mullingar | 16 | 2 | 5 | 5 | 46 | 264 | 109 | 178 | 410 | 149 | 254 |
| Midland Regional Hospital, Portlaoise | 31 | 8 | 13 | 7 | 9 | 125 | 20 | 100 | 82 | 77 | 287 |
| Midland Regional Hospital, Tullamore | 5 | 2 | 5 | 7 | 71 | 89 | 77 | 22 | 169 | 267 | 290 |
| Monaghan General Hospital | 13 | 4 | 17 | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a |
| Nenagh General Hospital | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | 2 | 0 |
| Our Lady of Lourdes Hospital, Drogheda | 301 | 91 | 293 | 289 | 236 | 776 | 604 | 165 | 346 | 680 | 391 |
| Our Lady's Hospital, Navan | 77 | 34 | 90 | 57 | 50 | 93 | 13 | 36 | 33 | 56 | 35 |
| Portiuncula Hospital | 2 | 10 | 2 | 67 | 62 | 97 | 32 | 45 | 48 | 49 | 40 |
| Roscommon County Hospital | 23 | 9 | 14 | 25 | 106 | n/a | n/a | n/a | n/a | n/a | n/a |
| Sligo Regional Hospital | 56 | 70 | 13 | 34 | 140 | 24 | 277 | 81 | 71 | 158 | 144 |
| South Tipperary General Hospital | 12 | 82 | 52 | 33 | 4 | 1 | 153 | 166 | 82 | 115 | 470 |
| St Luke's Hospital, Kilkenny | n/a | n/a | n/a | n/a | 13 | 52 | 55 | 139 | 84 | 255 | 197 |
| University Hospital Galway | 76 | 123 | 238 | 256 | 232 | 554 | 195 | 146 | 319 | 458 | 400 |
| University Hospital Kerry | 94 | 55 | 9 | 9 | 37 | 70 | 81 | 49 | 95 | 108 | 148 |
| University Hospital Limerick | 29 | 32 | 85 | 105 | 186 | 342 | 247 | 224 | 458 | 618 | 610 |
| University Hospital Waterford | n/a | n/a | 25 | 18 | 64 | 76 | 120 | 180 | 47 | 159 | 291 |
| Wexford General Hospital | 293 | 13 | 189 | 344 | 140 | 490 | 44 | 73 | 135 | 70 | 101 |
| Country total | 2,242 | 1,142 | 1,780 | 1,877 | 2,322 | 3,995 | 2,622 | 2,237 | 2,828 | 4,154 | 4,739 |
| NATIONAL TOTAL | 3,698 | 3,219 | 4,115 | 4,043 | 4,924 | 6,624 | 4,415 | 3,913 | 4,648 | 6,518 | 6,136 |

Comparison with total figure only: Decrease between 2015 and 2016: -6% Increase between 2012 and 2016: 39% Increase between 2009 and 2016: 52%
 Increase between 2014 and 2016: 32% Decrease between 2011 and 2016: -7% Increase between 2008 and 2016: 49%
 Increase between 2013 and 2016: 57% Increase between 2010 and 2016: 25% Increase between 2007 and 2016: 91%
 Increase between 2006 and 2016: 66%

Additional staff key to ED winter plan

THE INMO welcomed the publication last month of a winter initiative plan to ease emergency department overcrowding complete with the allocation of additional funding of €40 million.

While welcoming all these initiatives, the Organisation warned that the key issue left unresolved within the plan is the ability of the public health service to recruit the additional staff, primarily nursing, that is required to increase bed and service capacity as specified.

The winter initiative set specific targets in critically important areas as:

- 55 additional acute beds
- 58 transitional care beds
- 18 additional step down beds
- 950 more homecare packages
- Expansion of community intervention teams

- A maximum target of 236 for the number of patients on trolleys each morning.

The INMO pointed out that it is in discussions with a number of hospitals on the issue of inadequate staffing for existing bed numbers, with an increasing likelihood of beds having to close in the short term due to staff shortages.

The Organisation said that many of the 300 beds opened under last year's winter initiative are now closed due to staff shortages and therefore the success of this year's plan will depend on the ability of the HSE to recruit sufficient staff to now open all available beds.

In addition, the INMO highlighted the need, as recommended in a recent report, to recruit additional permanent nursing staff to look after

admitted patients in EDs. It also pointed to the growing difficulty of recruiting staff to provide home help services.

The INMO is seeking immediate meetings with the CEOs and chief officers of the hospital groups and community health organisations (CHOs), to determine how they intend to implement the winter plan as it applies to them and, in particular, what new measures they intend to initiate to address the crisis of nurse shortages across the system.

INMO general secretary Liam Doran said: "The allocation of additional funding (€40 million) and the more specific targets within this plan are most welcome and are absolutely necessary as we face into the autumn/winter period. However, the plan, by

Liam Doran, INMO general secretary:
"By failing to address the difficulties in recruiting and retaining nursing staff, the winter initiative plan runs the risk of falling short"



failing to address the difficulties in recruiting and retaining nursing staff, runs the risk of falling short, in terms of implementation, as local services will not be able to recruit the staff required to expand services. Additional services, either in terms of acute beds, step-down beds and/or community intervention teams are dependent on there being additional nursing staff."

Ongoing push on implementation of ED agreement

The Workplace Relations Commission undertook its fifth review of the national ED agreement between INMO/Department of Health/HSE on September 2. The meeting was attended by ED nurse representatives from several hospitals, together with full-time INMO officials. The management side was led by Liam Woods, HSE director of acute services, together with other senior officials from the Department of Health/HSE.

At this meeting the INMO raised several issues including:

- The reality that the number of patients on trolleys had reduced within the Dublin area, but the situation was still deteriorating in several hospitals outside Dublin
- There continued to be delays and prevarication by a number of hospitals with the filling of posts established under the agreement
- A continued absence of senior

clinical decision makers in some hospitals out of hours and at weekends, which needed to be addressed

- Much greater progress was needed with cross-consultant discharge/delegated discharge to assist patient flow
- The need for the security reports required under the agreement to be made available to the INMO
- The ED Expert Group on Staffing had issued its report, which under the terms of reference was to be considered, by a high level group, including Teresa Cody, head of HR, Department of Health; Liam Woods, director of acute services, HSE; and Liam Doran, general secretary, INMO.

This group met on September 6 to examine the expert group recommendations including:

- The establishment of permanent nursing posts, within each ED to care for admitted patients in the department

- The immediate appointment of ANP posts in six EDs and early progress on appointing 148 ANPs in EDs across the country
- Dedicated advertisement to fill the remaining 80 vacant, funded, ED staff nurse posts across the country
- The Taskforce on nurse staffing to commence immediate work on determining safe nurse staffing levels for all EDs.

Arising from the fifth WRC review, the management side reaffirmed its absolute commitment to the implementation of all elements of the ED agreement. In relation to the filling of posts, established under the agreement, it was confirmed that all outstanding matters would be addressed within seven days.

A specific issue had arisen with commencing a consultancy project on patient flow in University Hospitals Galway and Limerick. The next step in this process will be a full

briefing of members locally, at the next hospital level meeting, to provide full details on what is proposed; an opportunity for input; and a commitment that all analysis from the project work will be brought back to the hospital fora established under the ED agreement for further consideration.

The WRC will undertake a further review of the implementation of the ED agreement on October 21, 2016.

Speaking as we went to press general secretary Liam Doran said: "In tandem with all of the foregoing, all of the meetings, at hospital and group level, continue to ensure all aspects of the agreement are implemented locally. All ED members must continue to utilise these local fora to insist on full implementation of the national agreement as, where the agreement has been implemented, we are now seeing improvements".

Safe practice vital when delegating

Members urged to maintain safe practice when delegating to HCAs

IT HAS come to the attention of the INMO that certain tasks are being delegated by nurses and midwives to healthcare assistants (HCAs) that are outside the nationally agreed job description for HCAs.

The agreed national job description for healthcare assistants recognises the important role of HCAs in assisting the nurse and midwife to deliver healthcare to their patients on a day to day basis.

The primary role of the HCA is to assist the nurse/midwife in the implementation of care, as determined by the registered nurse/midwife.

The job description for HCAs also recognises that nursing/midwifery staff will delegate duties in accordance with their professional judgement and

within the competence of the HCA.

It also states that nursing/midwifery staff must not allocate any duty to the HCA for which he/she has not been trained.

The national agreed job description is a FETAC, Level 5 qualification, and it allows for the HCA to undertake clinical observations on patients if this is delegated to them by a nurse/midwife.

In recent weeks the INMO Executive Council has become concerned at certain incidences where nurses and midwives are delegating tasks to HCAs that are not within the national agreed job description, and for which the HCA has not been appropriately trained.

Examples of these are HCAs

now being asked to perform ECGs or to perform phlebotomy even though they are not employed as a phlebotomist in this area. These practices expose the nurse or midwife in the area of delegation.

The Nursing and Midwifery Board of Ireland (NMBI) defines delegation as "the transfer of authority by a nurse or midwife to another person to perform a particular role/function".

Under the NMBI Professional Code of Conduct and Ethics the responsibilities of the registered nurse/midwife are clearly stated and it includes that you are accountable if you make a decision to delegate a nursing or midwifery task to someone who is not a registered nurse or midwife.

It is clear that nurses and midwives who delegate certain tasks to HCAs who are not trained to perform these tasks, and which do not fall under the national job description for HCAs (agreed with the INMO in 2005), may be exposing themselves in relation to that task not being appropriately performed.

The INMO would reaffirm our policy position to all members to only delegate tasks to HCAs that are within the confines of the agreed national job description of 2005. Any members who require further information on this issue are asked to contact the INMO or their local industrial relations officer.

See *INMO Position Statement on Delegation* opposite.



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*For every new member or re-joining member recruited, you receive a €20 One4all Gift Card.

Phil Ní Sheaghda, INMO director of industrial relations,

Ongoing battle to restore incremental credit for 2011-2015 graduates

FOLLOWING protracted discussions in late 2015, the INMO and other nursing unions concluded an agreement with the HSE and the Department of Health that restored recognition of the 36-week nursing/midwifery internship for incremental credits from 2011 onward.

The INMO has been seeking restoration of this incremental credit for the fourth year rostered placement, which was unilaterally cut in 2011 without any discussion or union agreement.

However, the Department of Public Enterprise and Reform (DPER) subsequently amended part of the agreement and only sanctioned recognition for 2016 graduates onwards. This left 2011-2015 nursing and midwifery graduates in a position where they will be earning less than their colleagues pre 2011 (to whom incremental credit was always awarded and not removed) and now less

Table 1. Graduating classes 2011-2015 - incremental credit

| Taking September of each year as the pay increment of the staff nurse date this table sets out the difference in pay | | | |
|--|---|---|------------|
| Qualifying year | Point 6 Staff nurse/midwife salary scale | Point 7 Staff nurse/midwife salary scale | Difference |
| 2011 | €34,666 | €36,137 | €1,471 |
| This person would now be on the sixth increment so it's the difference between sixth and seventh point | | | |
| Qualifying year | Point 5 Staff nurse/midwife salary scale | Point 6 Staff nurse/midwife salary scale | Difference |
| 2012 | €33,189 | €34,666 | €1,477 |
| This person would now be on the fifth increment so it's the difference between fifth and sixth point | | | |
| Qualifying year | Point 4 Staff nurse/midwife salary scale | Point 5 Staff nurse/midwife salary scale | Difference |
| 2013 | €31,710 | €33,189 | €1,479 |
| This person would now be on the fourth increment so it's the difference between fourth and fifth point | | | |
| Qualifying year | Point 3 Staff nurse/midwife salary scale | Point 4 Staff nurse/midwife salary scale | Difference |
| 2014 | €30,537 | €31,710 | €1,173 |
| This person would now be on the third increment so it's the difference between third and fourth point | | | |
| Qualifying year | Point 2 Staff nurse/midwife salary scale | Point 3 Staff nurse/midwife salary scale | Difference |
| 2015 | €29,497 | €30,537 | €1,040 |
| This person would now be on the second increment so it's the difference between second and third point | | | |

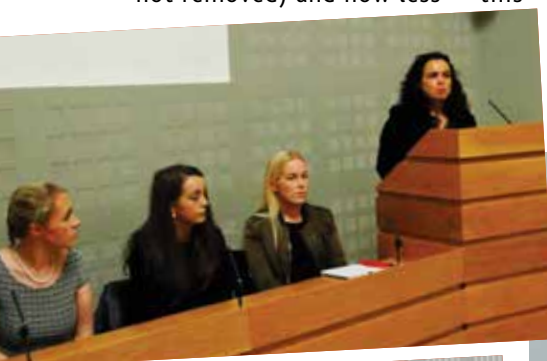
than some of the new graduates of 2016.

In a letter to the Minister for Public Expenditure and Reform, Paschal Donohoe, the INMO stressed that this has created a wholly inequitable situation, which has no precedent across the public service. The

Department had stated that incremental credit would not be restored for 2011-2015 graduates until a review was undertaken of the impact on retention on graduates in 2016 arising from restoration.

"This is an untenable approach, which will in any event be undermined by the reality that many health

employers are refusing to offer permanent posts to 2016 graduates. This makes it impossible, even if it were necessary, to measure the impact of the restoration of incremental credit in any meaningful way", Liam Doran, INMO general secretary told the Minister. "In other words, any delay in restoring full incremental credit for the



Ahead of special briefing meetings in the Department of Health and with health spokespersons from opposition parties on incremental pay for 2011-2015 graduates were (above, back, l-r): Liam Conway, INMO; Peter Hughes, PNA; John Handey, SIPTU; Aisling Culhane PNA; Liam Doran, INMO general secretary; Phil Ní Sheaghda, INMO director of industrial relations; Mary Leahy, INMO first vice president; Bernie Heneghan, SIPTU; (front, l-r): Helen Keogh, INMO; Mairead Gordon, INMO; Thomas Ahare, PNA; Philip Doyle, PNA; Caitriona O'Neill, PNA; (top, left): Phil Ní Sheaghda, INMO director of industrial relations, addressing the meeting; (left) Mairead Gordon, INMO, explaining the effects of the incremental pay anomaly



reports on current ICTU, WRC and national IR issues

purpose of any 'review' is now indefensible."

The INMO urged the Minister to appreciate that the current situation completely undermines any attempt to recruit new young professional nurses and midwives and address the current critical shortage of these professionals in the health service.

Against this background, the INMO is continuing to engage on this issue with graduate members. Meetings were held on September 22 with the Department of Health and health spokespersons of opposition parties who were invited to attend a briefing (see photos). In addition, as we went to press the INMO and other nursing unions were planning a protest outside the Dáil for September 27 – the day the Dáil resumed. The INMO stressed that the retention of the small number of nurses/midwives who qualified since 2011 and who stayed in Ireland is imperative and recruitment of those who left during the crisis is now essential, considering the crisis in nursing/midwifery retention and recruitment.

"This is the only way to ensure the additional beds needed for the ED winter initiative will be opened, and overtime and agency costs will be reduced, and therefore requires special measures," INMO director of industrial relations Phil Ní Sheaghda told TDs and senators in a recent letter, urging them to support the nursing unions' stance on this matter.

Examination of measurement of all hours worked has now commenced

TALKS have commenced between the nursing unions and the HSE/health service management to examine the issue of 'how to measure all time worked by nurses and midwives to ensure all attendance hours are captured'.

The two recent public service agreements, Lansdowne Road and Haddington Road, committed the HSE and health service management to meet

with nursing unions on this issue.

The INMO's position on this is that nurses and midwives are attending for periods far in excess of their contractual requirements, and that this has to be taken into account and considered as working time.

The discussions on this issue are protracted and slow and the INMO is seeking a focused approach from the employer,

as, the current reliance on the good will of nurses and midwives working through breaks, staying on at end of their shifts and coming in early for commencement of shifts, simply cannot be taken for granted.

Keen to progress this matter, the unions is continuing to seek that all matters relating to it are prioritised with the employer side.

Review of sick leave scheme underway

THE review of the revised Public Service Sick Leave Scheme, which is applicable to all public servants, is ongoing between the public service trade unions, which includes the INMO, and the Department of Public Expenditure and reform.

