€5.75 Vol 30 No 8 October 2022

WIN

Journal of the
Irish Nurses and
Midwives Organisation

World of Irish Nursing & Midwifery

Latest INMO CPD education programme
See page 25

Winter chaos looms
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More college places essential
page 9

Focus on advanced practice
page 17

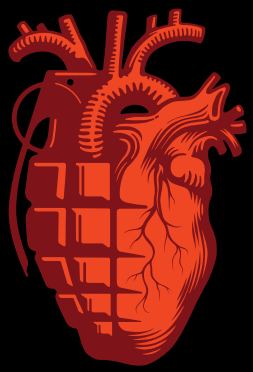
Negative health effects of ageism
page 44

Union people

Key union links between you and your employer

ATTR-CM
SUSPECT & DETECT
UNCOVER THE CLUES FOR DIAGNOSIS

SUSPECT ATTR-CM
(TRANSTHYRETIN AMYLOID CARDIOMYOPATHY)



A LIFE-THREATENING DISEASE THAT CAN GO UNDETECTED

Life-threatening, underrecognized, and underdiagnosed, ATTR-CM is a rare condition found in mostly older patients in which misfolded transthyretin proteins deposit in the heart.[1-7] It is vital to recognize the diagnostic clues so you can identify this disease.

CONSIDER THE FOLLOWING CLINICAL CLUES, ESPECIALLY IN COMBINATION, TO RAISE SUSPICION FOR ATTR-CM AND THE NEED FOR FURTHER TESTING

HFpEF — heart failure with preserved ejection fraction in patients typically over 60 years old[5-7]

INTOLERANCE — to standard heart failure therapies (ACEi, ARBs, and beta blockers)[8-10]

DISCORDANCE — between QRS voltage and left ventricular (LV) wall thickness[11-13]

DIAGNOSIS — of carpal tunnel syndrome or lumbar spinal stenosis[3,8,14-20]

ECHO — showing increased LV wall thickness[6,13,16,21,22]

NERVOUS SYSTEM — —autonomic nervous system dysfunction-including gastrointestinal complaints or unexplained weight loss[6,16,23,24]

LEARN HOW TO RECOGNIZE THE CLUES OF ATTR-CM AT:
SUSPECTANDDETECT.IE

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Date of Preparation: February 2021 GCMA code: PP-RDP-IRL-0105

Pfizer Rare Disease

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

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Staff Nurses/Midwives and Enhanced Nurses/Midwives

If you have at least 17 years' service you may qualify for the Senior Staff Nurse/Midwife Increment or the Senior Enhanced Nurse/Midwife Increment

- All staff nurses/midwives and enhanced nurses/midwives who have 17 years' post-qualification service are eligible for payment of either the senior staff nurse/midwife increment or the senior enhanced nurse/midwife increment. All service, inclusive of part-time/job sharing service, is reckonable
- Service constitutes all genuine nursing/midwifery experience in Ireland and abroad
- The reference date for determination of service and payment is November 1 each year
- Application forms can be obtained from your human resources department

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

(ISSN: 2009-4264)
Volume 30 Number 8
October 2022

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

medmedia publications

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

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Protecting our professional practice

IT IS surprising that the debates and concerns regarding the shortages of healthcare workers globally seem to take place devoid of bespoke recruitment and retention measures. Recruitment is one side of the coin; retention is the other. The turnover figures in nursing and midwifery are high not least because nurses and midwives are increasingly making the decision to take early retirement. The INMO recently received figures following a Freedom of Information request to the HSE that illustrates the average service for pension purposes of female nurses/midwives on retirement is 24 years. Male nurses fare better with an average service of 30 years.

Undoubtedly, conditions of employment contribute to any decision to take early retirement, with poor staffing levels being a significant factor. This is then aggravated for those remaining in the service. We know that correct staffing and skill mix assists with staff retention – areas with optimum staffing levels record higher levels of job satisfaction and lower levels of burnout. There are also better outcomes for patients as treatment is delivered on time.

The INMO pre-budget submission sets out the urgent measures needed to correct the difficulties in recruitment and retention. We issued this to government and opposition parties and commenced an information campaign on the key asks for nurses and midwives in Budget 2023 and beyond. By the time you read this, the budget will have been announced and we will continue to lobby politically for real investment in the nursing and midwifery workforce, for safer workplaces and for a specific division of the Health and Safety Authority focused on the health service as a workplace. The crisis emerging in maternity services is unlike any we have seen before as we see maternity wards closing due to a shortage of midwives and no plan B in place.

During October, the INMO will be contributing to debates and lobbying plans at a European level; we have contributed to the position paper that will be considered at the October General Assembly of the European Federation of Nurses Associations (EFN) which seeks to ensure the title and definition of nurses are protected across the European Union. There is an emerging concern across nursing organisations that the shortages will lead to attempts by governments and employers to dilute skill mix ratios and only look at tasks and not at the wider remit of clinical nursing judgment and decision-making.

The EFN draft paper will highlight the issues relating to: increasing concern across the global nursing community that the International Labour Organisation (ILO) definitions do not reflect the realities of nursing practice and the differences between nursing roles. This has resulted in countries reporting data about the composition of their nursing workforce which are not valid or reliable, having a negative impact on national workforce policy development and planning.

The aim of this work is to develop and contribute to a new definition: "that builds on the recent ILO report on the *General Survey on the International Standards related to Nursing Personnel,* stating in Chapter 2 on nursing personnel definitions that: it is important for patient safety as well as for the nursing profession to be able to distinguish between the role of registered nurses and the equally valuable but different role of healthcare assistants". The report by the committee of experts also helpfully identifies some of the critical factors to be considered, including the use of clinical judgment and concludes that the definitions of role and scope of practice of nursing need to reflect what is distinctly nursing.