Some positive restructuring of the current scheme is emerging and there is much discussion on a number of

issues which the trade unions are objecting to.

However, there continues to be a lot of negotiation and dialogue to complete and it is likely that the talks in relation to this will continue into early November.

Issues under discussion include: civil awards, temporary rehabilitation remuneration, critical illness protocol, application of the

Injury Grant (Article 109), partial sickness absence, psychological injury, TB and occupational acquired illnesses, critical illness protocol, recording of sickness absence. In the event that agreement cannot be reached, it is likely that the normal dispute resolution procedure will be used, that is referral of all outstanding matters to the Workplace Relations Commission.

Restoration of time and one-sixth circular awaited

THE restoration of the time and one-sixth payment for hours worked from 6-8pm, retrospectively to January 1, 2016, is now awaited.

The required independent scrutiny of progress on the

national agreement has been completed. The Department of Health and the HSE have been notified and accept that the nursing/medical interface verification process is complete and that nurses and

midwives in acute hospitals have fully complied with the agreement and verification process.

The circular to instruct payment is awaited from the HSE at the time of going to print.

Know your rights and entitlements

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

Contact Information Officers Catherine Hopkins and Karen McCann at

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Email: catherine.hopkins@inmo.ie, karen.mccann@inmo.ie

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



Limerick midwives to work to rule

GIVEN the delays in implementing key aspects of the Workplace Relations Commission agreement from November 2015, members at University Maternity Hospital, Limerick have re-balloted with 97.2% in favour of a work to rule.

The INMO has engaged

monthly with the HSE in relation to the implementation of the agreement. While progress has been made on some issues, midwives still await additional healthcare assistants on a seven day roster and extra night porters.

The work to rule has been sanctioned by the Executive

Council.

Separately INMO members welcomed the setting up of an Obstetric and Midwifery Forum.

This was initiated by INMO correspondence to the CEO in July and resulted from a subsequent meeting with the CEO, the clinical director of

maternity services and INMO midwife representatives on August 16.

Additionally from this engagement, the INMO secured confirmation of an extra 30 hours senior medical cover in the maternity emergency unit.

Mary Fogarty, INMO IRO

Industrial action may commence at UHL

A CRITICAL shortage of nurses on the medical/surgical wards at University Hospital Limerick resulted in a ballot of members in August seeking measures from management to address poor nurse to patient ratios.

The outcome was 98.4% in favour of lunchtime protests and/or a work to rule on the medical/surgical wards. This is a clear indictment of the strength of feeling among nurses at the hospital, that if vacant positions cannot be filled then beds will have to be closed.

The INMO notified hospital management of this outcome on September 2, but

at the time of going to press no response had been received. An in-house INMO committee is to be established to co-ordinate this dispute.

Concurrently INMO representatives engaged in a pilot on four wards, highlighting a range of issues related to organisation of work, health and safety, and rosters on the medical/surgical wards.

If these identified issues were addressed by management, INMO representatives believe they will assist in alleviating some of the hospital workload that falls to nurses to complete.

Mary Fogarty, INMO IRO

Brothers of Charity Limerick dispute in WRC

A DISPUTE referred to the Workplace Relations Commission by the INMO was heard on August 24, in relation to the introduction of new eligibility criteria for access to the sick pay scheme and to top-up maternity pay at Brothers of Charity Limerick. These changes were introduced by management without discussion or agreement of the unions.

At the WRC, the INMO also raised roster anomalies within the service whereby nurses working a 39-hour week cannot access their full-time hours and the unilateral removal of time and a quarter



Mary Fogarty, INMO IRO: "Changes introduced without discussion or agreement"

to two nurses who have been in receipt of same since 1997 and who are covered by a local collective agreement.

Brian McGinn chaired conciliation where management agreed to revert to the INMO under the auspices of the WRC within a month.

Mary Fogarty, INMO IRO

New members join INMO Executive Council

FOLLOWING the resignation of two members from the Executive Council, two new members have been nominated to fill

their positions on the Clinical seats. Marie O'Brien from Ennis and Thomas Caulfield from Ballinasloe have now

joined the Executive, replacing Theresa Dixon and Kate Finnermore.

Over the coming months, all

Executive Council members will be introduced in *WIN*, beginning this month with the first and second vice presidents, see page 28.



Marie O'Brien, CMN1, Ennis General Hospital. Marie did her general nurse training in Mid-Western Regional Hospital, Limerick and midwifery training in St Munchin's Maternity Hospital, Limerick. She then worked at St Mary's Orthopaedic Hospital, Cork in orthopaedics and burns. She moved to Ennis General in 1985. Marie became active in her local INMO branch in the 1980s as a temporary nurse. During this time, she and her local branch achieved many improvements for staff locally, ie. improved rosters and working conditions etc. She was part of the reconfiguration negotiations for the mid-west, where the branch worked hard on LRC intervention to get the best outcome for patients and staff.



Tommy Caulfield, CNM1, Portiuncula Hospital Ballinasloe, Galway. Tommy trained in Portiuncula, completed a postgraduate hDip in perioperative nursing from NUJ Galway, and also has a certificate in sterile services technology from Tallaght IT. He worked for many years as a theatre nurse and is currently working in the central decontamination unit in Portiuncula. Tommy has been an INMO rep in Portiuncula since the 1990s and has been chairperson and vice chairperson of the Ballinasloe Branch in the past. He has been involved in disputes, both nationally and locally, including LRC and regional meetings.

Refurbishment work is continuing apace at the Richmond Building to create the INMO Education and Event Centre. On completion of the planning process, work on the site began in late July and is expected to be completed in January 2017, with a formal opening in the spring.

Pictured here is the bones of the new cafeteria, which will cater for members attending courses and events at the centre. Members can follow this refurbishment work via the photographic gallery on www.inmo.ie



Action deferred at South Tipperary

Scientific review of staffing needs ongoing at hospital

A SUBSTANTIAL vote in favour of engaging in industrial action and serving notice of a work to rule was carried out at South Tipperary General Hospital, Clonmel in August in pursuance of appropriate and safe nurse staffing levels for the provision of quality and safe patient care.

The following proposals emanated from a meeting with the group CEO on August 16:

- The conversion of 20 temporary nurses to permanent appointments, inclusive of four nursing graduates
- Increasing of complement of healthcare assistants (HCAs) by 12 in order to positively

Mary Power, INMO IRO:
"The reality remains that there are not enough nurses to provide quality and safe patient care requirements at the hospital"



impact on patient care needs

- A scientific review of the staffing needs in all departments/wards. This is being supported by expert advisor Prof Jonathan Drennan of UCC.

The local committee proposed to defer the work to

rule to secure these additional conversions and positions. The working group has commenced a review to identify the staffing requirements for South Tipperary General Hospital. A detailed briefing document was circulated to all members supported by briefing sessions provided to members regarding the proposals. A ballot was conducted with the outcome:

- 78.8% accepted
- 19.7% rejected
- 1.5% spoiled votes.

"Members are pleased that 20 of their nursing colleagues will have their temporary contracts converted to permanent

contracts plus additional HCAs are being appointed to assist in patient care needs. However, the reality in South Tipperary General Hospital still remains that there are not enough nurses to provide quality and safe patient care requirements at the hospital," said INMO IRO, Mary Power.

"We are hopeful that the scientific review on staffing, supported by Prof Drennan, will advise the number of additional staff that is required and that the HSE will secure the appropriate funding to enhance the existing approved nursing and midwifery complement at the hospital."

Clonmel hospital initiative must put patients first

Following recent media reports of a 'patient hotel' planned for South Tipperary General Hospital in Clonmel, the INMO warned that any initiative seeking to increase bed capacity in Clonmel must put patient care as its absolute priority.

The daily reality in the hospital is one of overcrowding and severe understaffing which undermines patient care, compromises patient privacy and leaves staff unable to practise safely. The INMO is currently involved in ongoing discussions with hospital management, seeking to agree measures to

address this crisis. The Organisation pointed out that while the need for additional beds is evident, any additional beds that are brought on stream must be adequately staffed, reflecting the care and observation requirements of every patient needing hospitalisation.

It is simply not true to suggest that any patient placed in a modular 'patient hotel' built to relieve overcrowding adjacent to the hospital, would require less care and staffing. All patients require care and those in Clonmel are entitled to the same level of care as

every other patient in a hospital bed.

The INMO has raised this issue directly with local management and at national level. In addition, as the 'patient hotel' concept (which is being compared to the Scandinavian situation – which is very different) is being mentioned as part of the ED winter initiative, the INMO raised this issue at the meeting of the ED Taskforce on September 6.

INMO general secretary Liam Doran said: "The situation in Clonmel represents an absolute crisis and is a direct

result of neglecting the hospital over many years with the resultant loss of nurses due to the moratorium. Efforts to recruit nursing staff have not produced sufficient numbers, to date, leaving the hospital severely understaffed to the detriment of patients and our members. Any initiative to increase bed capacity must be quality assured with the necessary level of additional staff to ensure all patient needs are met. The crisis in Clonmel is not only about a shortage of beds, it is also about the severe shortage of nurses."



At the Global Nurses United fifth annual delegate congress in Dublin last month were (l-r): Dave Hughes, INMO deputy general secretary; Prof Leonard Rubenstein, chairman, Safeguarding Health in Conflict Coalition; Patricia King, general secretary, Irish Congress of Trade Unions; Kenneth Zinn, political director NNU, coordinator GNU; Jean Ross, NNU co-president; Martina Harkin-Kelly, INMO president; and Liam Doran, INMO general secretary



Kenneth Zinn, political director National Nurses United, co-ordinator Global Nurses United; Jean Ross, registered nurse and National Nurses United co-president; Brendan Carr, Lord Mayor of Dublin; Martina Harkin Kelly, INMO president; and Dave Hughes, INMO deputy general secretary



Elizabeth Adams, INMO president; Silas, president of the Carr, Lord Mayor of Dublin; and Dave Hughes, INMO deputy general secretary

Caring in conflict zones

Attacks on health workers and health facilities must be seen as unacceptable and not inevitable, delegates at the Global Nurses United annual congress heard in Dublin last month

The INMO hosted delegates from 12 countries across the globe on September 22, as part of its commemoration of the Easter Rising of 1916 and the role played by nurses and midwives during that bloody week in which 485 people, including 260 civilians, were killed. In total 38 of the civilians killed were children and a further 2,217 civilians were wounded.

The conference opened with a documentary charting the events of 1916, after which nurse and historian Mark Loughrey outlined in detail the impact of the Rising on Dublin city and its civilians, and the significant role played by nurses and midwives who practised in appalling conditions throughout that week. He also recounted the role played by nurse Elizabeth O'Farrell in delivering the surrender note and subsequently conveying to the rebels their leaders' decision which brought an end to the Rising.



Mark Loughrey, nurse historian, presented at the GNU conference on the role played by nurses and midwives during the 1916 rising

which brought an end to the Rising.

Nurses from the Royal College of Nursing in Northern Ireland, Prof Jean Orr, Mary McCullagh and Margaret Kerr, provided delegates with first-hand experience of the Northern Ireland Troubles using photographs and a short documentary and reading their own stories which are recorded in the book *Nurses' Voices*.



(l-r): Prof Jean Orr, Margaret Kerr and Mary McCullagh, members of the Royal College of Nursing in Northern Ireland, who relayed stories for the Northern Ireland Troubles

Following a civic reception by Lord Mayor

of Dublin Brendan Carr, delegates heard from Leonard Rubenstein, a leading expert on current conflict zones and chairman of the Safeguarding Health in Conflict Coalition, on its report *'No Protection, No Respect – Health workers and health facilities under attack 2015 and early 2016.'*

Prof Rubenstein told delegates that, appalling as the conditions were 100 years ago in Ireland and more recently in Northern Ireland, the lack of respect and non-observance of the Geneva Conventions and international law in current conflict zones around the world is breathtaking. He cited examples of hospitals, ambulances and medical supply transports being attacked and looted in many countries, sometimes intentionally, and sometimes due to attackers failing to distinguish between military and civilian objects.

Health workers and medical staff have died in such instances. In countries such as Afghanistan, Iraq, Libya, Syria and Yemen, hospitals have been subjected to aerial bombings, as well as to explosives launched from the ground. In Syria, where the most rigorous reporting has taken place, at least 122 attacks on hospitals were documented in 2015, with some facilities hit multiple times. He described 'double tap' attacks in Syria when government and Russian allies launched a second strike after rescuers came to aid those wounded in the first attack. Some 31 people have been killed and 150 wounded in such attacks. In Yemen health facilities have been attacked at least 100 times.

Prof Rubenstein said attacks on health services take many forms but can be grouped into four major categories:

- Bombing, shelling and looting facilities or transports, sometimes as a result of targeting the facility or transport, other

times because of an indiscriminate attack that failed to take precautions to avoid harm to the facility

- Violence inflicted on health workers, independent of an attack on a facility or transport
- Military takeover of hospitals, or fighting in and around hospitals
- Obstruction of access to healthcare, medicine and essential supplies.

Prof Rubenstein stressed attacks on healthcare workers must be seen as unacceptable and not inevitable. He called on the nursing trade union leaders at the conference to lobby their governments to support the humanitarian call for action from the Safeguarding Health in Conflict Coalition for the following urgent actions:

- That states must respect medical missions, train their military to do so and take measures to prevent abuses of human rights and access to healthcare
- That the UN and member states should implement a mechanism to investigate, at international level, all major attacks on health services through the International Humanitarian Fact-Finding Commission or otherwise
- That the Office of the High Commissioner for Human Rights (OHCHR) should increase field investigations and training activities concerning attacks on healthcare
- The Security Council should declare that national laws criminalising providing healthcare to individuals based on their claimed status as enemies are contrary to international law.

ICTU general secretary Patricia King chaired the final session of the conference at which delegates showed great enthusiasm for the call to action.

– Dave Hughes, INMO deputy general secretary



INMO director of professional development; Linda
the Canadian Federation of Nurses Unions; Brendan
Dublin; and Martina Harkin Kelly, INMO president;
INMO deputy general secretary



Delegates from 12 different countries at the
Global Nurses United Conference 2016

Global Health United technical report

THE second day of the GNU fifth annual delegate congress saw the members present discuss a range of technical and other issues which can be summarised as follows:

New affiliations

The meeting agreed to accept the New Zealand Nurses Organisation into full membership with immediate effect. The Spanish Nurses Association would also be accepted into membership once various processes within that body, were complete. The Philippine Nurses Union was accepted into associate membership, pending completion of formal registration.

Privatisation of healthcare

The meeting heard a number of contributions from participating unions, detailing the increasing trends, across many countries, to privatise essential healthcare as part of cost cutting initiatives by various governments. Examples were given from Brazil, Australia, Philippines and the US, where the pay and conditions of nursing staff was being attacked as health services were privatised and profit was being demanded from new shareholders.

It was unanimously agreed that the GNU should act as a hub of information for all affiliates so members could learn from the experience of others and, specifically about campaigns that have been mounted and their success, in opposing the trend to privatise essential public health services.

Safe staffing – nurse/patient ratios

The meeting heard of a number of positive developments in Australia (Queensland and Victoria) and in some states in the US, towards achieving mandatory nurse/patient ratios. In contrast the meeting also heard of appalling low ratios in such countries as Brazil, Spain and the Philippines. The INMO delegation outlined the Organisation's ongoing efforts to secure consistent, safe staffing levels through the work of the Taskforce on Medical/Surgical Nursing and the ED expert group. The INMO is making available to all GNU members, all the various reports to emerge in the past 12 months on this

matter to assist sister unions in their own campaigns, in their own countries, on this critically important issue.

It was again agreed that the GNU would act as a hub, for all various reports or agreements on staffing, to appraise all affiliates of progress. In addition it would also assist in avoiding the attempts, by managements in many countries, to delay the introduction of safe staffing on the basis that more research has to be undertaken before implementation, even though that research has been carried out in a neighbouring country. It was also agreed that this safe staffing/nurse to patient ratio issue would be a central theme in the work of the GNU over the next five years. The conference unanimously adopted expressions of support and solidarity to the several affiliates currently engaged in protracted campaigns in pursuance of safe staffing.