It is important that all nurses and midwives are supported and protected when raising issues regarding patient care based on their clinical judgment. What we do is so necessary for better patient outcomes and our role in delivering expert and timely clinical care must be something we advocate for at ward, policy and strategic levels. Clinical autonomy and accountability are also about contributing as an equal in the multidisciplinary team approach to care planning (*see page 34 for more on this*).

Phil Ní Sheaghdha
General Secretary, INMO

Irish **Nurses** and **Midwives** Organisation
Working Together

Nurse and Midwife Representative Training 2023

Thank you 2022 has proved to be an extremely successful year for INMO Nurse and Midwife Representative Training and we would like to thank our members for making this possible. By the end of 2022 the INMO will have trained in excess of 100 new representatives.

The aim of this training course is to provide members in the workplace with the knowledge, skills and confidence to represent and support members in the workplace. The representative also acts as a liaison between the INMO members, INMO officials and INMO head office.

The course takes place over two days and there are agreements within the public health service for paid released time off to attend INMO rep training courses.

The INMO also provides an Advanced Representative Training Course. This training is at advanced level, the requirement for attending the advanced representative training is to have completed the basic representative training and have been an active INMO representative in the workplace for at least one year.

If you are interested in attending a representative training course in 2023, please make contact with your INMO official and they will issue you with an "Expression of Interest Form" to complete and return.

2023 DATES*		
February	**March**	**May**
7th & 8th Cork	1st & 2nd Dublin	24th & 25th Waterford
21st & 22nd Dublin	28th & 29th Galway	
27th & 28th Dublin (Advanced rep training course)		

June	**September**	**October**
13th & 14th Dublin	20th & 21st Dublin	3rd & 4th Cork
20th & 21st Midlands/Cavan	27th & 28th Sligo	12th & 13th Dublin
27th & 28th Limerick		

**Please note that the dates and locations are subject to change*

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A positive focus with the president

Karen McGowan, INMO president

Safe hands of the RNID

I WAS delighted to attend the RNID Section meeting in Galway. It was a wonderful gathering of professionals who strive for the very best for the clients in their care. We reaffirmed that the role of the RNID is instrumental from the cradle to the grave. The role of the RNID has come a long way and we must continue to apply pressure to see the necessary changes. It was an honour to attend and a lovely opportunity to meet the Section members in person and to meet our INMO-endorsed NMBI election candidate Mary Rose Loughnane. It is vital to have a strong voice in these important roles. When the meeting concluded I was shown around the Brothers of Charity campus and met some of the wonderful clients there. I left with a sense of pride, knowing that the work being done in this area is in safe hands.

Providing a service to your community

THIS month I spoke with James Geoghegan who is the operational lead of the integrated care programme for older persons (ICPOP)in east Galway. Mr Geoghegan who trained in University Hospital Galway has more than 19 years of nursing experience in various different roles. This new position gives his experience a greater opportunity to influence how the service evolves. Like many ICPOP teams, Mr Geoghegan's multidisciplinary team is busy recruiting as this initiative is in its infancy. While always having the patient at the centre of any decisions, multidisciplinary teams working in the community are the drivers of essential change in the delivery of patient centred care.

James Geoghegan, east Galway operational lead of the integrated care programme for older persons

The service is being rolled out nationally with the aim of developing pathways for older people with complex needs in the community. The service will be co-located with the ambulatory care hub alongside the chronic disease management teams. This interdisciplinary set up is a useful step that can save patients from having to go to the ED.

Mr Geoghegan told *WIN* that his nursing experience is pivotal in this role. "It is a fantastic opportunity to be involved in a project at the outset as we can give it the time to shape it to what the service needs to be. The interdisciplinary teams react quickly to a patient's needs from a GP or frailty at the front door referral. The service is in line with Sláintecare and the older people's care model, which prioritises care in the right place at the right time."

Avoiding admission to hospital is a huge benefit to this delivery of care by having these close connections with community teams and GPs. Not only is the focus on admission avoidance but also in fast tracking early discharge from acute hospitals, meaning patients are being cared for in the most appropriate place. With any new initiative there will always be challenges but Mr Geoghegan is resolute in his approach and is keeping the vision in mind.

"It's a wonderful feeling to be part of a team that is going to be providing a service for your community," he said.

Executive Council update

THE Executive Council met in person in September. There were online meetings in advance of this to discuss the new pay proposals as we felt it was necessary to consider them and make a collective decision promptly. One function of the Executive Council is to voice the concerns and ask the difficult questions on new pay deals. We discussed this at length and have made the recommendation to accept the proposals. The ballot for the new pay deal with information sessions is being rolled out online and in person. This was well underway at the time of going to print.

The INMO has endorsed three candidates for the forthcoming NMBI elections and the Executive Council wishes them all well in their endeavours. Mary Leahy is running for the PHN seat, Donna Hyland for the care of the older persons seat, and Mary Rose Loughnane for the RNID seat. The Executive Council is thankful to the candidates for putting themselves forward as it is imperative to have experienced voices in these seats. The results will be announced just after this issue of *WIN* has gone to print.

The problem of hospital overcrowding was discussed at length by members of the Executive Council. We raised these concerns at the ED Taskforce on September 19. The minister attended this meeting and we looked for immediate measures to alleviate the pressure on hospitals. We sought the immediate publication of the winter plan, which was yet to be published as we went to print. We also met with Dr Colm Henry of the HSE and pointed out some of the immediate steps the HSE must take to prevent an unmanageable situation arising in our hospitals this winter.

The European Federation of Nurses Associations will hold its general assembly in Slovenia this month. This is always an opportunity to raise issues and share knowledge at European level. This meeting will see the return of the first in-person delegation since the pandemic hit.

The next Executive Council meeting will be held October 17 and 18.

Get in touch

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

World news

Nurses and midwives in action around the world

Australia
- Nurses union calls for full-time hours to be slashed
- Patients out of patience: record numbers give up on NSW emergency departments
- Greens push for free nursing and midwifery degrees to combat staff shortages

Brazil
- Nurses signal strike against suspension of national nursing minimum salary

Canada
- Overwhelmed emergency department leaves seriously sick, injured patients waiting for care
- Canada's real problem is not job losses, it's the rush to retire

New Zealand
- Health Minister met with silent protest over nurses' pay equity agreement

Portugal
- Hospital nurses deliver a petition demanding a 35 hour week

UK
- MPs should have to walk in weary nurses' shoes
- 'Disappointment' over omission of nursing in new health secretary's priorities

US
- Pay, staffing and fatigue: Minnesota nurses strike highlights worsening shortages across US
- 15,000 nurses just walked out of work – one of the largest strikes in the sector's history
- Thousands of striking nurses return to work in Minnesota
- Court bounces another union try for permanent federal coronavirus protection

Current trolley figures a sign of winter chaos to come

THE INMO has called for meaningful and targeted interventions to prevent another predictable winter of out of control overcrowding and cancellations of elective procedures.

This comes as the number of patients without a bed in Irish hospitals was nearing 600 in the middle of September, including over 20 children under the age of 16.

INMO general secretary Phil Ní Sheaghdha said: "We are facing into yet another completely predictable winter crisis unless urgent action is taken.

"The number of children under the age of 16 on trolleys was steadily increasing throughout September.

As the Dáil returned from its summer break, the INMO said: "The political system must intervene in the now predictable overcrowding which faces our members and their patients this winter. The Minister for Health must publish a fully funded winter plan to coincide with the publication of Budget 2023. We cannot wait for this situation to get worse until we see meaningful and targeted interventions.

As we went to press the Emergency Department Taskforce was set to meet. "Practical solutions and measures that arise from this meeting must be implemented immediately in order to prevent this entirely predictable surge," said Ms Ní Sheaghdha.

"Over the coming months, we cannot see any obstruction when it comes to recruitment and retention measures. Nursing and midwifery vacancies need to be filled so that patients get the care they need.

"Unless action is taken now to stem the worst of overcrowding, we will be sleepwalking into another winter of crisis for our members and their patients."

New August overcrowding record

OVER 9,603 patients went without a hospital bed in Irish hospitals in the month of August according to the INMO's monthly Trolley Watch figures.

The top five most overcrowded hospitals were:
- University Hospital Galway, 1,166 patients
- University Hospital Limerick, 1,130 patients
- Cork University Hospital, 919 patients
- St Vincent's University Hospital, 754 patients
- Sligo University Hospital, 720 patients.

INMO general secretary Phil Ní Sheaghdha said: "For the third time this year, we have seen another monthly overcrowding record broken with 9,603 patients on trolleys through out the month of August.

"The consistently high levels of overcrowding we have seen this summer are sounding the alarm for a very bleak winter ahead unless immediate action is taken by the Minister for Health and the HSE in the form of a fully funded, winter plan. This plan should be published prior to the Emergency Taskforce reconvening on September. It is not good enough to publish a plan for winter when healthcare workers and patients are in the throes of a winter crisis.

"For the first time since September 2021, University Hospital Limerick is not the worst overcrowded hospital. This is due in part to the work of the expert team led by Dr Mike O'Connor by listening to what nursing ward managers, staff nurses and nursing managers have been constantly saying.

"Now this team is actioning into improving the operational processes in UHL which has seen significant results. This has been achieved by ramping up the discharge and internal/external patient flow processes through robust implementation by the review team.

"What has been implemented in University Hospital Limerick (UHL) in the past six weeks must be replicated in other hospitals with chronic overcrowding problems. It should not take this union and its members consistently shining a spotlight on problems with overcrowding for action to be taken."

Ms Ní Sheaghdha continued: "As we head into a winter of unknowns in our health service, the Minister for Health and senior HSE management must make it their business to take every step that they can to protect nurses, midwives and patients.

"We know that over 1,171 healthcare workers have contracted Covid-19 in the past four weeks. It is vital now that the booster and flu vaccines are provided to healthcare workers. The health and safety of our healthcare workforce and patients depends on it."

(Further details on UHL review process, page 12)

Measures to heighten patient safety must be core part of Budget 2023

ON WORLD Patient Safety Day (September 17), the INMO called for the immediate publication of a winter plan to protect patients and nurses, midwives and other healthcare workers. This call was particularly pertinent as it came at the end of a week that had seen over 2,698 patients, including 63 children, without a bed in Irish hospitals.

INMO general secretary Phil Ní Sheaghdha said: "On World Patient Safety Day we must take stock of the impact that chronic hospital overcrowding is having on those who are in our hospitals without a bed and our members who are often their first port of call when it comes to their treatment.

"Nurses and midwives are facing into yet another winter where they are left in impossible and often dangerous care environments. To this end, we are calling for the Minister for Health and the HSE to publish the 2022/2023 Winter Plan in tandem with a multi-annual budget allocation for the health service as part of Budget 2023.

"Budget 2023 must have a laser focus on the recruitment and retention of nurses and midwives. There must be an investment in maternity services to give women greater choice about childbirth and also to address the fact that maternity wards are closing due to a chronic shortage of midwives. There must be a change in mindset of how we configure maternity services that allows for more midwife led units.

"Sláintecare as it was intended must be a core plank of the upcoming health budget. Emphasis on care in the community can only lead to better outcomes for patients.

"As we head into a winter of known unknowns, action must be taken now to ensure that patients and nurses are not in unsafe environments."