Transatlantic Trade and Investment Partnership (TTIP)

The meeting received an update on the campaign of opposition by the wider trade union movement to the new Transatlantic Trade and Investment Partnership (TTIP). The meeting noted that a key demand, of those seeking a new TTIP agreement, was to confer special legal right to corporations, through access to a new Investment Court System, where private corporations have the right to sue governments for financial compensation if they believe their rights have been violated when government actions or policies 'interfere' with their ability to make a profit.

The GNU Congress unanimously agreed that the GNU would join with trade unions, in Europe, Asia and North America, in opposing this initiative which, bluntly, seeks to reduce wages and minimise the rights of workers, with the corporation's right, to pursue profits, protected in law.

Workplace violence against nurses

The meeting also received reports from affiliates on the ever increasing rise in assaults on nurses in the workplace. Many examples were given including, from

the INMO, the latest Irish figures which showed that, in 2015, there were 3,500 incidents of assault with 2,300 of these being on nursing staff. The meeting unanimously agreed that the GNU committee should draw up a guidance document for all affiliates. This could be used as a basis for collective engagement with employers, on the premise that prevention of assault must be the objective rather than dealing with the consequence of assaults.

Working in conflict zones

Arising from the proceedings of day one of the conference, the technical meeting then discussed what steps the GNU needed to take, as a collective body, to raise public awareness of the ever increasing incidence of attacks on healthcare workers in conflict zones.

In that context the congress unanimously adopted the following motion:

The 5th Annual Delegate meeting of the Global Nurses United, having considered the report, 'No Protection, No Respect', which charts the appalling level and number of attacks on health workers in conflict zones, resolves to:

- Endorse UN Declaration No 2286 which provides key steps to increase protection of health workers
- Lobby each individual member's government to adopt a directive and use their influence to have other states called to account for breaches of humanitarian standards
- Promulgate understanding among nurse and midwife members of the extent and level of the attacks on health workers and facilities in modern warfare
- Declare that it is never acceptable to hinder, impede or prevent the delivery of healthcare, or to attack those delivering it, regardless of circumstances.

Closing commitment

The meeting closed with all participants declaring their full commitment to the GNU, and to encourage nursing unions, in neighbouring countries, to join Global Nurses United over the next 12 months.

– Liam Doran, INMO general secretary



Human rights and health in conflict zones

Elizabeth Adams focuses on international nursing and midwifery initiatives and activities of interest to INMO members

VIOLENCE against healthcare workers, facilities and patients is one of the most serious and overlooked humanitarian challenges in the world today. In recent years, the frequency and severity of attacks on health workers, patients, hospitals, and clinics throughout the world have increased.

During armed conflict or civil disturbances, assaults on health facilities, health workers and the patients they serve are all too common. In addition to the human toll, these attacks compromise the ability to deliver care to populations in great need, impede efforts to reconstruct health systems after war, and lead to the flight of health workers whose presence in a time of great social stress is essential.

Safeguarding health

The Safeguarding Health in Conflict Coalition was founded by Prof Leonard S Rubenstein in 2010 to address the under-reporting of attacks on health workers and facilities in conflict areas. The INMO is a member of the

Coalition, with over 30 leading international non-governmental organisations, including the International Council of Nurses.

Prof Rubenstein is a lawyer and senior scholar and director of the Program in Human Rights, Health and Conflict at the Center for Human Rights and Public Health at the Johns Hopkins Bloomberg School of Public Health, and a core faculty member at the Berman Institute of Bioethics at Johns Hopkins University. Prior to coming to Johns Hopkins in 2009, he was

a Jennings Randolph senior fellow at the United States Institute of Peace and, for a decade before that, executive director and then president of Physicians for Human Rights.

Prof Rubenstein has engaged in extensive research and writing on human rights and health that have appeared in professional journals and major media such as the *New York Times* and *Washington Post*. His current work focuses on increasing protection of human rights and health in volatile environments, including armed conflict and prisons. He has worked closely with organisations working in Syria and was lead author of the 2015 report with the Syrian American Medical Society, *Syrian Medical Voices from the Ground: The Ordeal of Syria's Health Professionals*.

He is a member of the Council on Foreign Relations and the Board of Directors of the Global Health Council and the International Federation of Health and Human Rights Organizations. He has served on the Governing Council of the American Public Health Association and the Committee on Scientific Freedom and Responsibility of the American Association for the Advancement of Science. He is the recipient of numerous awards, including the Congressional Minority Caucuses' Healthcare Hero Award, and the Sidel-Levy Award for Peace of the American Public Health Association.



INMO director of professional development Elizabeth Adams pictured with Prof Leonard S Rubenstein at the Global Nurses United International Conference in Dublin, which was hosted by the INMO in September

As founder and chair for the Safeguarding Health in Conflict Coalition, Prof Rubenstein seeks to reduce interference with health workers, patients, facilities and transports. He has led efforts to increase the role of the World Health Organization, the High Commissioner of Human Rights and the United Nations (UN) Security Council in protecting health workers from attack. He was central to lobbying for the recent UN Security Council Resolution 2286 (2016), which strongly condemns attacks against medical facilities and personnel in conflict situations.

The Coalition, in the third annual report *No Protection, No Respect*, found that during 2015 and the first three months of 2016, deliberate or indiscriminate strikes on health-care have killed medical workers and patients, decimated medical infrastructure and robbed countless civilians of vital medical care in 19 countries around the world, including:

- 122 hospitals attacked in Syria
- 100 health facilities attacked in Yemen
- 200 humanitarian compounds and transports attacked and looted in Central African Republic
- 28 polio vaccination workers murdered in Pakistan
- 60 women detained and raped in a hospital in Sudan.

The report also found that, in many instances, parties to conflicts failed to take required steps to avoid harm to medical facilities, staff and patients, and obstructed access to healthcare. The after-effects of attacks are far reaching and negatively impact the health of people in specific areas in need of urgent care. Healthcare deprivation is one of the major effects, due to a loss of facilities and medical staff. Such losses are detrimental to the public, as a single closure can leave an entire population without access to appropriate healthcare.

In recent months, the UN agencies have reported an appalling number of people in dire need of healthcare access. Population displacement, lack of resources and civilian injuries are all contributing factors. The Safeguarding Health in Conflict Coalition's report *No Protection, No Respect* can be found online at www.safeguardinghealth.org/report2016

Prof Rubenstein presented at the Global Nurses United International Conference hosted by the INMO, marking the centenary of the 1916 Rising under the title '*Delivering Nursing and Midwifery Services in Conflict Zones*' on September 22 (see page 20-21).

Elizabeth Adams is INMO director of professional development

Major international conferences

Ireland hosts international conference on Violence in the Health Sector

The fifth International Conference on Violence in the Health Sector takes place in Dublin on October 26-28 2016 in the Crowne Plaza Hotel and Conference Centre in Santry. This is the largest worldwide conference dedicated to workplace aggression and violence within the health and social services sector and the theme this year is '*Broadening our view – Responding together*'. Work-related aggression and violence within the health and social services is a major problem which diminishes the quality of working life for staff, compromises organisational effectiveness and impacts negatively on the provision and quality of care.

Dr Kevin McKenna, lecturer with Dundalk Institute of Technology, is a founding member and has co-chaired both the organisation and scientific committees of the International Conference on Violence in the Health Sector since its inception in 2008. With Prof Ian Needham, chair, and Nico Oud, organiser, they have worked collaboratively with many national nursing associations under the umbrella of the International Council of Nurses (ICN) for over a decade in delivering this international conference.

This conference is supported by over 40 national and international agencies including the ICN, International Labour Organization, Public Services International, World Medical Association, International Hospital Federation, American Nurses Association, Sigma Theta Tau International, and International Alliance of Patient Organisations. The INMO is active in the local planning committee to support the hosting of the 2016 conference. Considerable attention and advancements in addressing the problem of aggression and violence in health and social care have been achieved from educational, research, practice, service and organisational perspectives nationally and internationally. In addition to raising awareness, the 2016 conference will provide a platform to share these international developments, with an emphasis on best practice research and initiatives to effectively respond to the problem. The conference provides a unique opportunity for nurses and midwives to network and establish contacts with a diverse community of colleagues engaged in this important area of work. Apart from the geographical diversity of delegates, there is also a multiplicity of perspectives including clinical/service, organisational, educational, research and regulatory. All nurse and midwife delegates attending will receive a certificate of International Continuing Nursing Education Credits from the ICN, which is internationally accepted as continuing professional development. See www.oudconsultancy.nl/dublin_5_ICWV/index.html

International Confederation of Midwives Congress

The 31st International Confederation of Midwives (ICM) Triennial Congress will be held in Toronto, Canada from June 18-22, 2017. This congress represents and works to strengthen professional associations of midwives throughout the world. The ICM represents 116 midwives associations, representing 102 countries across every continent. The theme for the 2017 Congress is '*Midwives – making a difference in the world*'. As new global initiatives are being developed, one strong message emerges from the 2011 and 2014 *State of World's Midwifery Reports* – that midwives do make a difference in saving the lives of women and newborns and promoting good health. The INMO Midwives Section is a member of the ICM and works closely in partnership with the confederation to promote, support and drive the strategic direction of midwifery practise and celebrate the value of midwives. Further information www.midwives2017.org



The International Council of Nurses Congress 2017

The International Council of Nurses 2017 Congress will be held in Barcelona in Spain from May 27 to June 1, 2017. The theme is '*Nurses at the forefront transforming care*'. Instructions for submitting abstracts for the scientific programme and details on the themes to be addressed can be accessed at www.icncongress.com. Online submission of abstracts will close on October 10, 2016. The plenary sessions will be dedicated to exploring the theme, with particular focus on the Sustainable Development Goals, human resources for health, universal health coverage and safe staffing. Featured main sessions will offer the most recent expertise on patient-centred healthcare, evolving scopes of practice, climate change, infectious and non-communicable diseases, mental health, migration, human rights, patient safety, policy, technology, leadership, education, and history. Themes for abstract submissions (concurrent sessions, symposia and posters) will address these issues plus developments in healthcare systems, health promotion, nursing workforce, disasters and regulation. The Congress will also be the venue for the ICN Network meetings.





Committed to community care

Dean Flanagan talks about his new role as IRO focused on community care in the midlands. Tara Horan reports

THE new community health structures and how they will affect public health nurses and community RGNs will be the main focus for Dean Flanagan in his new position as INMO industrial relations officer for Longford, Westmeath, Laois and Offaly community health organisations.

This role has come about as a result of restructuring of IRO areas to mirror the HSE hospital groups and community health organisations (CHOs). As well as the midlands CHOs, Dean will cover Portluncula Hospital, Ballinasloe and care of the elderly facilities in the area.

The reporting structure being introduced for CHOs by the HSE is the main challenge ahead, under which managerial and care decisions are being withdrawn from nurses to non-clinician managers. "The HSE has all but decided on the top layers of management in CHOs, with no nurse representation whatsoever," said Dean. The new reporting structures being imposed place PHNs and community RGNs below top level management. Under it, they will report to a network manager, who then reports to top level management, who then reports to the chief officer.

"As well as being a hindrance for nursing practice, this will also hinder PHNs and community RGNs (CRGN) from getting to the top level of the managerial ladder. It's somewhat insulting to the amount of work that PHNs/CRGNs are doing, covering everything from mental health to social care and primary care in the community, that they will be reporting into different lines and steams rather than just having one person to report to any more. This is obviously going to dilute care, create more paperwork and more frustrations, and will also mean that PHNs/CRGNs will be responsible to three or four line managers

who have no input whatsoever into patient needs and no input into the workload that needs to be carried out. This will still rest with the PHN/CRGN, who will be ultimately responsible because they are the registered profession, despite not having a say on where resources go," said Dean.

The INMO is engaged with the Workplace Relations Commission on this issue and is refusing to engage with the new reporting structure that has been put in place. The Organisation has just concluded nine regional meetings with PHNs/CRGNs and directors and assistant directors of public health nursing throughout the country, to decide on the way forward.

"The situation could escalate to industrial action following balloting of members in order to bring the HSE back to the table on this issue. The HSE seems to be fully convinced that these structures are the way it wants to go, but they fail to recognise the work done by nurses and midwives in the community," said Dean, pointing out that any industrial action by PHNs/CRGNs would have a knock-on effect on other sectors as community health backs up the acute care system, through Fair Deal and community care assessments etc.

"In the restructuring of the acute hospital sector, the HSE has recognised nurses/midwives at the top level of management, yet it won't afford that same basic management structure to community care. At the end of the day, the HSE is saying they want all care to be predominantly in the community, yet the management structure is not going to recognise the PHN/CRGN's role," said Dean.

On taking up his post on October 3, Dean said he would set about meeting with all the current Branch structure and INMO stalwarts to identify all

issues that need addressing in the area.

"This will be a challenging role because the nature of community care is that people are spread out geographically, so I will need very good communication systems. I want to get an INMO rep in each and every workplace in the area. We need to ensure we have good communication through branch structures, the journal and the website to ensure we reach all members working in the community."

Career

Prior to this appointment, Dean has been the INMO student and new graduate officer for the past three years, during which time he counts the main achievements as restoration of incremental credits for the internship year (completion of which is ongoing) and ensuring the supernumerary status of students on placements.

Dean served as president of the European Nursing Student Association (ENSA) from 2014-15, and as part of this worked closely with the European Federation of Nurses (EFN). Dean is also a member of the ICTU youth committee, on which he has been vice chair for the past year.

A native of Lisdoonvarna, Co Clare, Dean trained as a general nurse in St Angela's College, Sligo. Following qualification and a spell working in a nursing home, Dean worked as a staff nurse in Sligo Regional Hospital.

His involvement with the INMO began with the Student Section and continued with the Sligo Branch, on which he served as vice chair, while INMO president Martina Harkin-Kelly was chair.

Dean Flanagan is currently based in INMO HQ but expects to set up an office in the midlands shortly. He can be contacted on email: dean.flanagan@inmo.ie

Spotlight on PHN Section

THE INMO PHN Section represents all public health nurse members and provides a forum to address all issues of national significance. Currently there are 1,500 PHNs employed in the Irish health service, a fall of circa 12%, arising from the 2009 recruitment moratorium. We meet approximately four times per year at INMO HQ and members are also welcome to join the meeting by conference call. We are fortunate to have three members sitting on the Executive Council including Mary Leahy as first vice-president, Eilish Fitzgerald and Grainne Walsh. We also have president of NMBI, Essene Cassidy.

The recent INMO/UCD report on *Missed Care in the Community* (available on www.inmo.ie under the education tab) provides stark reading with regards to the serious and significant challenges that currently face public health nursing. These issues are to the fore at our national section meetings. The report highlighted the impact of the reduced staffing in a time of ever increasing demands on overstretched resources.

With ongoing crises seeing earlier discharges, growing hospital waiting lists and devastating reduction in home help services, it is crucial that the PHN Section remains strongly united. We will continue to lobby for improved resources to ensure the ongoing delivery of a world class quality health service to our patients in the community. We are more than eager to welcome new members and we won't rest until conditions of employment are significantly improved for all our members.