INMO's key pre-budget calls

IN ITS pre-budget submission, the INMO called for urgent action to tackle the years of underfunding, understaffing and under-resourcing exposed by the Covid-19 pandemic. The union also called on the government to budget for:

- Full implementation of the Report of the Expert Review Body on Nursing & Midwifery
- For all nurse staffing to be legally underpinned by the Framework Model for Safe Nurse Staffing and Skill Mix – which must be implementation faster, with completion of phase 1 and phase 2 by year-end 2023
- Implementation of the recommendations of the Health Service Capacity Review, with bed occupancy reduced to 85%
- Sláintecare must be enshrined in legislation, with the government committing to multi-annual funding
- Zero tolerance for ED and hospital overcrowding
- Prioritisation of the physical and mental health of nurses and midwives, with funding for a health service division within the Health and Safety Authority to ensure protections for healthcare workers from increased workplace assaults, burnout and occupational infections.

INMO calls for additional publicly funded nursing and midwifery college places

RESPONDING to a government-commissioned report that states that the intake of nursing students will have to double in the higher education system in the next 20 years, the INMO has long called for additional publicly funded and provided college places.

This report, together with the recommendation to review the undergraduate nursing and midwifery programmes recommended by the Expert Review Group on Nursing and Midwifery, must be prioritised.

INMO general secretary Phil Ní Sheaghdha said: "The INMO has long warned that Ireland's health service will be under even more severe pressure unless the amount of undergraduate nursing places is increased and that Ireland will not be able to uphold its obligations under the WHO's Global Code of Practice on the International Recruitment of Health Personnel. The INMO has been flagging this as an issue to government and the HSE as far back as 2016.

"The government has ignored its obligation in this regard for some time. We must thank all those who have come from non-EU countries, their contributions have and continue to be significant in the delivery of healthcare in Ireland.

"We must now ensure that any additional places that are provided are publicly funded. It is not enough to just provide the college places, we must ensure that the Irish health service is an attractive and safe place to work on graduation. Unfortunately, this is not the case for the class of 2022.

"Alternative pathways to nursing and midwifery must be prioritised. Additional places must be reserved for those who complete pre-nursing courses in our colleges of further education.

"It is not enough to provide sufficient undergraduate places. Safe staffing levels must be provided for in teaching locations in order to allow for safe and appropriate learning.

"Ireland must continue to recruit staff from around the world, but also to train more ourselves. We train far fewer nurses and midwives than we need, but we know that thousands more want to join the professions.

"Over 4,363 students put a nursing or midwifery course as their first choice on their CAO this year. We provide 1,700 places. The demand is there for our profession but we must ensure that nursing and midwifery is an attractive career pathway for young people by fast-tracking recruitment and retention measures."

INMO director of industrial relations **Albert Murphy** updates members on

Ballot underway on cost-of-living package in public service pay deal

HAVING considered the proposals on public service pay which emerged from the Workplace Relations Commission last month in response to the cost of living crisis, the INMO Executive Council recommended acceptance of the package. Key points include a general round increase in annualised basic salaries for public servants of 3% on February 2, 2022, 2% on 1 March 2, 2023 and 1.5% or €750, whichever is greater, on October 1, 2023.

As we were going to print, the INMO was holding meetings of members throughout the country to provide information on the proposals and to give members the opportunity to ask questions on the package.

The union strongly urged all members to participate in the ballot on these pay proposals. Balloting will conclude on October 4 and the official count will take place on October 5, 2022.

In accordance with normal practice, the ICTU Public Services Committee will meet on October 7, 2022 to ascertain whether the package has been accepted.

All HCWs now invited for second boosters

FOLLOWING pressure from the INMO, the HSE has now invited healthcare workers in any age group to access a second Covid-19 booster by booking a slot at a vaccination centre (see **www.hse.ie/covid19vaccine**) or at a participating GP/pharmacy. Before attending for a second booster, at least four months must have elapsed since a Covid-19 infection or receiving the first booster.

Minister for Health Stephen Donnelly has now accepted new recommendations in relation to the use of adapted bivalent vaccines in the Covid-19 booster vaccination programme.

The recommendations were made by the National Immunisation Advisory Committee (NIAC) to the interim chief medical officer who has endorsed these recommendations.

Adapted bivalent Covid-19 vaccine boosters include components of the original virus strain and the Omicron variant.

Talks with HSE on PHN short staffing and assessment tools pressures

DUE to the current high number of vacant public health nurse (PHN) posts nationally (> 600), a number of directors of public health have taken the decision to prioritise work being carried out in their CHO areas.

As well as the considerable pressures on time due to ongoing need to cross-cover for vacant posts, PHNs are also being overwhelmed by extra work due to various assessment tools. Some such forms are paper based and very lengthy.

At a meeting with the HSE on these matters on September 9, 2022, the INMO outlined our members' serious concerns about pressures at work due to short staffing, resulting in excessive levels of cross cover, as well as the additional pressures caused by completing assessment tools.

The HSE stated it intends to set up an internal HSE committee comprising management from various parts of community operations, as well as two PHN representatives.

The September meeting was attended by INMO director of industrial relations Albert Murphy, director of professional services Tony Fitzpatrick and the officers of the PHN Section. Management was represented by Jackie Nix, assistant national director for community operations, Virginia Pye, and Yvonne Moore from the Office of the Nursing and Midwifery Services Director and Anne Lynnott, national director of public health nursing.

Further engagement between the INMO and the HSE is ongoing on this issue.

Pandemic recognition payment now given to some cohorts of workers

ACCORDING to the latest figures provided by the HSE over €120 million has been paid in respect of the pandemic recognition payment to people working in the HSE and associated employments.

Progress has not been as readily forthcoming in relation to other cohorts of workers, including agency nurses working in hospitals and other locations, members of the Defence Forces and other groups.