Section Officers

Chairperson



Catherine Rotte-Murray
catherine.rottemurray@gmail.com

Vice chairperson



Mary Leahy
maryj.leahy@hse.ie

Education officer



Sinéad Harte
snharte@hotmail.com

Secretary



Essene Cassidy
essene.cassidy@hse.ie

Affiliation Form for INMO Section Membership

Name: _____

INMO membership No: _____

Home Address: _____

Tel (work): _____

Tel (home/mobile): _____

Email: _____

Place of employment: _____

Job title: _____

Second section option (to obtain information only):

Forward completed form to:

Mary Cradden, membership services officer,
INMO, Whitworth Building, North Brunswick St, Dublin 7

Tick ONE relevant Section you wish to affiliate with

- | | |
|---|--|
| <input type="checkbox"/> Assistant Directors of Nursing/Midwifery/ Public Health Nursing/ Night Superintendents | <input type="checkbox"/> Nurse/Midwife Education |
| <input type="checkbox"/> Care of the Older Person | <input type="checkbox"/> Occupational Health |
| <input type="checkbox"/> Clinical Placement Co-ordinators | <input type="checkbox"/> Operating Department |
| <input type="checkbox"/> CNM/CMM | <input type="checkbox"/> Orthopaedic |
| <input type="checkbox"/> CNS/CMS | <input type="checkbox"/> PHN |
| <input type="checkbox"/> Community RGN Nurses | <input type="checkbox"/> Radiology Nurses |
| <input type="checkbox"/> Directors of Nursing/ Midwifery/Public Health Nursing | <input type="checkbox"/> Research Nurses/Midwives |
| <input type="checkbox"/> Emergency Nurses | <input type="checkbox"/> Retired Nurses/Midwives |
| <input type="checkbox"/> GP Practice Nurses | <input type="checkbox"/> RNID |
| <input type="checkbox"/> International Nurses | <input type="checkbox"/> School Nurses |
| <input type="checkbox"/> Midwives | <input type="checkbox"/> Student Allocation Liaison Officers Network |
| <input type="checkbox"/> National Children's Nurses | <input type="checkbox"/> Student Section |
| <input type="checkbox"/> National Rehabilitation Nurses | <input type="checkbox"/> Telephone Triage Nurses |
| | <input type="checkbox"/> Third Level Student Health Nurses |

Pictured at the OHN Section Conference were members of the conference planning committee and speakers (l-r): Mary Forde; Claire Mahon; Caroline Crotty, psychotherapist; Una Feeney, OHN Section officer; John Lonergan, former governor of Mountjoy Prison; Anne-Marie Graham, OHN Section officer; and Margaret Morrissey



OHNs focus on power of positivity

OVER 85 occupational health nurses gathered in Cork recently for the OHN Section conference, which was described as "the most informative and enjoyable conference yet" by attendees.

The morning session was opened by Jennifer O'Sullivan, a solicitor, who gave an informative talk on legal issues impacting occupational health nurses, including information on data protection and confidentiality, recruitment, reasonable accommodation and employment equality and bullying. Ms O'Sullivan also outlined relevant case studies.

Following the discussion on legal issues, came a talk on the

power of positive thinking and how greater emotional wellbeing and happiness can lead to greater success.

Ultan Sherman, a work and organisational psychologist in the University of Limerick, led this discussion on positive thinking, which also focused on scientifically proven strategies to boost happiness and success.

A key message to emanate from the discussion was that happiness is a precursor to success. We need to work on our happiness levels by building positive emotions through doing things that we enjoy on a daily basis and, importantly, by practising gratitude.

The remainder of the day

focused on moving from reactive to pro-active strategies in occupational health, a topic which was extensively covered by OHN Section officers Una Feeney and Anne-Marie Graham.

The conference also heard an update on the Healthy Ireland Project from Biddy O'Neill, national project lead on the health and wellbeing project within the Department of Health.

Steve Goodwin, director of Circadian UK which provides work and safety solutions for businesses, delivered an informative talk on shifting the risk – assessing and managing fatigue.

John Lonergan, author and former governor of Mountjoy Prison, and Caroline Crotty, psychotherapist, gave a presentation on nurturing happiness and contentment, which was well received by all in attendance, with some important messages for the audience to take home.

The OHN Section urges section members to come along to future annual conferences as a fantastic opportunity to network and find out, both through the exhibition that runs alongside the conference and the topics covered, the most relevant and up-to-date information to help you in your workplace.

CPC Section to address concerns with NMBI

THE CPC Section is holding an extraordinary meeting on Wednesday, October 5, at which members will meet with Judith Foley, education officer with the NMBI, to discuss a number of concerns, including the Preceptorship Project and the role of clinical placement co-ordinators in the process.

New standards and requirements, implementation and impact on the role of the CPC, standardisation of clinical

assessment documents and of development plans, training and ongoing support for CPCs and CPC to student ratio, are among the topics to be discussed at the upcoming meeting.

If you are a clinical placement co-ordinator and were not notified in person about this meeting, please contact the INMO at Tel: 01 6640600 to ensure that you are aligned to the correct section.

RNID Section Conference

The RNID Section is delighted to announce that its annual conference will take place on Tuesday, November 22, 2016 in the Crowne Plaza Hotel, Santry, Dublin 9. See page 64 for the full conference line up.

DoN Section seminar to focus on national issues

A NATIONAL overview of strategic and operational opportunities and challenges currently facing directors of nursing, midwifery and public health nursing will be among some of the topics discussed at the upcoming section seminar taking place in INMO HQ on Wednesday, October 19.

INMO general secretary Liam Doran will deliver the national overview to the Directors of Nursing/Midwifery/Public Health Nursing Section.

Edward Mathews, INMO director of regulation and social policy, will speak on fitness to practise considerations for directors.

Dave Hughes, INMO deputy

general secretary, will outline and discuss the operation of the grievance and disciplinary procedures and how directors need to be aware of these.

Colette Mullin, INMO information and research executive, will present on the duty to provide a reasonable accommodation under the Employment Equality Act 1998-2015.

This seminar will be a very informative day for directors of nursing, midwifery, public health nursing, and all section members are urged to attend.

For further information see page 6 or contact section officer Jean Carroll at email: jean.carroll@inmo.ie

Introducing Executive Council members



Mary Leahy
RGN, RM, RPHN, BNS (Hons)
mediator, PHN, Doughiska Primary
Care Centre, Galway

I WAS elected first vice president of the INMO Executive Council at the annual delegate conference in Killarney in May. I am a public health nurse in a busy primary care team at Doughiska Primary Care Centre, Galway.

Since my student days, I have been an INMO activist and am currently vice chair of the Organisation's Public Health Nurses Section and chair of the Galway Branch.

I have been a member of the

Executive Council for the past four years and will now serve as first vice president for the 2016 to 2018 period.

I have worked in a large variety of posts as a nurse, midwife, practice nurse and public health nurse in both Ireland and the UK. I trained in Galway, where I worked as a staff nurse and midwife before gaining further experience in Wales and London.

One of my main aims during my term of office will be to continue to highlight and reinforce the need for sustained investment in our public health service. A fit-for-purpose health service is essential and it is vital that investment is made now and into the future to ensure that a world class service can be delivered to all those who need it.

The INMO recently launched a report on *Missed Care – Community Nursing in Ireland* by Dr Amanda Phelan and Sandra McCarthy from

UCD, which points to the lack of necessary reform in community nursing. The service is struggling to meet the demands from challenges including a changing national demographic, earlier acute care discharges, more complex case management and moratorium consequences. Given my experience of nursing in the community, the issue of adequate resources within public health nursing and improved conditions including pay for all our members on the ground will be my top priority as I undertake my role.

I feel strongly that nurses and midwives are highly qualified professionals who work extremely hard, always advocating in the best interests of our clients and patients. In that regard, I intend to be a strong and vocal advocate for members and look forward to the challenge.

Email: maryj.leahy@hse.ie



Margaret Frahill
CNM3, Mercy University Hospital,
Cork

I WAS elected second vice president of the INMO Executive Council at the annual delegate conference in Killarney in May.

I have been actively involved in the INMO for the past 30 years at local and branch level and I am currently branch chairperson of the Cork Voluntary/Private Branch. I have been a member of Executive Council for the past two years and will serve as second vice president for the 2016 to 2018 term.

I did my general nurse training in Mercy University Hospital, Cork and midwifery training in the Doncaster Royal Infirmary in the UK. I have worked for many years in the theatre department of Mercy University Hospital and I currently hold the position of clinical nurse manager 3.

I have been elected second vice president at a very critical time in the Irish public health service – a time when nurses and midwives have, over recent years, suffered a pay reduction of up to 16%, the loss of 5,200 posts and an increase in working hours, all of which have led to a crisis in recruitment and retention.

Nurses and midwives have experienced a sustained crisis in all of their workplaces over recent years, with increasing evidence of burnout, stress and low morale.

As a theatre manager, I am acutely aware of the huge daily challenges

faced by nurses in theatres, wards, departments and the community, and the difficulties faced by all to provide a safe environment for patients and frontline staff. In that regard, the whole area of recruitment, retention and staffing levels will be a priority issue for me in my role as second vice president of INMO Executive Council.

One of the key demands from delegates at this year's annual delegate conference was the restoration of pay and working hours due to the severe recruitment and retention problems facing the professions. I intend to work tirelessly during my term of office to achieve this goal of restoration of both pay and hours.

I am delighted to have been elected second vice president of the INMO. I am very proud of our professions and it will be my privilege and honour to represent nurses and midwives nationally.

Email: margaretfrahill@gmail.com

Is your INMO membership up to date?

In difficult times the INMO will be your only partner and representative.

If you are not a fully paid up member, you cannot avail of the Organisation's services and support in such critical areas as: Safe practice, fitness to practise referrals, pay and conditions of employment, other workplace issues and continued professional development.

Please advise the INMO directly if you have changed employer or work location

Contact the membership office with any updates through the main INMO switchboard at Tel: 01 6640600

or email: membership@inmo.ie



Important
message from
the INMO



Bulletin Board

With INMO director of industrial relations Phil Ní Sheaghda



Query from member

I work for the HSE and I understand the regulations on paternity leave have been introduced, have you any information on this?

Reply

The HSE has issued a guidance document which is available on its website to inform all employees of their entitlement under the Paternity Leave and Benefit Act 2016, which was recently signed into law and commences from September 1, 2016. The Act has two main tenets:

- To entitle an employee who is a 'relevant parent' to two weeks leave from work to enable him or her to provide, or assist in the provision of, care to the child or to provide support to the relevant adopting parent or mother of the child, as the case may be, or both. The Act also entitles a surviving parent to avail of paternity leave on the death of a relevant parent
- To provide for the granting of State paternity benefit to employees who meet the eligibility criteria for payment.

Payment while on paternity leave

Employees on paternity leave may be eligible for paternity

benefit paid by the Department of Social Protection. Paternity benefit will be paid at the same rate as maternity benefit and will be based on the same PRSI contribution requirements. All employees applying for paternity benefit must have their paternity leave certified by their employer. A form 'PB 2: Employer Certificate' is available for this purpose. Further information on the arrangements relating to paternity benefit and frequently asked questions are on the DSP website www.welfare.ie/en/Pages/Paternity-Benefit-FAQ.aspx

While the legislation does not provide an entitlement to remuneration during paternity leave (apart from the provisions relating to State paternity benefit), health service employees who take paternity leave under the 2016 Act are entitled to receive the following from their employer:

- His/her normal basic remuneration plus normal fixed allowances less paternity benefit, to which he/she may be entitled from the Department of Social Protection (subject to PRSI contributions)
- This payment does not include additional amounts due to night work, overtime, shift work, working unsociable hours, standby or on-call allowances

The entitlements to paternity leave under the 2016 Act and the payment for such leave will supersede the entitlement under Department of Health Circular 153/2000 which provides for three days special leave with pay to male employees.

Query from member

I am a nurse working in the community and I have been advised that there are changes to the HSE policy on child protection. Can you advise if any discussions have been held on this with the INMO?

Reply

Yes, the HSE is revising its *Children First: National Guidance for the Protection and Welfare of Children* guidelines and it has drafted a new policy entitled *Child Protection and Welfare Policy 2016*. It is currently in draft format and we are in the process of consultation on it. All trade unions representing HSE employees are currently examining this draft policy and our collective position, comments and suggested

changes were returned to the HSE by September 26.

The INMO asked Executive Council members to review the draft document and they completed their review on September 22. The INMO has received confirmation from the HSE that:

- This policy is an updated version of Children First guidelines and is based on Children First Guidance 2011, Children First Act 2015, current legislation and HSE structures. It will be adapted to reflect future policy updates, dates of commencement of the Children First legislation and changed structures
- It does not bestow any additional responsibilities on designated officers. All HSE nursing personnel, including PHNs, are listed designated officers as was the case up to now; all training undertaken in respect of this policy, whether online or otherwise will be considered working time and staff are entitled to compensation if undertake in their own time.



A column by
Maureen Flynn

Quality & Safety

Irish Hip Fracture Database: Measuring care through clinical audit

THIS month's column focuses on measuring care through clinical audit, using the Irish Hip Fracture Database as an example.

What is an audit?

The Commission on Patient Safety and Quality Assurance¹ defined clinical audit as "a clinically led, quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and to act to improve care when standards are not met."

The Irish Hip Fracture Database is an example of a national clinical audit. It is one of several under the governance of the National Office of Clinical Audit (NOCA).

The Irish Hip Fracture Database audit gathers information about the care of patients admitted to hospital with a hip fracture. It is a clinically led, web-based audit which measures the care and outcomes of patients with hip fractures.

Hip fracture management takes a patient through a complex clinical pathway involving a wide range of specialties. It is an ideal marker condition for the care of older patients in an acute hospital and also tells us how well the trauma service is functioning. The incidence of hip fractures is rising, with some 3,591 hip fractures occurring in 2015 at an estimated cost of more than €45 million for acute hospital care.²

The database has been in evolution since 2008 following collaboration between the Irish Gerontological Society and the Irish Institute of Trauma and Orthopaedic Surgery. The audit is now established in all 16 trauma centres in the Republic of Ireland.

The mission of the Irish Hip Fracture Database is to optimise, surgical, medical, nursing, rehabilitation and secondary prevention care for all hip fracture patients.

Nationally, the Model of Care for Trauma and Orthopaedic Surgery³ declared the Irish Hip Fracture Database an integral part of driving clinical and organisational improvements in quality and effectiveness of care after a hip fracture.

What is measured?

International evidence shows that the synergy of care standards (see table 1), clinical audit and feedback drive measurable improvements in hip fracture outcomes.

The types of information gathered in the database are: gender, age group, source of admission, pre-fracture mobility, type of fracture, mode of access, ward type, time to and time of surgery, assessment by geriatrician, type of anaesthesia, type of surgery, mobilisation, development of pressure ulcers, bone health assessment, falls assessment, destination on discharge, length of stay and re-operation within 30 days.

To date, the Irish Hip Fracture Database has published two national reports and will soon publish the third. The volume of hip fracture cases with clinical data collected on the database has now reached over 80%. This is predominantly down to the contribution of many nurses and other healthcare staff entering this valuable data directly into the hospital in-patient enquiry system.

We now know the average age of hip fracture patients is over 80 years, over two-thirds are female, 80% are admitted from home, 89% have either mild to severe systemic disease, 54% were mobilising without aids and the most common fracture type is intertrochanteric. The average length of stay is 19 days in the acute hospital and 87% receive care on an orthopaedic specialist ward.⁴

Opportunity to get involved

At your next ward or team meeting you might like to talk about your role in audit and the care of patients with hip fractures. For specific information for your service you can contact the Irish Hip Fracture Database coordinator at email: Louisebrent@noca.ie. A patient information leaflet for the Irish Hip Fracture Database is available on NOCA's website.

The next *Irish Hip Fracture Database National Report* will be published on the November 2, 2016 at the fifth National Hip Fracture Meeting in the Royal College

Table 1: Hip fracture care standards (Blue Book Standards)

- All hip fracture patients should be admitted to an orthopaedic ward within four hours of presentation to the ED
- Hip fracture patients who are medically fit should receive surgery within 48 hours of admission and within normal working hours
- Patients should be assessed and cared for with a view to minimising their risk of developing a pressure ulcer
- Patients presenting with a fragility fracture should be managed on an orthopaedic ward with routine access to acute orthogeriatric medical support from the time of admission.
- Patients presenting with a fragility fracture should be assessed to determine their need for anti-resorptive therapy to prevent future osteoporotic fractures
- Patients presenting with a fragility fracture following a fall should be offered a multidisciplinary assessment and intervention to prevent future falls

of Surgeons in Ireland. If you wish to attend this meeting, please contact Louise Brent, national Irish Hip Fracture Database coordinator at email: Louisebrent@noca.ie



For more information on the Irish Hip Fracture Database and other NOCA national audits please visit the website www.noca.ie

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

*Acknowledgements
A special thanks to Louise Brent, Roseanne Smith and Mary Baggot of the National Office of Clinical Audit for sharing information and assisting in the preparation of this column*

References available on request (Quote: Flynn M. WIN 2016; 24(8): 33



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





INMO here at your service

Dean Flanagan encourages all students and new graduates to keep up the good fight

THIS is my final Student Focus article in my current role as the INMO student and new graduate officer. I would like to thank everybody I have met during my time in this role, including the students around Ireland, university lecturers, clinical placement co-ordinators, the student allocation liaison officers and of course the staff nurses and midwives.

There have been several key issues over the past three years and I am sure that there will be many more to keep up the fight. Over the next few weeks I will be travelling to all the 13 colleges and universities of nursing and midwifery across the country in order to encourage the first year students to sign up with the INMO. While many students will have been recruited in this way, not everyone would have been there on the day that the INMO visited your college. Anyone who missed the opportunity can easily join online at www.inmo.ie – it's free for students. Please let your fellow students and friends know about this. Perhaps put it up on your Facebook group.

Over the past year the INMO has had a fantastic, vibrant and active Student Section with committee members Aoife Kiernan (NUIG), Stephen Woods (UCD), Bose Allen (TCD) and Mary Escoto (TCD). However, as the internship will be drawing towards the end a new Student Section committee will need to be formed. If you are interested in becoming involved in the INMO Student Section please put your name forward, it will be an excellent opportunity to network and be involved in National, European and International work (including even a few days away).

Send in your class photos

It is great to get a collection of the graduating or last day photos of newly qualified nurses and midwives. If you have a few please send them on to dean.flanagan@inmo.ie along with where the picture was taking for publication in *WIN* – the INMO's journal.



Members of the Student Section at the INMO annual delegate conference in Killarney in May were (l-r): Stephen Woods, UCD; Aoife Kiernan, NUIG; Bose Allen, TCD; and Mary Escoto, TCD

Fight for 2011-2015 incremental credit

On December 24, 2015, the INMO, along with other nursing unions, signed off on an agreement with the HSE and the Department of Health that gave recognition of the Internship from 2011-2015. However, the Department of Public Expenditure and Reform subsequently withdrew this part of the agreement, and only allowed recognition from this year's graduates onwards.

They did however allow for a review to be carried out in 2017, which in the view of the INMO is much too distant in light of the shortages in staffing and the difficulties in retaining nurses and midwives. The INMO is seeking immediate commencement of this review with a view to immediate application of this incremental credit. This increment is worth at least €1,000 per person in every cohort from 2011-2015. As we were going to press, the INMO and other nursing unions were set to hold a demonstration on September 27 outside Dáil Éireann to publicly protest against the treatment of the 2011-2015 graduate groups. This will be covered in full in the next issue of *WIN*.

Student membership coming to a close

Congratulations to those of you now graduating. Your INMO student membership will stay active for the next month and you will receive further correspondence from the INMO prior to this. I can only encourage you to continue and protect your registration by becoming full

members of the INMO. The great benefits of being part of this Organisation include:

- Having a say in the largest professional organisation in the health sector, ensuring appropriate support and representation, if required, in the event of a fitness to practise hearing with the Nursing and Midwifery Board of Ireland
- Ensuring access to expert support, advice and guidance with regard to all employment and industrial relations issues
- Access to relevant courses to assist with your further continuing professional development obligations at discounted rates for INMO members
- Free access to the INMO library and information office services including access to up to date relevant developments, important to you as a nurse/midwife, through:
 - two dedicated websites (www.inmo.ie and www.nurse2nurse.ie)
 - regular E-Zine news bulletins and Facebook updates
- An array of special offers and discounts exclusively available to INMO members, under the INMO Groupscheme arrangement (www.inmo.groupscheme.com)
- Access to the new INMO Rewards Scheme supported by Cornmarket where any new INMO member can get a discount of €70 on their car insurance, €120 on their home insurance and nine months FREE income protection worth over €500.

Dean Flanagan is stepping down as INMO student and new graduate officer to take up a new role as INMO industrial relations officer in the Midlands Region (see page 25)

Bacterial meningitis

In the latest clinical update in this continuing professional development series, Navreet Paul, Charlotte Bowe and Gerry Morrow examine bacterial meningitis

MENINGITIS is a rare but serious infection of the brain and spinal cord membranes (meninges),^{1,2} which, if left untreated, can be fatal in up to 50% of cases.³ Meningitis can be caused by infective pathogens such as viruses, fungi or bacteria, or by non-infective means such as certain cancers, autoimmune disorders and injury.

Several different types of bacteria can cause meningitis, though the most common causes are *Streptococcus pneumoniae*, *Haemophilus influenzae type b* (Hib), and *Neisseria meningitidis*.^{1,2} Infections caused by *N. meningitidis* are known as meningococcal disease, and infections from *S. pneumoniae* are referred to as pneumococcal disease.

While meningitis is rare, Ireland has the highest prevalence of meningococcal disease in Europe.⁴ On average there are 200 cases of meningitis in Ireland each year.⁴ About half of all cases occur in children aged under five years of age⁴, with approximately one in 12 cases in children and one in five cases in adults resulting in death.² The epidemiology of bacterial meningitis has changed considerably over the past two decades due to the introduction of widespread vaccination programmes. The Hib vaccine has reduced cases by more than 99%.² This decline is most obvious in the youngest (children aged two years and younger have reduced by 64%) and the oldest (those older than 65 years have reduced by 54%).²

Bacterial meningitis is transmitted person-to-person through droplets of respiratory or throat secretions from carriers.³ The virus does not survive for long outside of the body and is therefore generally only passed on to people through close or prolonged contact. The average incubation period is four days but can range anywhere between two and 10 days.³

Risk factors

The bacteria that cause meningitis are

common and are present in the upper respiratory tract.¹ It is estimated that 5-11% of adults and 25% of adolescents are carriers. That is that they have the bacteria in their throat or nose without any signs or symptoms of illness.⁵ It is only when the bacteria are acquired by a susceptible person that this causes invasive disease.¹

It is not fully understood why some people are more vulnerable to developing meningitis. Key risk factors however include age (those younger than five or older than 65 years of age), non-immunised infants, people who have no spleen (increases the risk of overwhelming bacterial infection), people with reduced immune system function or underlying medical conditions (such as sickle cell disease).²

Environmental effects can also have an influence on the development of meningitis. These factors include the particular season (meningitis is more common in the winter months), lower socio-economic status, exposure to pathogens (such as having a close contact who has meningitis), smoking, and living in 'closed' or 'semi-closed' communities such as university halls or military barracks.⁵

Complications

Acute bacterial meningitis is one of the top 10 causes of infection-related death worldwide. For those who survive 30-50% experience permanent neurological damage ranging from minor coordination and movement problems, to epilepsy, paralysis and severe mental impairment.⁴ Although overall mortality has fallen in recent years, the rate of complications have not.

The most common complications are: hearing loss (33.6%), seizures (12.6%), motor deficit (11.6%), cognitive impairment (9.1%), hydrocephalus (7.1%) and visual disturbance (6.3%).

In the most severe cases, meningitis can

result in brain damage through injured or destroyed nerve cells; the nerve cells become damaged from poisons produced by the bacteria, the increased pressure on the brain and reduced blood supply.⁴ If septicaemia develops, blood clots can develop, which restricts oxygen to tissues, resulting in necrosis. This can lead to widespread scarring and even the need for limb amputation.

During the first few days of treatment it is often possible to determine whether there will be any permanent damage, and in most cases any serious problems become apparent while the patient is still in hospital.⁴

Prevention

Currently, there are three main types of vaccinations freely available to the public to prevent meningococcal disease.³ These are:

- Polysaccharide vaccines, which cover combinations of A, C, Y and W forms
- Meningococcal conjugate vaccines, which protect against group C
- The most recently developed Bexsero vaccine, which protects against capsular group B3.

There is also a vaccination available to protect against pneumococcal disease called PCV (pneumococcal conjugate vaccine), which can target up to 13 of the most prevalent serotypes.⁶ Vaccination against meningitis is provided with the routine childhood immunisation programme. For further information see: www.hse.ie/eng/health/immunisation/hcpinfo/guidelines/immunisationguidelines.html

Adverse reactions

Adverse reactions following immunisation are common. Pain, tenderness, swelling or redness at the injection site are common in all age groups. Crying, irritability, drowsiness, impaired sleep, diarrhoea and vomiting are commonly seen in infants and toddlers, and muscle pains (myalgia),

headaches and drowsiness are frequently seen in older children and adults. Neurological reactions such as dizziness, febrile seizures, faints and numbness following MenC conjugate vaccination are very rare.⁵

Diagnosis

Diagnosing meningitis can be difficult as it normally presents with common, non-specific features. The classic symptoms of meningitis are: a non-blanching rash, a stiff neck, unusual skin colour, shock and hypotension, slow capillary refill time (resulting in cold hands and feet) and back rigidity.

However those at the highest risk such as the very young, old and immunocompromised may not have these 'classic' symptoms and instead tend to present with so-called 'atypical' or non-specific symptoms. Common non-specific symptoms include: fever, nausea/vomiting, lethargy, irritability, ill appearance, headache, refusing food and drink, muscle aches and respiratory signs.

The very nature of these non-specific symptoms can make it difficult to rule out other possible viral infections such as enteroviruses. It is therefore imperative that a careful history should be taken including immunisation history. Clinical judgment should be used, taking into account parental or carer concern relating to the progression of the illness and overall severity.

Assessment

If bacterial meningitis is suspected, it is important to check and document the following vital signs: conscious level, heart rate and blood pressure, respiratory rate, temperature and capillary refill time. The person should also be closely monitored for any signs or features of shock such as unusual skin colour, tachycardia, hypotension, respiratory problems, leg pain, altered mental or toxic state, or poor urine output.

If a rash is present, it may appear as a scanty petechial rash (red or purple non-blanching macules smaller than 2mm in diameter) or a purpuric rash (spots larger than 2mm in diameter). The rash is most typically associated with meningococcal meningitis, and is noted in 80-90% of patients.²

The rash normally appears between four to 18 hours after the initial symptoms of illness, but the disease can be in the advanced stages before the rash starts to appear, and a rapidly evolving petechial or purpuric rash is a sign of very severe infection.

If meningitis is suspected, all cases should be urgently referred to secondary care as an emergency by dialling 999.¹

Management

For cases where a non-blanching rash is present, parental (IV) antibiotics should be given at the earliest opportunity, provided this does not delay referral.

In cases where a rash is not present, antibiotics should not be given unless urgent referral is not possible; delaying antibiotic administration until the patient is in secondary care is recommended in less severe cases as the rate of progression of the disease is slower when compared to septicaemia.

For all cases, a lumbar puncture should be performed in secondary care to extract cerebrospinal fluid (CSF) unless this is contraindicated. CSF is used to confirm diagnosis and determine what bacteria are present, which will ensure that the appropriate antibiotic is used.^{1,3}

Although the initial diagnosis can be made following a clinical examination it is impossible to differentiate between viral and bacterial meningitis without a culture of CSF.

Once admitted, patients should be closely monitored for signs of deterioration as meningococcal disease can worsen rapidly, regardless of any initial assessment of severity.¹

While the risk to close contacts is low, and 97% of cases are isolated incidents,⁴ households of those who have developed the infection are at higher risk of developing the disease.

The risk is highest in the first seven days following onset, and can persist for at least four weeks.⁵ This risk of meningitis can be reduced by providing prophylactic treatments to those people identified as being at high risk.

These include people who have had prolonged contact with the original index case in a household or those who have been exposed to large particle droplets/secretions from the respiratory tract of the infected individual.

A seven day course of prophylactic antibiotics² should be provided to close contacts of the patient as soon as possible, ideally within 24 hours of diagnosis, and vaccinations arranged where necessary. The MenB vaccine however is not currently recommended as a prophylactic treatment for household contacts of an index case or for contacts in an educational setting.⁵

It is important to note that meningitis is a notifiable disease in Ireland, and all cases

should be reported to the director of public health/medical officer of health for the area of residence of the patient.⁷

Follow up

Individual care plans should be created for the patient before they leave hospital to coordinate rehabilitation when it is needed.⁴ Once discharged, all patients should be monitored closely and assessed for any signs of complications.¹ Children and young people who have had bacterial meningitis should be offered a review by a paediatrician, with their hearing tested either before or within four weeks of discharge.

This is especially important as it provides an assessment of their need for a cochlear implant, which if required, should be placed as soon as the child has recovered from the acute stage of the disease.² Other complications considered during this assessment should include cognitive impairment, seizures, motor problems, hydrocephalus, visual disturbances and renal failure.

Information and support should be provided to the person and family members from support groups and charities; some people may also find it helpful to talk with someone who has been through a similar situation. Support groups such as Meningitis Research Foundation (www.meningitis.org/ireland) and Act for Meningitis (<http://actformeningitis.ie/>) provide support services and helplines for those affected by the disease.

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

CPD Quiz

1. Meningitis can be caused by:

- A) Viruses
- B) Fungi
- C) Bacteria
- D) Poor hygiene

2. Risk factors for bacterial meningitis include:

- A) Obesity
- B) Season of the year
- C) Immunosuppression
- D) Age over 65

3. Should parental antibiotics be given to a patient immediately who is suspected of having meningitis without a non-blanching rash (referral is possible)?

- A) Yes B) No

4. What complications can occur from the disease?

- A) Coordination problems
- B) Hearing loss
- C) Paralysis
- D) Seizures

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

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

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

Rep Training

Are you interested in representing the INMO?

Kilkenny (Newpark hotel)

- October 5/6 2016: Basic nurse rep training course

Galway (Connacht Hotel)

- October 18/19, 2016: Basic nurse rep training course

Cork (INMO Cork Office)

- October 26/27, 2016: Basic nurse rep training course

Dublin (INMO HQ)

- November 10/11, 2016: Advanced nurse rep training course



For all enquiries email: martina.dunne@inmo.ie



Helping women to feel whole again

Catherine Altman, a nurse specialist in micropigmentation, spoke to Ann Keating about her career to date and how she helps women who have had breast cancer

CATHERINE Altman is a nurse specialist in micropigmentation (medical tattooing) in St Vincent's Private Hospital, Dublin. She did her general nurse training in the Mater Hospital in 1978, after which she travelled for a few months to Australia. Catherine then did her midwifery training in the National Maternity Hospital, Holles Street, followed by a theatre course in the Mater.

She got married in 1984, had her first child in 1986 and took six years off work. She then returned to work part-time in theatre in St Vincent's Private and has worked in the hospital for almost 25 years.

Path to medical tattooing

Catherine then had the opportunity to work in the dressing clinic in Vincent's Private Hospital, where she worked closely with Dr Margaret O'Donnell, who did breast reconstructions. When a patient has a reconstruction following a mastectomy, they have a mound, which is the new breast. When that settles down the patient has to go back and have a nipple reconstruction, they then go on to have colour tattooed around the nipple, which completes the look.

When dealing with a patient who wanted the tattooing, Dr O'Donnell suggested that Catherine do it so she decided to give it a try. The hospital got trainers in from England to teach Catherine and she started up the practice in the private hospital.

Some six weeks after nipple reconstructions, patients come to Catherine for micropigmentation. After a brief general medical questionnaire, Catherine takes before and after photos and then does the tattoo. She uses a stencil and modifies it to match the other breast and then tattoos pigment into the skin to form a new nipple and areola. It takes about an hour to complete. Instead of the woman just having a mound, she now has a more realistic looking breast. Having the colour tattooed to

finish the reconstruction brings closure to her patients – it is the end of their journey and the start of a new one. It gives them back their dignity and makes them feel complete again.

Catherine has received great feedback from her patients and derives great satisfaction from her work in micropigmentation. One woman sent her the following message, which really says it all: "Thanks again for the tattoo work. I was telling a friend that I finally feel that I am done with it all and it's a terrific feeling after almost two and a half years of hell, setbacks and tears. You make a huge difference to women like me."

Some time later, a few patients asked if Catherine would do eyebrow tattooing for them post-chemo. In some cases while hair tends to grow back, eyebrows don't. So in 2012 Catherine did a course in England and has been doing eyebrow tattooing since then. She also works with patients with alopecia or whose eyebrows have fallen out following a major trauma such as a car crash. Patients wishing to get medical tattooing can self refer to Catherine.

Working life

Catherine works a one week on, one week off rotation. One week she spends in day surgery in Vincent's Private Hospital and the next week she does two days tattooing for the hospital. She carries out five tattoos a day and always has a full list. Catherine finds her job really interesting and is delighted to be a part of enabling women to get back to feeling themselves after going through cancer.