The Department of Health has indicated that it wishes to outsource dealing with this issue to a private provider and that this matter will need to be sent for tender for public procurement.

The Staff Panel group of unions expressed its dissatisfaction with this response from the Department of Health and sought engagement in order to ensure that prior to a list being drafted of the relevant employments that there is full engagement with the unions concerned.

In a letter to the Minister for Health Stephen Donnelly, the staff panel called for his intervention on this matter.

The INMO will update members as soon as further details on this process are received.

current national issues

Pay parity for pensioners a priority

INMO pursues delays in pension payments

THE INMO, in conjunction with ICTU, has negotiated a cost of living package for retired public servants. Unions are currently carrying out a ballot on these proposals – the outcome will be known on October 5, 2022.

In line with existing arrangements the ICTU Public Services Committee wrote to the Minister for Public Expenditure and Reform seeking that pensions be adjusted in order to maintain parity between the pay of serving staff and pensioners. The INMO expects that this arrangement will continue to apply and we will keep retired members informed on this matter.

Delayed 1% pension increase

As covered last month, the INMO has been pursuing payment of the 1% pension increase due from October 2021. It was confirmed to the unions that the outstanding pensioners – which remained at approximately 40% nationally in August – would be paid in September 2022 and would be backdated to October 2021.

Individual delays in pensions

Having been made aware of delays in commencing pension payments for a number of individuals, the INMO brought this to the attention of the Pensions Authority, which in turn engaged with the HSE on the matter. There is a statutory requirement under the Pensions Act that pensions are paid within three months of the date of application. Currently the situation in the HSE is that 70% of pensions are paid within three months of application. This means that the HSE is not complying with its statutory obligations in the case of 30% of applications.

HSE Pensions Management has put a number of reasons forward for this, saying it was primarily due to staff shortages and delays in the requirement for specialist training for staff on pensions. The HSE has stated that it aims to improve the situation with the appointment of staff. In addition, the HSE has indicated that it is working on streamlining the on-line tool in relation to the calculation of pensions. This will be available to staff for calculating their pension in the near future.

The INMO is meeting the head of pensions on a six-weekly basis and can confirm that all individual cases referred to the INMO have been expedited following representations from the union.

Any individual experiencing a delay in their pension payment should contact the INMO, with a brief summary of the issue, through: *Cora Duffy, Tel: 01 6640603 or Email: cora.duffy@inmo.ie*

Section 39 members take action for pay parity with public sector

AS WE went to press, staff at St Joseph's Foundation, Charleville were taking strike action on Wednesday, September 21, 2022. This follows a ballot of INMO members working in St Joseph's who voted overwhelmingly in favour of industrial action.

This action is part of the cross-union *Valuing Care, Valuing Community* campaign organised by the ICTU, which is seeking to have pay parity restored for Section 39 organisations across the country. Members of the INMO, Fórsa, SIPTU and all trade unions employed by St Joseph's were taking part in the dispute.

Members have been forced to take this action due to the fact that they have not had the terms of Building Momentum applied to the them and nor is there a mechanism for which their pay can be adjusted to keep pace with developments in the public sector.

Similar industrial action was taken in July by employees working in the Irish Wheelchair Association, which is also a Section 39 organisation. Further stoppages in other Section 39 employments were also due to commence as we went to press.

INMO assistant director of IR Colm Porter said: "The decision for any nurse to withdraw their labour is not one that our members here in St Joseph's Foundation take lightly. Members working in the community and voluntary sector have not had a pay increase in over a decade."

Expert review body – implementation of structures

THE first meeting of the body to oversee the implementation of structures recommended in the Expert Review Body on Nursing and Midwifery Report is due to take place on September 30, 2022. Correspondence outlining the implementational structures was received by INMO deputy general secretary Edward Mathews. The union has concerns about the representation outlined in this letter and intends to address these concerns.

Interventional radiology location allowance

PROGRESS has been made in relation to the question of location allowance being extended to interventional radiology, with Mater Misericordiae University Hospital, Tallaght University Hospital and St James's Hospital recently advising that they will apply the location allowance to those working in interventional radiology.

There has been significant progress on this matter and it is anticipated that we will shortly be able to request that interventional radiology will attract the location allowance in all workplaces from now on.

Patient flow finally improving in UHL

Performance Monitoring and Improvement Unit overseeing changes

SINCE the HSE Performance Monitoring and Improvement Unit (PMIU) was assigned to University Hospital Limerick in July, it has delivered initial improvements for patients and staff.

The PMIU is working on-site with hospital and CHO3 management to help it respond to pressures and develop a programme of work to assist on a day-to-day basis.

This followed repeated lobbying by the INMO of both the HSE and HIQA to address the challenges facing the hospital, spurred on by our members' view that improvements in patient flow were achievable separate from the need for more beds.

The work of the PMIU to date demonstrates that our members were correct in advocating for improvements in patient flow and seeking external supports to achieve this goal. The most tangible evidence of the PMIU's work to date is that the unsafe practice of placing admitted patients on trolleys on inpatient wards has ceased. Previous to this there were 25-27 patients a day being cared for on corridors and the cessation of this practice has had a significant impact on morale.

These results have been delivered through a ramping up of discharge and patient flow processes through robust implementation by the review team of the SAFER bundles. In addition senior decision-maker reviews are taking place, all patients having expected discharge dates and patient pathways are being streamed, with the involvement of the multidisciplinary team.

Increased use of the community intervention teams, outpatient parenteral antimicrobial therapy (OPAT) services and other community supports are credited with the success with regards to discharges.

While the emergency department at UHL remains overcrowded, the INMO understands that the review team will focus on this challenging environment next. Plans include the opening of a new 10-bed frailty unit for patients over 75 years of age, which will be under the governance of ED. Significant resources are being sought to manage this cohort of patients who are often admitted on a trolley and left in the ED for some time.