In order to do the tattoo, Catherine needs to get up close and personal with her patients so she gets to know them well and hears all about what is going on in their lives from traumas to celebrations. She finds that women are far less modest now than in years gone by. They go to the gym, go swimming and strip down in front



Catherine Altman gets a lot of satisfaction from her job, where she works with everyone from cancer survivors to alopecia patients

of others, and they feel whole again after cancer when they get the tattoo, which is the final piece of the puzzle.

Catherine is continuously expanding her knowledge of medical tattooing and has also done some work with scars. She puts a pigment into facial scars, which are a silver colour when they heal. It can be difficult to do but her patients have been happy with the results. She also does dry needling into raised scars to flatten them out.

Personal life

In her spare time Catherine does gardening, furniture restoration, plays tennis and likes hillwalking. She also loves cooking and shares recipes with her patients. She loves to spend time with her mum, who is 92 and lives on her own. Catherine and her husband have three children; a son in Dubai, a son in Vancouver and a daughter in San Francisco. They were very lucky to visit Vancouver and San Francisco during the summer.

She wants to keep learning how to do new things to help women feel whole again. Catherine can be contacted by email: caltman@svph.ie

Helping babies breathe in Sudan

A hospital-to-hospital partnership between Cork and Sudan aims to reduce neonatal deaths in Sudan by focusing on training village midwives in neonatal resuscitation techniques

AS THE deadline for the United Nations Millennium Development Goals passed in 2015, sub-Saharan Africa continues to have the highest rate of child mortality and did not reach its predefined targets by 2015.¹ In addition, this region has the highest rate of neonatal death and shows some of the least progress in this area. An increasing proportion of child deaths occur in the neonatal period, which is becoming a significant global health problem.

While the neonatal mortality rate in Sudan has declined from 38 per 1,000 live births in 1990 to 31 per 1,000 live births in 2011, the absolute number of neonatal deaths has actually risen from 32,000 to 35,000 in the same period, according to a UN report.³ Almost one in four of these (23%) can be attributed to complications arising from birth asphyxia, where the newborn infant fails to initiate or maintain regular breathing at birth. Interventions to address this could help reduce the significant loss of life at this early age.

A systematic review indicates that few babies need advanced resuscitation and simple low-cost interventions, such as training healthcare workers in neonatal resuscitation techniques, could reduce the neonatal mortality rate by up to 43%.⁴

There are almost 16,000 village midwives in rural Sudan serving a population of over 35 million people. Many of the midwives are lone practitioners in villages with limited community resources for home delivery. Education of midwives in Sudan can be challenging due to variations in training at the district midwifery schools, diploma schools and university nurse midwifery programmes. As almost 80% of births in Sudan occur outside medical facilities, usually in the home in isolated rural villages, a well-trained village midwife who attends most deliveries is key to

reducing neonatal death. While they have strong maternity skills, village midwives are not routinely trained in resuscitation and yet about 10% of babies require some resuscitation at birth. To address this, a unique hospital-to-hospital partnership has successfully changed its focus from the hospital to the community by implementing a sustainable national newborn resuscitation training programme called Helping Babies Breathe (HBB), directed specifically at village midwives in Sudan.

In 2002 an international partnership was established between Cork University Maternity Hospital and Omdurman Maternity Hospital in Sudan. Its primary objective was to develop educational and research programmes to improve mother and child care, and create a robust bilateral international healthcare partnership model.⁵ Implementation of the HBB programme was a recent initiative by this partnership to address neonatal mortality in Sudan.

Helping babies breathe programme

HBB is an evidence-based educational programme developed by the American Academy of Pediatrics (AAP). It is designed specifically to train village midwives and other healthcare workers who lack neonatal resuscitation skills, as the majority of babies in low resource settings are born in the community. It is a 'train the trainer' programme that incorporates a number of key life-saving skills, such as rapid assessment at birth, stimulation to breathe and assisted ventilation with a bag and mask, which are delivered within the first 'golden minute' after birth. Use of simple measures such as drying the baby, keeping them warm, clearing the airway and providing stimulation to breathe is effective in resuscitating the majority of newborns. Therefore, HBB focuses on simple, low-cost



interventions that village midwives can easily learn and put into practice to reduce neonatal mortality.

This HBB project was supported by grants from Irish Aid and the Irish Government's Programme for Overseas Development as well as from the Ministries of Health in Sudan. It received the approval of all relevant national governmental and professional bodies before being rolled out. It was undertaken in partnership with the Sudanese State and Federal Ministries of Health, the National Training Authority, the Continuous Professional Development Directorate and the Sudanese Paediatric and Neonatal Associations. This helped ensure HBB was aligned with strategic national goals for maternal/newborn services and through local ownership the programme could be tailored to the Sudanese context.⁶

An initial HBB 'train the trainer' course was run in both English and Arabic in Khartoum in January 2013. Sudan was the first country to have the HBB programme rolled out in Arabic. All HBB materials were translated into Arabic by the Sudanese partners, with permission from the AAP and funded through Irish Aid. A sample of 30 paediatricians, 12 senior midwives and 42 health visitors were recruited from the major maternity hospitals in Khartoum and each of the regional health centres across the 17 states in Sudan. These individuals were selected due to their extensive experience in labour and delivery, fluent English and Arabic, and senior roles within their respective communities of practice.

The HBB master and facilitator trainer courses were held over four days and delivered to 42 senior paediatricians and midwives, and 42 health visitors respectively. They were run by an international HBB team from Ireland, the US and Sudan with the aim of training enough regional trainers, who in turn could train others within their healthcare facility or local community.

HBB self-evaluation and assessment was administered after the training course. An MCQ with an 80% pass mark and post-training assessment of bag and mask skills, as well as two objective structured clinical examinations, were given. A training evaluation questionnaire was also distributed to all participants.

Results

The results of the English-based MCQ assessment showed an overall mean score of 98%; ranging from 71-100%, with two scores below 80%. Results of the Arabic

MCQ showed an overall average of 89%; ranging from 71-100%, with eight scores below 80%. This demonstrates participants gained key knowledge in relation to neonatal care and evidenced-based resuscitation practices. All candidates successfully passed the OSCE of bag-mask ventilation skills. Participant observation showed mastery of ventilation skills and the integration of these skills into case management scenarios in a simulated classroom setting. Participants reported a high satisfaction with the HBB programme, including the attainment of key neonatal resuscitation skills.

Extension of the HBB programme

On successful completion of the course, each participant was given a HBB training kit comprising a pictorial resuscitation algorithm chart, a learner workbook with guidelines on neonatal resuscitation, a bidirectional flipchart with training instructions, a neonatal simulation mannequin and equipment, including a reusable bag-mask ventilator, and a bulb suctioning device. This will enable the HBB 'train the trainer' programme to be implemented across rural Sudan. Since January 2013, we have provided over 1,000 bag and masks and 100 sets of training equipment to CPD centres for distribution. This has resulted in more than 1,200 village midwives being trained via the HBB registered provider course.

National implementation is being driven by local healthcare workers, regional HBB facilitators, national HBB master trainers and regional Ministry of Health staff. Several train-the-trainer courses have now taken place ensuring HBB facilitators have been trained across the 17 states. Trainers are now responsible for delivering the standardised educational programme in their localities with support from the master trainers and the central State Ministry of Health. This approach will continue until the target figure of 16,000 trained village midwives is reached. The rate limiting step is the cost of the equipment (bulb suction and bag-mask device) given to each midwife, which currently costs around €25 per set.

The HBB programme has also been incorporated into the midwifery training schools curriculum by the National Academy of Health Sciences. This will ensure the sustainability of neonatal resuscitation techniques in midwifery education so that every graduating village and hospital midwife in Sudan will have the key life-saving skills necessary to support newborns.

The HBB initiative has shown how a collaborative partnership based on collective action and local ownership can bring real improvements in health services delivery for newborn care. Important lessons have also been learned that are guiding the future direction of the partnership. There are a number of limiting factors that could prevent the HBB programme and neonatal resuscitation from becoming embedded in routine clinical practice in Sudan:

- Sudan's large land mass and often inhospitable terrain make the accessibility of any national training challenging
- The financial cost of purchasing additional essential training equipment, eg. neonatal mannequins, bulb suction and bag
- The sustainability of the programme will require regular upskilling of village midwives at provincial community centres
- A recent systematic review concluded that training in basic newborn care in the immediate neonatal period is a necessary adjunct to structured newborn resuscitation training courses to reduce early neonatal mortality in developing countries.⁷ Therefore, village midwives also need to be trained in new programmes such as the AAP's Essential Care for Every Baby, in addition to HBB, if significant improvements in neonatal mortality are to be achieved.

The priority in the medium term will be to provide resuscitation equipment for the remaining village midwives. A long-term exit strategy needs to include a means of either local production or more competitive pricing on the resuscitation equipment.

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Promoting excellence in children's nursing

Kathleen Fitzmaurice reports on the continuing education, training and professional development available at the CCNE



CHILDREN'S nursing exists within a rapidly changing healthcare setting where registered children's nurses and RGNs must deliver quality care that is appropriate, safe, effective and efficient, thereby enhancing the outcome for the child and family. The Centre of Children's Nurse Education (CCNE) offers continuing education, training and professional development for children's nurses, other registered nurses/midwives, support staff and health and social care staff, who provide and deliver healthcare services for children across Ireland.

Education programmes

The CCNE provides approximately 64 education programmes, which are primarily for nurses but are open to teachers, special needs assistants and social care workers where appropriate. Each of the evidenced based programmes is designed to meet the current needs of the target audience.

Programmes for nurses include gastrostomy, pain, intravenous cannulation, venepuncture and management of the acutely ill child with a cardiac condition (ward level). Programmes for teachers include tracheostomy and epilepsy, with a specific schools focus. All continuing professional education and training programmes related to nurse education provided by the CCNE have NMBI post registration category 1 approval or are accredited with a third-level institution. Certificates of attendance are presented on the day of training to all participants.

Established in 2006, the CCNE (hub) is located at Our Lady's Children's Hospital, Crumlin and works in partnership with two satellite centres located at Children's University Hospital, Temple Street and the National Children's Hospital, Tallaght.

Continuing education is a vital component of continuing professional

Philosophy of the CCNE

The CCNE acknowledges that every nurse is responsible for their own lifelong learning and in the identification of their individual learning needs. Each nurse has a unique learning style and the CCNE aims to provide an environment that encourages intellectual curiosity, creativity and self-direction for each nurse enhanced by active participation in learning and flexible teaching methods.

The CCNE values the wealth of knowledge and experience, both personal and professional, that nurses as adult learners bring to the education setting. It endeavours to promote collaborative learning with the educator, facilitating the sharing of knowledge and skills, thus advancing deeper learning and furthering the development of reflection, analysis, critical thinking, problem-solving and competence.

The CCNE believes that continuous evaluation of the effectiveness of programmes is an essential quality mechanism to ensure delivery of education and training programmes that will ultimately benefit both the child and their family.

development and consists of planned learning experiences that are designed to augment the knowledge, skills and attitudes of registered nurses.¹

Professional competence

In recent times, both the Nurses and Midwife Act 2011 and the Code of Professional Conduct and Ethics for Registered Nurses and Registered Midwives (2014) stated that a registered nurse/registered midwife shall maintain professional competence on an ongoing basis. Therefore, it is imperative that there is specific continuing education and training accessible to healthcare professionals who care for children and their families, both locally and nationally.

The CCNE is responsive to national and international developments which influence children's healthcare and nursing education and ensures that programmes are aligned with these developments. The CCNE also plays an active role in influencing and informing current and emerging developments in children's healthcare in Ireland, particularly the National Model of Care for Paediatrics and the forthcoming National Children's Hospital.

Further information

The CCNE works in collaboration with the Nursing and Midwifery Planning and Development Unit, the board of management of the CCNE, nurse practice development units, clinical nurse specialists, clinical nurse facilitators/educators, nursing staff and the multidisciplinary team in the planning and delivery of education programmes.

Further information on the CCNE including the 2016 prospectus is available on www.hse.ie/ccne/

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Reference
1. ABA 2000

CCNE values

- **Quality:** Commitment to delivering high-quality education which is evidence-based and quality assured
- **Respect:** Valuing our stakeholders, children families and each other
- **Reflexivity:** Reflecting on our experiences and applying the learning
- **Accessibility:** Ensuring our programmes are inclusive and accessible
- **Commitment to lifelong learning:** Belief in each individual's ability to learn and grow their commitment to continuous professional development
- **Leadership:** Nurturing a culture of competence, confidence and achievement
- **Accountability:** In our decisions, words and actions

Setting up a new service

Margaret Dobbin describes how the nurse-led haemochromatosis clinic came about at St Michael's Hospital, Dun Laoghaire

"I GENTLY pushed the needle into the bulging blue vein, and held my breath as I watched the flow of dark red blood down the plastic tubing and into the bag. I removed the tourniquet and let it flow. The bag was warm to touch and within a few minutes it was full. On removal of the large needle, I had completed my first venesection."

It was back in 2003 when I met my first haemochromatosis patient and had performed my first venesection. I was the manager in a busy day ward/endoscopy unit where we accepted all disciplines, including orthopaedics, urology and endoscopy, to name but a few. The last thing we needed was another service, but as professionals we all know it is hard to say no.

The service commenced in 2003 with one patient attending for treatment for phlebotomy (venesection) on a monthly/three-monthly basis. The procedure was performed at that time by a doctor. Given the time restrictions and depending on how busy the doctor was, the patient may have been waiting for an hour or more before the procedure was done. I decided to bring this service to a more efficient level and so began a haemochromatosis clinic.

Clinic inception

We had only one patient 'in treatment' for haemochromatosis for a long time. As it was such a different service to all others, with our patient returning on a frequent basis for venesections, it was necessary to develop an assessment tool to chart progress and continued care. I wrote a local policy on haemochromatosis/venesection with the help of my colleagues in practice development and our hospital policy committee. This was no easy task, as it takes time to review and agree, but eventually we got it right. Patient information was another necessity and after much research, this was also included in the mix.

Of course you cannot run a service, no matter how small, without the involvement of other departments in the hospital. Luckily for us we had everything on our doorstep. After many formal and informal meetings and discussions, we had gathered

all the necessary stakeholders to make the service work. This included the admissions office, laboratory, x-ray, dietitian, catering, portering services to ensure safe disposal of clinical waste, the medical records department and outpatients. It took a number of years to set it up as an independent unit but eventually all necessary services and documentation were in place. We had become a nurse-led service and I was very proud. The service continued to develop and the numbers increased greatly over a period of 12 years.

Unfortunately, it became difficult to manage the service on the ward with the increasing number of referrals for haemochromatosis, so an alternative plan was devised with the support of the director of nursing. I eventually relocated to an area within the hospital where I now run a standalone haemochromatosis clinic.

Clinic services

The existing clinic services North and South Dublin and Wicklow. It is the only clinic of its kind in this area. It offers patients a one-to-one service for treatment assessment/education and evaluation for their haemochromatosis. Initial assessment includes a full blood screen and an ultrasound of the abdomen and liver.

All patients are reviewed by the consultant at regular intervals or whenever necessary. I have two clinics a week from 7.30am to 3pm. There can be as many as 15 patients a day. My patients come from all walks of life and each has an individual treatment plan to suit their working and home lives. All patients who attend the clinic have either a blood test or a venesection.

While in treatment to achieve normal ferritin levels, they are referred for therapeutic phlebotomy. This is the process used to bring ferritin levels down to normal. A pint of blood can be taken weekly but more commonly fortnightly. It can take a few years to bring levels down sufficiently depending on the ferritin level the patient starts out with. They then attend on a

yearly basis to monitor changes. Once they reach their normal ferritin (iron) level they are then referred for maintenance phlebotomy. This is when the patient is monitored at regular intervals for their ferritin levels. This will be done throughout their lifetime.

I also have two outpatient clinics a year in attendance by a liver consultant, who reviews all patients and ascertains further or future needs of the patient.

The service provided is a wonderful professional and personal achievement. It was a long, frustrating and difficult journey, but to see the standards that have been achieved makes it so worthwhile. It is complemented by the wonderful ongoing support of St Michael's Hospital. I hope to expand the clinic in the near future to provide more care to more patients with haemochromatosis. I look forward to providing education to the public and also to medical and nursing staff.

Haemochromatosis

Haemochromatosis is an inherited (genetic) condition which causes the body to absorb too much iron from the diet. The excess iron gradually accumulates, usually in the liver, joints, pancreas, heart or the endocrine glands. Simple and effective treatment is available but if the excess iron is not removed, irreversible damage can eventually occur, especially to the liver. It is rare for iron to build up to a damaging level in childhood and it often does not happen for several decades.

The underlying cause is the inheritance of a mutated gene, which stops the iron control working properly. Haemochromatosis can only be inherited. It cannot be caught from anyone else nor can it be given to anyone else (except by having a child). It is also known as hereditary haemochromatosis (HH) or the HFE gene. It used to be called 'copper syndrome' due to the coppery tint of the skin of sufferers.

The good news is that treatment for haemochromatosis is simple and effective. Early diagnosis and treatment prevent complications.

Margaret Dobbin runs the haemochromatosis clinic at St Michael's Hospital, Dun Laoghaire

Saving valuable time for clinical staff

Melanie McDonnell and Melissa Corbally outline how a colour-coded system for stock is saving valuable staff time in Beaumont Hospital

VENEPUNCTURE and intravenous (IV) cannulation are among the most commonly practised skills in the clinical area. A lot of time can be wasted by nurses and doctors assembling the necessary equipment required to perform these procedures. Following a pilot study and project which assessed the problem of time wastage, the storage of equipment was standardised and a colour-coded system was implemented, with the result of saving valuable staff time.

Initial findings following implementation of a red zone (an area where all items for phlebotomy and cannulation were kept) found a significant improvement in the time spent by junior doctors collecting items for cannulation. Additionally, the number of steps that it took to gather the items for this procedure was also significantly reduced. Due to this success, a standardised colour-coded system for stock is being rolled out across Beaumont Hospital.

The problem of unnecessary time wastage in searching for equipment is something that resonates with every member of the healthcare team and has been well documented.^{1,2} Throughout hospitals, layouts of wards can vary and as a result, there can be huge variation on where particular items of equipment are stored.

Although some standardisation is evident across wards, anecdotal evidence suggests that junior doctors (NCHDs) and staff nurses new to wards struggle to find equipment. This wasted time was taking away from essential bedside care. Additionally, nurses reported that doctors regularly interrupted them during their work to ask for help in locating equipment and items for procedures. To improve the layout of wards and storage areas, a multidisciplinary working group was convened to develop a system that could be replicated throughout all wards and clinical areas.



Figure 1. The red zone, with clearly labelled drawers

Background

Beaumont Hospital, a large tertiary hospital, has engaged with the Productive Ward: Releasing Time to Care Initiative.³ One of the aims of this initiative is to increase time available to nurses and ward users for direct patient care by improving ward environments and processes to enhance safety, efficiency and cost-effectiveness. The productive ward programme is underpinned by lean methodology – an improvement technique originally developed by Toyota car manufacturers to simplify processes, improve flow and reduce waste.⁴

Training on the principles of the productive ward was undertaken by all members of the multidisciplinary team and enabled staff to examine present ward practices, with a view to releasing more staff time for care activities.

From this exploratory work, it was

decided to examine the problem of time wastage among staff searching for equipment and develop a more efficient standardised system to save time. The overall aim was to reduce the distance staff had to walk to obtain stock or equipment, thus saving time.

Baseline measurement

To determine the extent of the problem on the wards, 18 NCHDs were asked about how easy it was to find equipment and how organised they felt the wards were. The majority (84%, n = 15) said they could not easily find equipment, stating that they felt the wards were not organised. This information supported anecdotal evidence from junior doctors and nurses regarding the difficulties experienced in finding equipment.

To back up this evidence further, a process map⁴ of a junior doctor collecting the items required to insert an IV cannula, filming and timing the process was performed. The procedure took a total of one minute 50 seconds, with the doctor taking 25 steps and moving between two rooms, opening presses and pulling out drawers searching for equipment. The junior doctor had previously carried out this procedure on this ward. If this task was performed 10 times a day in an eight-hour shift this would equate to 15 minutes time wasted looking for equipment, and up to 45 minutes wasted (three times as much) if the junior doctor was on call at night or the weekend.

The activity of five registered nurses on five wards was also followed to observe and record the amount of time nurses spend on different ward activities, direct and indirect patient care, administrative tasks and being interrupted over a 12-hour shift. In relation to all interruptions recorded, 18% of such interruptions related to queries from staff regarding equipment. This process clearly identified that the problem of poor stock location was also wasting valuable nursing time.

Design

With the problem identified, engagement was sought from all users of the ward, including NCHDs, nurses and healthcare assistants (HCAs). A working group was then set up which included trained and experienced staff, NCHDs, clinical nurse managers, staff nurses and HCAs. The aim was to discuss further the problem of ward layouts and storage, and to come up with solutions. A decision was made to pursue standardised, easily identifiable storage through colour coding as evidenced through recent research findings.^{1,2} Staff consultation via social media (WhatsApp groups) with the initial study group of doctors, meant decisions regarding essential content of the phlebotomy and venepuncture equipment areas were made. This particular area was colour-coded the 'red zone'.

Project strategy

Having decided on a research informed system of usage, the colour-coded system was trialled in the initial ward studied.

A Plan-Do-Study-Act (PDSA) cycle series reflected a quality improvement project process. In cycle one, one cupboard was chosen with several drawers, rearranging the items so that every piece of equipment required for phlebotomy and cannulation was placed here. Red signage was made and all items were clearly labelled and identified. A large 'red zone' sign was also placed above the cupboard (see Figure 1).

All staff working in the unit were informed of the changes. Feedback sheets were placed beside the 'red zone' and improvements and comments were requested. The verbal and written feedback obtained was overwhelmingly positive, with most finding it very helpful. It was suggested that the trial be extended.

Cycle two of the PDSA involved extending the 'red zone' trial to two other ward areas. The zone was replicated exactly on each ward, including labelling and signage. The project manager consulted with the nursing staff on each of the wards, promoting the red zone and educating the doctors working on these wards. Once again, the feedback was very positive and reflected the current research evidence identifying good outcomes following colour coding and standardisation of stock.^{1,2}

Evaluation

It was only when the intervention was evaluated that it was discovered how much staff time was actually saved.

Following the rearrangement and setting



Figure 2 Colour coded system to identify colour zones for all clinical equipment

up of the red zone, the same doctor was again filmed and timed collecting items for insertion of a cannula. It took 41 seconds in total, translating to a time saving of one minute nine seconds per event. Considering if this procedure was replicated 10 times per shift (per doctor), as described above, over 11 minutes is potentially saved and in on call/night/weekend situations, potentially 34 minutes is saved per doctor.

The process mapping procedure in the new zone was also replicated and found that the number of steps taken to walk around the clinical room and gather the items was also reduced from 25 steps initially to six steps; a fourfold reduction in steps required to get the equipment.

Previously, the junior doctor had to walk between two rooms. The colour coding system has eliminated this need as doctors now just walk to the designated zone and find the items clearly identified and labelled in red signage.¹³

Of the 18 doctors who participated and completed an evaluation survey, 85% (11) stated that it is much easier to find equipment for venepuncture, with 91% (12) agreeing that the colour coding makes it easier to find essential clinical equipment.

Although a replication of the activity among the nursing groups was not undertaken, it is clear that the radical reduction in time wasted by doctors would translate to fewer interruptions of busy staff nurses, enabling them to get on with the essential practice of nursing.

Discussion

The pilot study and project has demonstrated that colour coding is a simple and effective means to save clinical staff time, making work more productive. It was so successful that following the piloting of the 'red zone', the working group met again and decided to expand the colour coding system to identify colour zones for all clinical equipment (see Figure 2). This colour coding system was approved by the director of nursing and has since been incorporated into all wards. It is hoped that this experience and evidence in leading change will

prompt other healthcare settings to consider adopting this useful initiative.

During the project, valuable lessons were learned. Firstly, the simplicity of the red zone was crucial to its success; staff related to the colour, as red signifies blood and it made sense to have items for blood in the red zone. Ensuring uniformity in design and using the same signage in each of the wards ensured that the work was deemed professional and looked visually pleasing to ward staff. These simple measures can lead to improved safety and efficiency on the wards.

Secondly, by engaging various members of the multidisciplinary teams and users of the wards, the group could think more creatively about what it hoped to achieve. It allowed for sharing of ideas so that the best solution for the wards came up. Those involved were proud of the concept and they were keen to promote it to their colleagues. Thirdly, having a facilitator/project leader was crucial in keeping the project going.

As with all projects, some challenges were experienced. Preliminary measures conducted lacked the rigour required to transfer findings to other settings. Secondly, redesigning the layout using lean methodology was time consuming and required a lot of effort to undertake. However, given the fervour with which the new system has been received, these efforts have been worthwhile as it frees up that most valuable resource – staff.

This project has illustrated that by standardising the storage and labelling of equipment into defined colour-coded zones, there is real potential for all healthcare settings to save our most valued asset (time) which can be used more productively in providing direct patient care.

Melanie McDonnell, directorate nurse manager/
productive ward project manager, Beaumont Hospital,
Dublin, Melissa Corbally, lecturer in nursing, Dublin City
University

Acknowledgments

Sheila McGuinness (chief nursing officer, RCSI Hospitals Group), Karen Greene (director of nursing, Beaumont Hospital), Susan Hawkshaw (nurse practice development co-ordinator, Beaumont Hospital) and all those involved in the Well Organised Ward working group

References

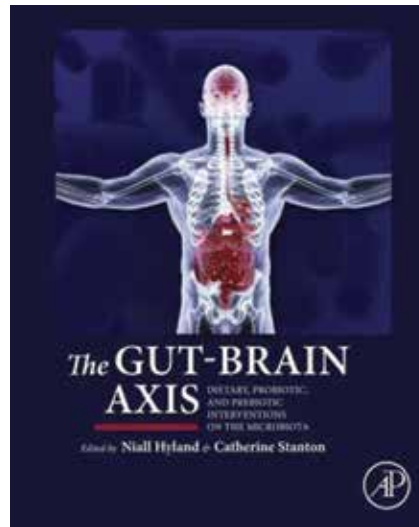
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Examining gut microbiota

The Gut Brain Axis, edited by Dr Niall Hyland and Prof Catherine Stanton of the APC Microbiome Institute at University College Cork and Teagasc, explores how diet, probiotics and prebiotics can help modulate the microbiome and how such interventions can impact the gut-brain axis.

The book, which was published in May of this year, also examines the potential for microbial manipulation as a therapeutic avenue in central nervous system disorders in which an altered microbiota has been implicated and explores the mechanisms by which the microbiota may contribute to such disorders. Other areas explored by the authors include the microbiome in aging and its impact on health and wellbeing, the influence of diet and the gut microbiota in schizophrenia and alcohol dependence, and the microbiota gut-brain axis.

The gut microbiota comprises trillions of bacteria with which we have evolved to co-exist. However, this relationship is not a static one and is susceptible to change by a variety of factors, including diet, age and where we live. Moreover, there appears to be a certain balance among the bacteria in our gut that confers particular health



benefits. The mechanism by which this occurs is likely to involve nerves, hormones and the immune system.

Emerging evidence now suggests that our gut bacteria may influence our brain, and the way we behave. This is an exciting concept in both health and disease, and raises many thought-provoking questions, including could bacteria in your intestine actually affect how you feel and think? If this is indeed the case, then altering the bacteria in our gut, by consuming pre or probiotics, or

through changing our diets, may positively influence our general health.

However, the challenge lies in defining what it is we consider a healthy microbiome and then to discover ways in which we can successfully create an ideal balance of gut bacteria, which, through careful characterisation, are most likely to positively influence brain function. This is dependent on the application of state-of-the-art technologies, in not only defining the microbiome, but also in identifying and characterising putative probiotic strains.

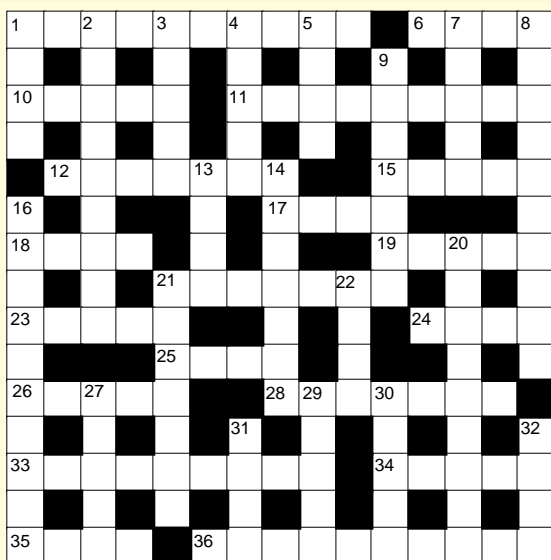
In *The Gut-Brain Axis*, the authors examine the application of such technological approaches in strain characterisation, as well as their bioactive metabolites, and the technologies required for their successful application as tools in the development of neuroactive functional foods and probiotics. Specifically, they also examine how the microbiota influences key host pathways most likely to affect brain function and behaviour, and discuss the possibility of positively altering the microbiota in the context of brain function and wellbeing.

The Gut-Brain Axis, edited by Dr Niall Hyland and Prof Catherine Stanton, published by Academic Press (first edition), RRP €136, ISBN 9780128023044

Crossword Competition



WIN A €30 BOOK TOKEN



Across

- 1. Sheer physical power may make one curt before moving (5,5)
- 6. Difficult (4)
- 10. Seat (5)
- 11. Ailment that could affect a nun if zeal is misplaced (9)
- 12. The front limb of a quadruped (7)
- 15. Poison (5)
- 17. Greek drink found in the bayou zone (4)
- 18. Pulmonary organ (4)
- 19. Birds' homes (5)
- 21. Extols (7)
- 23. Military group one cared for (5)
- 24. Island country of the South Pacific, capital Suva (4)
- 25. Hire (4)
- 26. Is it really high land, or is it just pretending? (5)
- 28. Lend a hand when the servants are unconscious? (4,3)
- 33. Tried (9) 34. Room, gap (5)
- 35. Dreadful, desperate (4)
- 36. Temperature regulator (10)

Down

- 1. Rear (4)
- 2. Under a don? That could make it plain (9)
- 3. Eagle's nest (5)
- 4. This is to sheep as feline is to cat (5)
- 5. The end of the sleeve (4)
- 7. Building added to a complex (5)
- 8 & 32d. Such an examination gets dictations edited! (10,4)
- 9. Character in the pantomime 'Cinderella' (7)
- 13. Shakespearean tragic king, perhaps real (4)
- 14. Giant slain by David (7)
- 16. Traditional educational surface that gets an old bra back around! (10)
- 20. With Linus, Matt prepared a pick-me-up (9)
- 21. The scent of a broken femur following PE (7)
- 22. Wicked (4)
- 27. Speak (5) 29. Breed of duck (5)
- 30. Such sauce has poets in a frenzy (5)
- 31. Skin irritation (4) 32. See 8 down

Solutions to September crossword:

- Across:**
 1. Memorandum 6. Song 10. Loses 11. Contusion 12. Mug shot 15. Liner 17. Oboe 18. Ludo 19. Rings 21. Drapery 23. Sidle 24. Writ 25. Rite 26. Dogma 28. Drought 33. Holy Grail 34. Hotel 35. Pays 36. Spider crab

- Down:**
 1. Mule 2. Misguided 3. Roses 4. Nacho 5. Urns 7. Onion 8. Generosity 9. Cutlery 13. Herr 14. Toppled 16. Closed shop 20. North Star 21. Derange 22. Reno 27. Gully 29. Riled 30. Usher 31. Wasp 32. Flab

The winner of the September crossword is:
Nessa Fitzgerald,
 Newcastle, Co Dublin

Name:
 Address:

The prize will go to the first all correct entry opened.
 Closing date: Friday, October 21, 2016
 Post your entry to: Crossword Competition, WIN, MedMedia Publications,
 17 Adelaide Street, Dun Laoghaire, Co Dublin

MONEY & MATTERS

Travel insurance: A practical guide

Ivan Ahern gives some tips on what to look out for when choosing travel cover

WITH the midterm break on the horizon, you may already be thinking about a weekend getaway or a break away to the sun. If so, remember having the right travel insurance will give you peace of mind in knowing that if something goes wrong, you're covered.