Scaling up the use of local injury units and medical assessment units and diagnostic capability is also proposed.

INMO members in UHL have welcomed the improvements seen to date and look forward to reductions in the number of patients on trolleys in the ED over the coming months through sustained service improvements.

– Mary Fogarty, INMO assistant director of IR

INMO information clinics keep members up to date

OVER the past three months the INMO has been running information clinics for members onsite in several workplaces across Kerry and Cork areas, including at Bon Secours Hospital, Tralee; University Hospital Kerry; and in local community nursing units.

These sessions, which were co-ordinated by local INMO representatives and facilitated by local management, offer drop-in clinics for members to meet their official and discuss any individual or collective queries or issues that arise.

Further information clinics will be provided across the area in the coming months. To arrange a clinic in your work location, contact the INMO Cork Office, inmocork@inmo.ie

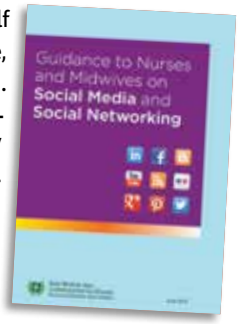
Fitness to practise

In addition, the INMO has run fitness to practise sessions at the Bon Secours Hospitals in Cork and Tralee over the past two months. These sessions provide important updates for members about the importance of documentation, what to do when you are asked to write a statement, receive a complaint etc.

Dangers of social media

Failure to follow the NMBI's guidance on social media usage can be problematic for nurses and midwives, and can lead to significant consequences from an NMBI perspective should an employer initiate disciplinary procedures arising out of comments made on social media.

Members should ensure they follow the 6 Ps outlined in the NMBI's guidance document: professional, positive, person-free/patient free, protect yourself, privacy, and pause before you post.



To update yourself with the guidance, see: **www.nmbi.ie/Standards-Guidance/More-Standards-Guidance/Social-Media-Social-Networking**

– Liam Conway, INMO IRO

Supporting Indian nurses in Cork

The INMO was delighted to be invited and to support the Cork Indian Nurses Association (COINNS) festival on August 20, 2022. We would like to thank the organisers and COINNS for their hospitality and support at this event and throughout the year.

The INMO provided an information stand on the day and the union continues to work with COINNS to support staff working in both the public and private sectors who have just arrived or continue to work in Ireland.

This partnership has grown throughout 2022 to the benefit of each nurse and midwife who has joined the INMO and avails of our services. We look forward to continuing our work with COINNS and Migrant Nurses Ireland within the region.

– Liam Conway, INMO IRO

Liam Conway addressing the COINNS festival and (inset) Liam Conway with Kathryn Courtney, INMO IRE, at the INMO information stand

Claim for location allowance as day unit now a 24/7 medical-surgical ward

THE INMO has referred a dispute to the Workplace Relations Commission in respect of the non-payment of a location allowance to members working in the former day unit in University Hospital Waterford, which was temporarily re-purposed as a medical-surgical ward last year.

The day surgical ward was originally established to cater for day surgical cases on a Monday-Sunday basis. However, last year management extended the opening hours of the unit to 24/7, and redeployed nursing staff from other medical-surgical wards and areas of the hospital to cover night duty in the unit. Redeployed staff who were already in receipt of the location allowance retained this allowance upon redeployment to the day surgical unit, and continue to do so.

The INMO sought payment of the location allowance to all members working in this unit, on the basis that the unit had been temporarily re-purposed to a medical-surgical ward to address surge capacity in the hospital, as part of an effort to alleviate overcrowding in the hospital's busy emergency department.

The INMO has pointed out to management that these members have been providing care to all patients in the unit since last year, whether they are day cases or patients admitted to the unit for 24/ 7 care.

However, management has repeatedly refused to extend the payment of the location allowance to nurses who have worked in this unit for many years when it was a day surgical unit, despite the fact that they now also care for medical and surgical patients who have been admitted to the unit for 24/7 care.

As this dispute could not be resolved at local level, the INMO has referred a dispute on the matter to the WRC for resolution, and a conciliation conference on the dispute is scheduled for November 1.

– Liz Curran, INMO IRO

Tallaght interventional radiology

THE INMO negotiated the location allowance for the interventional radiology department in Tallaght University Hospital recently.

This hospital is now a designated trauma centre and therefore complex cases will arise from this. In light of this, management has conceded the location allowance for this unit.

This follows negotiations for the location allowance in interventional radiology at two other Dublin locations *(see IR Update, page 11)*.

– Joe Hoolan, INMO IRO

For ongoing updates on industrial relations issues see **www.inmo.ie**

INMO secures settlement following termination

THE INMO engaged with a private nursing home employer regarding a notice of termination of employment issued to a member while on probation.

The termination was timed to occur prior to the completion of the probationary period of one year. In the notice to terminate, the employer referenced performance, competency and capability issues. However, our member advised that there had been no complaints about her work and no issues that may have required performance review. Furthermore, no issues about the member's work had been raised at her six-month probationary review assessment.

Under Irish employment legislation, employees on probation are entitled to natural justice and fundamentally fair procedures. The INMO secured a substantial settlement for this member and confirmation from the employer that fair procedures had not been adhered to.

– Grainne Walsh, INMO IRE

Low staffing levels addressed

THE INMO has secured agreement on safer staffing levels on night duty on two units in St Ita's Community Hospital, Newcastle West, Limerick.

Staff had been reporting this issue for over 12 months via risk assessment forms. Further to INMO representations and a recommendation from the Health Information and Quality Authority (HIQA), management has agreed to an additional staff nurse on night duty in one unit and an additional multi-task attendant (MTA) on night duty in the other unit.