Finding the policy that is right for you

There are many benefits to travel insurance and these can vary depending on the policy type and the level of cover you wish to have. Below are some of the key benefits you should include in your cover:

- Cancelling your trip
- Medical and other expenses outside the Republic of Ireland
- Hospital benefit
- Cutting your trip short
- Missed departure
- Missed connection
- Travel delay
- Abandoning your trip
- Personal belongings and baggage
- Delayed baggage
- Personal money
- Passport and travel documents
- Personal accident
- Legal expenses.

What happens if you cancel your trip?

Cancellation cover provides cover for your flights and accommodation in the event that you are unable to travel for specific reasons. One such reason could be 'unforeseen emergencies' such as illness, injury or death of a travel companion or relative.

Common misconceptions are that travel insurance provides cover if you cancel your holiday due to business obligations, deciding not to travel or if your airline goes out of business. However, the terms and conditions on travel policies are different with each provider, so make sure you are satisfied with the level of cover offered and any exclusions that apply.

What type of cover should you choose?

Another consideration when choosing the correct travel policy is to decide on the



type of cover you need for the destination you are going to.

Travelling to Europe is covered under most travel insurance policies. If you have decided to travel further afield, you can avail of worldwide travel insurance cover.

Many people do not realise that if you take your holidays at home in Ireland, your travel insurance policy will also cover you while you are holidaying here.

Getting the best price

The level of cover, how many trips you need to take and where you are travelling to will determine the premium of your travel insurance policy.

Single trip will always be the cheapest as it covers just the one trip. An annual multi-trip policy is ideal if you plan to be away more than once in the year. If you have health insurance with medical expenses cover abroad, you may get a discount on

your travel insurance premium. Make sure to check this when you are purchasing a policy.

Ivan Ahern is a director of Cornmarket Group Financial Services Ltd

Cornmarket is currently offering discounts on travel insurance when you buy a new policy online before October 31, 2016. There is 10% off single trip travel insurance when you enter code FGH73iJK and 20%* off annual multi-trip travel insurance when you enter code 20%OFFCM. Up to four children (under 18) are covered for free on a family policy*

**Offers are only available to Republic of Ireland residents taking out a new travel insurance policy through Cornmarket and underwritten by AIG Europe Ltd before October 31, 2016. Discount must be requested at quotation and cannot be issued retrospectively. AIG Europe Ltd is authorised by the Prudential Regulation Authority of the United Kingdom, and is regulated by the Central Bank of Ireland for conduct of business rules. Cornmarket Group Financial Services Ltd is regulated by the Central Bank of Ireland. Cornmarket is part of the Great-West Lifeco group of companies, one of the world's leading life assurance organisations*

Call for debate on end of life planning

MANY healthcare staff are not prepared or trained to help patients with a life-limiting illness plan for end of life, the Irish Hospice Foundation (IHF) has claimed in a new perspective paper on planning for end of life.

IHF chief executive Sharon Foley said: "The literature suggests that good advance care planning results in better care decisions, especially at end of life. However, while every healthcare provider caring for a person with a life-limiting illness should be able to engage in this process, the IHF experience tells us that many healthcare staff are not prepared and that there are many training gaps in communication skills and in these discussions." She said the most substantive debate is around the value of advance healthcare directives – a legally binding document where you write down what healthcare treatments you wouldn't like in the future.

The Oireachtas passed the Assisted Decision-Making (Capacity) Act 2015 in December last year. Under the provision

of this legislation, an adult can make a legally binding statement refusing any treatment including life-sustaining treatments, if they lose capacity sometime in the future and they are unable to make treatment decisions for themselves.

Ms Foley said: "It is clear from our own work with healthcare staff and the implications of the new legislation, that training of healthcare staff will be required if we are to enable staff support good end-of life healthcare planning for those who wish to make advance healthcare directives."

She added: "Our experience is that there is little 'system readiness' for the introduction and implementation of care planning and without attention to training it will be very slow to change."

The Irish College of General Practitioners Post Graduate Resource Centre director Dr Brendan O'Shea welcomed publication of the Irish Hospice Foundation paper. He said overall people are beginning to become more comfortable talking about and planning for end of life.

Dr O'Shea who is a lecturer at Trinity College Dublin acknowledged there is an "educational need" among healthcare professionals about end of life planning issues and the advance healthcare directives, but the situation is improving.

The IHF's new 56 page paper – *A Perspective on Advance Planning for end of life*, is presented to inform debate in Ireland on the issue.

As a leader of the debate on dying, death and bereavement in Ireland, the IHF feel it is important to prompt debate on relevant areas and provide balanced input into these discussions.

A copy of the perspective, is available at www.hospicefoundation.ie



Providing invaluable psychosocial support for cancer survivors

MINISTER for Health, Simon Harris TD, recently met with people affected by cancer and their families to hear about their health service experiences and to see first-hand the benefits of psychosocial supports.

The minister visited the ARC Cancer Support Centre on Eccles Street, opposite the Mater Hospital in Dublin, where he met with cancer survivors, as well as volunteers and staff. The drop-in centre is one of two in Dublin.

Minister Harris spoke of the importance of supports for cancer patients following their treatment: "We have made great strides in the development of cancer services in recent years and there are now more than 150,000 cancer survivors in Ireland. This is largely due to early detection and effective cancer treatment. Centres such as ARC are so important. The services ARC provide have helped so many people to successfully deal with the physical and psychological side-effects of a cancer diagnosis."



Pictured (l-r): ARC client Niamh O'Donoghue, Navan Road, Dublin; Minister Simon Harris TD; Deirdre Grant, CEO, ARC Cancer Support Centres; and ARC client Vonie Macken, Slane, Co Meath.

Deirdre Grant, CEO, ARC Cancer Support Services, took the opportunity to thank the minister for the strong focus on psychosocial support and survivorship evident during the drawing up of a National Cancer Strategy 2016-2025.

"We know that between 20 and 30% of people who receive a cancer diagnosis are likely to develop some form of psychological disorder. Research tells us that when people receive psychosocial support at the right time and in the right place, their quality of life

improves, which can also positively impact their families," said Ms Grant.

Martin Sweeney, from Dublin who was diagnosed with prostate cancer, spoke at the event about how ARC Cancer Support Centres provided a real lifeline to him and to his family: "The services provided by ARC have been invaluable for me in dealing with my cancer diagnosis, treatment and ongoing recovery. No words can adequately describe the importance of the support I have received since the first day I walked through the door."

Sligo citizens honoured for reaching highest office in their roles

IN A speech made in Sligo in July, INMO president, Martina Harkin-Kelly, congratulated Pat Fallon, president of the Trade Union Impact, on his achievement of holding the highest office in the organisation.

Sligo now boasts the accolade that five of its citizens hold the highest office in their respective organisations, including Pat Fallon and Martina Harkin-Kelly. Among the other citizens are:

- Ann McGee, a native of Leitrim, who has worked in social welfare in Sligo all her life and is president of the Civil and Public Services Union
- Sligo-born Martin O'Sullivan, president of the Irish Rugby Football Union
- Kieran Christie, a teacher at St Ann's Community School, Tubbercurry, who was appointed as ASTI general secretary.

Speaking at the event to honour

Mr Fallon, Ms Harkin-Kelly said: "I am delighted to share in this event with Pat. Pat, like myself, is a HSE employee and has worked his way up through the ranks of the union."

Clarification

The report on Margaret Burke's retirement in last month's WIN (page 70) contained a misprinted location. The event took place in University Hospital Galway.

Diabetes roadshow

DIABETES Ireland, in partnership with MSD, has launched a national diabetes roadshow, with a series of diabetes awareness days in selected pharmacies. Taking place in 20 locations nationwide, the awareness days are open to all adults, especially if they have diabetes or a family member with diabetes.

The screening is very simple and takes only a few minutes so adults are encouraged to visit the Diabetes Ireland team at selected pharmacies and get their free risk assessment and screening for type 2 diabetes.

ALCI hold annual all-Ireland conference

THE Association of Lactation Consultants in Ireland held this year's Annual All-Ireland Conference from September 30 to October 1 to coincide with National Breastfeeding Week.

Catherine Watson Genna, an international board certified lactation consultant in New York City, was keynote speaker at the conference this year. Ms Watson Genna is an international speaker and published author with titles including *Selecting and Using Breastfeeding Tools* and *Sucking Skills in Breastfeeding Infants*.

Dietitians, speech and language therapists and national breastfeeding co-ordinator Siobhan Hourigan were among other speakers at the conference.

Ms Watson Genna facilitated a practical workshop on positioning and attachment, while Caoimhe Whelan discussed becoming an international board certified lactation consultant from a non-medical background.

As part of the conference, three annual scholarships were awarded to help first-time international board certified lactation consultant candidates.

Inactive registrants urged to come back

ALMOST 14,000 nurses classified as 'inactive' are being encouraged to return to the nursing workforce. The Nursing and Midwifery Board of Ireland (NMBI), in conjunction with Nursing Homes Ireland (NHI), is writing to 13,774 nurses who are categorised as 'inactive' on the NMBI register.

"The quality of patient care across our health system is hugely dependent on an adequate workforce of nurses. The aim of this initiative is to encourage some of the many thousands of nurses whose names are on the inactive file of the register to consider reactivating their registration and returning to practice in Ireland," said Mary Griffin, NMBI CEO.

"Currently there are significant employment opportunities throughout the country, both on a full-time and part-time basis, that offer nursing staff the prospect of advancing their education further and developing new skills. We urge nurses currently out of practice to consider returning and bringing their specialist

skills to bear within communities and care facilities in need of nursing care and expertise."

Tadhg Daly, NHI CEO, said: "Nursing homes in our local communities offer great opportunities for inactive nurses to return to practice by offering them fulfilling roles that bring immense satisfaction. Their background and experience can bring enormous benefits and support to the dedicated home-from-home health-care settings in our communities that are nursing homes."

A bursary to the value of €1,500 is available to nurses wishing to complete HSE return to nursing practice courses. The inactive nurses are being informed about this bursary, how they can reactivate their registration and about current career opportunities in the nursing home sector (see www.careersinnursinghomes.ie)

Nurses' testimonials

Marie Colgan, bed manager at Orwell Healthcare, Dublin, stopped working due to family commitments and in 2016

returned to nursing after 21 years out of the profession.

Before her career break, Marie worked in psychiatric nursing in St Vincent's Hospital and as a staff nurse in North Infirmary Hospital, Co Cork.

After taking up the role of bed manager at Orwell Healthcare, Rathgar, Marie said: "Understandably I was apprehensive to begin with but this apprehension is slowly subsiding as I gain more experience within my new role and learn the systems within Orwell Healthcare. It brings a good feeling to be getting on top of aspects of the job and is very reassuring after being away from the workplace for such a long amount of time."

She said she would recommend a nursing home environment to any inactive nurse considering a return to practice "It is a less stressful environment to re-enter nursing after being inactive due to the mix of relatively healthy residents and therefore a good place to re-familiarise with technology and nursing practices."

Raising awareness on neonatal herpes

BEREAVED couple John and Louise Wills, have called for increased awareness and policy changes after their daughter Éibhlin died, aged just 12 days old, from the herpes simplex virus 1 (HSV01), more commonly known as the common cold sore virus.

Since Éibhlin's death, the couple have been working to create greater public and professional awareness and education on neonatal herpes, where, in Ireland, it is not currently a notifiable disease and acquiring accurate statistics on the virus in babies is difficult.

They aim to encourage maternity hospitals to include a specific infection protocol that applies to any staff member with active herpes simplex virus working with newborn babies and to ensure infection control sections of maternity hospital websites provide relevant information for patients and visitors.

John and Louise Wills have created a website in their daughter's memory, www.rememberingeibhlin.org



Pictured (l-r) as Tallaght Hospital marked World Sepsis Day on September 13 were: Karn Cliffe, assistant director of nursing sepsis Dublin Midlands Hospital Group; Anne-Marie Barnes, emergency response services co-ordinator, Tallaght Hospital; Dr Catherine Wall, lead clinical director, Tallaght Hospital; Shauna Ennis, nurse practice development co-ordinator (adult services); Siobhan O'Connor, nurse practice development co-ordinator (children's services); and Christina Lydon, nurse practice development advisor. Tallaght Hospital marked World Sepsis Day as part of Sepsis Awareness Month, during which specific efforts are made to educate the public about sepsis, how it affects the body and how to recognise the symptoms so that it can be treated quickly

Pausing to reflect on life and death

THE 'Pause', a new practice idea in which physicians and care teams pause for a moment to reflect following the death of a patient on their table, is being implemented in hospitals in the US and across the world.

The medical 'Pause' is a practice which offers closure to both the medical team and the patient. It is a means of marking the importance of the moment of death. Through silence, this shared event is honoured by a multicultural medical staff. Silence allows individuals to personalise their practice while not imposing onto others.

The idea of the 'Pause' came from

trauma nurse, Jonathan Bartel, following efforts to save the life of a young woman who had been struck by a car. Despite the best efforts of Mr Bartel and the care team, the woman died.

Normally following the death of a patient, the physicians and care team would take their gloves off and walk away from the room but on this particular day, Mr Bartel requested that everyone in the room take a moment to stand in silence as a team and both honour the patient and the efforts they had put into her care. By doing this, Mr Bartel acknowledged that the care team had made their loss different.

October

Saturday 8

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

Saturday 8

ODN Section meeting. 11.30am. Midland Regional Hospital, Portlaoise. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Saturday 8

CRGN Section meeting. 11am. INMO HQ. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Thursday 13

All Ireland Annual Midwifery conference. Crowne Plaza Hotel, Dublin. Contact linda.doyle@inmo.ie or Tel: 01 6640641 for further details

Saturday 15

Third Level Student Health Nurses Section meeting. INMO HQ. 10am – 3.30pm. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Wednesday 19

Directors of Nursing/Midwifery/Public Health Nursing Section seminar. INMO HQ. See page 6 Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

November

Thursday 3

ADON Section meeting. INMO HQ. 11am. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Friday 4

Nurse Midwife Education Section meeting. INMO HQ. 11.30am. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Wednesday 9

Research Nurses Section meeting. Venue to be confirmed. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Tuesday 15

National Childrens' Nurses Section meeting. INMO HQ. 11am. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Tuesday 22

RNID Section Conference. Crowne Plaza Hotel Santry, Dublin. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

December

Tuesday 6

Care of the Older Person AGM. INMO HQ. 11am. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

January

Wednesday 18

Telephone Triage Section AGM. INMO HQ. 11am. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Saturday 21

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

Reunion

- ❖ A class reunion for nurses who trained at the Limerick University Hospital from February 1976 to May 1979, will take place on Saturday, October 15, 2016 at Bunratty Castle Hotel. Overnight stay with dinner. Contact Eilish Fitzgerald (née O'Doherty) at Tel: 086 8423301 or email: ellenfitzgerald@hotmail.com

INMO Professional Development Centre Library Opening Hours

October
Monday-Thursday: 8.30am-5pm
Friday: 8.30am-4.30pm

For further information on the library and its services, please contact:
Tel: 01-6640-625/614
Fax: 01-01 661 0466
Email: library@inmo.ie

INMO Membership Fees 2016

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

Conferences and training programmes

- ❖ A special one-day conference on maternal morbidities will take place on Tuesday, November 8, 2016. The conference theme is 'Minding Mothers with Morbidities'. For more information see www.trinityhirc.com
- ❖ One-day ear irrigation training programmes with Category 1 NMBI approval and four CEUs will be held on November 17, 2016 in the Education and Conference Centre, Royal Victoria Eye and Ear Hospital, Adelaide Road, Dublin 2. For further details contact Sabrina Kelly, nurse tutor at Tel: 01 6644652 or email: sabrina.kelly@rveeh.ie
- ❖ The 32nd Annual ENT Nursing Conference will take place on Saturday, October 22, 2016 at the Education and Conference Centre, Royal Victoria Eye and Ear Hospital, Adelaide Road, Dublin 2. Category 1 approval by NMBI pending. 4 continuing education units. For further details or to book a place contact Sabrina Kelly, nurse tutor, at Tel: 01 6644652 or email: sabrina.kelly@rveeh.ie

www.nurse2nurse.ie