It was agreed that the additional staff nurse would be added to the roster immediately and the additional MTA should be in place following an interview process in late October.

– Karen Liston, INMO IRE

New roster agreed in Meath Community Unit

Pictured at the ballot count in the Meath Community Unit on August 24 were (l-r): Manjula Ruwan A/CNM2, Jennifer Buela A/CNM2 and Mark O'Connor IRE

AFTER consulting with local reps and members working in the Meath Community Unit, Dublin, the INMO sought engagement with CHO7 management to negotiate a new roster to implement the Haddington Road Agreement (HRA) hours reduction.

The INMO negotiated a new roster that, through incorporating the HRA hours reduction, achieved a major improvement to our members work-life balance.

This new roster proposal was put to our members through ballot and was overwhelmingly accepted.

– Mark O'Connor, INMO IRE

Freda Hughes caught up with a number of INMO workplace reps to learn about the work they do on behalf of their colleagues and what inspired them to become actively involved with the union

Representing your workplace

WORKPLACE union representatives are the backbone of the INMO. These reps act as the link between members, the employer and the union itself. They organise, represent and negotiate on behalf of their colleagues and fellow INMO members in the workplace. They also play a vital role in recruiting new members and educating their peers on the importance of having a collective voice.

The INMO runs a training course that is tailored specifically to the needs of workplace reps. The aim of this course is to provide INMO reps in the workplace with the knowledge, skills and competencies required to represent and support members in the workplace and to act as a liaison between members, INMO officials and the employer.

The course arms reps with practical skills in relation to dealing with members' problems and how to represent them at local level with basic grievances. Workplace reps are supported by their union through their industrial relations officer (IRO) or industrial relations executive (IRE).

The course also provides reps with useful sources of information so that they can offer information to members on various issues, agreements, rights and entitlements.

Attending a recent INMO rep training course were (back row, l-r): Sasha Motzo, Helen Scully-Gilligan, Colin Redmond, Bobin Mundiyanikel (front row, l-r): Bukola Adeyemi, Elmira Somosierra, Sheena Saavedra and Rinci Philip

'It has made me more confident at work'

Bukola Adeyemi is a staff nurse in St Mary's Hospital in the Phoenix Park in Dublin. She joined the INMO to find out more about her rights and entitlements when she moved to Ireland to work as a nurse. She soon experienced the benefits of being a member of a union representing nurses and midwives exclusively and later decided she wanted to become a workplace rep. Ms Adeyemi liaised with a senior rep in her workplace to find out how to achieve this and through consultation with the rep and her IRE, Karen McCann, she found out about the INMO's rep training course and was eager to take part.

Ms Adeyemi told *WIN*: "Learning how to engage in negotiation and bargaining was the highlight of the training for me.

It taught me how to protect and promote the interests of INMO members and how to create a fair and equal workplace. I was able to put these skills into practice when I returned to work. It was also a great opportunity to meet other nurses and share our experiences. We also learned how to write statements. The training is really relevant to my needs and was delivered to a high standard."

Ms Adeyemi said engaging with her union helped her to maximise her entitlements when she realised she could apply for the enhanced practice salary scale, and she was able to inform her colleagues who were also eligible for the scale. Her skills as a rep have been called upon in dealing with challenging workplace changes. At that time she was able to escalate their concerns to her IRE who negotiated on their behalf to resolve the matter.

"Information is power. I became much more confident after the rep training course. I was able to tell people about all the benefits of joining the INMO. The information really gave me the boost and motivation I needed to go out and tell more nurses that if you're not in a union, you're missing out and you need to join the INMO. As an international nurse I also know I have support I can rely on. It has made me more confident at work. I know I am not on my own," Ms Adeyemi said.

'The tools for negotiating are invaluable'

Helen Scully-Gilligan is an operating theatre nurse in neurosurgery at Beaumont Hospital. She has worked at Beaumont since 1990 and has been workplace rep for her department there for a number of years. She felt that a specialised area like theirs needed representation, so when the previous rep moved on she took up the role. She told *WIN* that there was an ongoing need for more reps in a hospital of that size and that people should not be afraid of taking up the role as it makes a positive contribution to the workplace and colleagues.

Ms Scully-Gilligan and the other reps at the hospital have a WhatsApp group that also includes their INMO IRO Maurice Sheehan. They use this group to keep in contact and support each other, and they try to meet once every six weeks with the new director of nursing. They also have an education session once a week and encourage people to join the union at these meet-ups. The reps try to attend all staff meetings to make sure no changes are being pushed through without consultation with staff.

INMO IRO Maurice Sheehan addressing participants at a recent rep training course held in INMO HQ

"Whenever we have a staff meeting with management about proposed changes I always go to give the union position," Ms Scully-Gilligan said. "This means colleagues know I'm the go-to person for union matters and they also know the INMO position."

When members come to Ms Scully-Gilligan with issues around pay scales, staff shortages, safe practice, delays in wages or implementing the enhanced salary scale or Covid-19 bonus payment, she first checks to see if she has the documentation to support them, eg. the grievance process or overtime rates. If she doesn't have the information they need, she will phone the INMO Information Office and contact the other reps within Beaumont Hospital. If the matter is not resolved at this point, she will then contact the IRO and discuss how best to proceed. She said the course has increased her confidence in dealing with these issues.

"After the rep training I feel like I have a whole toolkit now. I feel really motivated after the course. It was great to meet other reps on the course and hear their issues and find out how they operate. We need to encourage more people to become reps. The representation and support if you need it legally and the tools for negotiating are invaluable," she added.

'Knowledge is power'

Ann-Marie O'Reilly has been a rep at St Michael's House for the past 20 years along with her colleague Eileen Colgan. Ms O'Reilly spoke to *WIN* about the benefits of the role.

"Being a rep really keeps us up to date with changes within the health service that may affect our working lives, either negatively or positively. It gives us the tools and language to debate with management on behalf of our members.

"Knowledge is power and the training given to us was very valuable. The back-up and access to IROs mean we're not alone in dealing with issues. We set up meetings with management so issues can be discussed at draft stage and collaboration reached, rather than waiting until its too late," said Ms O'Reilly.

Get involved

The INMO provides the costs of training for reps and, where required, accommodation, travel and subsistence will be paid to members who attend. There are agreements within the public service for paid release to attend INMO rep training courses, so you do not lose pay when you attend. Once you have been accepted on to a course you will receive a letter to show your manager seeking your release for the two days.

There are normally 10 courses held each year. In addition to rep training, the INMO provides bespoke training and information sessions for reps. These can include topics such as statement writing, advice on the rules of a sick pay scheme, pension advice and fitness to practise.

In addition, the INMO has provided courses such as 'Tools for Safe Practice' which provides members with practical advice on how to protect their practice, particularly in relation to writing up nursing/midwifery notes. The courses take place over two days and normally start on the afternoon of the first day with a full day on the second day.

For information on upcoming dates for rep training courses contact your INMO official at: Dublin 01 6640600; Cork 021 4703000; Galway 091 581818; & Limerick 061 308999

Introducing Executive Council members

Elizabeth Allauigan

Senior staff nurse,
St James's Hospital, Dublin

ELIZABETH Allauigan is a senior staff nurse at St James's Hospital, Dublin. She has worked as an RGN since 2004, having practised in Libya, Saudi Arabia and in her native Philippines, where she completed her degree in nursing. She had always wanted to go into medicine and was delighted when she got a scholarship to study nursing in Manilla.

As student union president she discovered the value of collective working. She worked for two years with the Red Cross travelling around the Philippines. When she moved to Ireland, she joined the INMO and completed a diploma in healthcare management and a master's in public administration.

"Being part of a union allows us to advocate for nurses and midwives and to protect their rights through collective action. Being a member of a union, you ensure safe working conditions and you advocate for better, and of course we ensure due process for disciplinary hearings and grievances is adhered to."

This is her second term on the Executive Council and she is proud to be a voice for nurses who have moved to Ireland to work in our health service. She served as chairperson of the International Section for six consecutive terms and has helped countless nurses and midwives adapt to living in Ireland and working in a new health service.

"When I see our new graduates I hope their working conditions will improve. I always tell them that they have to look after each other. Compassion, optimism and kindness will not go unnoticed. Hope is a thing with feathers that perches in the soul. Many of my colleagues qualified during the pandemic. They worked so hard and learned so much. I love when they come to me for advice or assistance. Nursing, like learning, is a lifelong process."

Margaret Birtley

Public health nurse, Cork

MARGARET Birtley is a public health nurse working in the north Cork area. Having worked in theatre and as a practice nurse, she decided to train as a PHN in University College Cork. She is chairperson of the INMO's lively Mallow Branch and is passionate about public health and believes that the roles of the PHN and community RGN are vital to an effective and functioning health service.

As a member of the Executive Council she vows to advocate for those working in community nursing by bringing the issues most pertinent to them to the fore at national level. She looks forward to working with her fellow PHNs on the Executive Council but is determined to represent all sectors. She is excited about working with her peers from other areas of nursing and midwifery.

"Being a member of a union affords you protection and the ability to fight for better pay and conditions. We have made some great gains in terms of pay since the 2019 national strike. The support the union provides in terms of representation and advice should a member ever be called before a fitness to practise hearing are invaluable.

Ms Birtley advises students to have patience and to give as much focus to their practical and clinical learning as to their theory. "So many nursing and midwifery students drop out of their courses while others leave the country shortly after qualifying due to the dire conditions they often face in the workplace. I would like to see more concrete measures in place to retain our nurses and midwives. I would also like to see more pathways to the professions. This would include more pre-nursing courses and greater access to training and university places. I want to be a voice for all nurses, not just PHNs."

Eilish Corcoran

CNM2, South Infirmary Victoria University Hospital

EILISH Corcoran has been a member of the INMO since she began training as a nurse in the 1980s and has been a rep since 1997. She previously sat on the Executive Council in the early 2000s and was a member of the ED Section and secretary of the Cork Voluntary Private Branch. She has spent 35 years working in various roles in South Infirmary Victoria University Hospital, Cork except for a brief stint in St James's in Dublin when she trained as an ED nurse. She has an in depth knowledge of the hospital and expertise in numerous sections of nursing. She set up the chest pain assessment unit in the cardiology wing and has also worked in ED, x-ray and wound management before taking up her role as CNM2 in outpatients six years ago.

"There was never any doubt that I would join the INMO as my mother and aunts who were nurses advocated the virtues of joining a union that solely represented nurses and midwives rather than multiple sectors of employment. In our professions we deal with life and death situations. The representation available to us through the INMO is essential in the event of a fitness to practise hearing. The INMO education centre with courses designed specifically for our professions is also a huge benefit to members."

Ms Corcoran wants to prioritise a review and expansion of the allowances system while on the Executive Council, but feels safe staffing needs to be addressed immediately. "Good staff nurses are the foundations of the health service. We have to tackle recruitment and retention and that will need to be multi-pronged. Until we have safe staffing levels nothing will encourage people to stay working as nurses and midwives in Ireland. It becomes a vicious circle. We have to improve wages to attract and retain staff."

Rachel Kenna, Photo Lisa Moyles

Chief nurse Rachel Kenna says advanced practitioners have a significant role to play in the future of Irish healthcare services. **Alison Moore** reports

Game changers

ADVANCED practice has been "a real game changer" in nursing according to Ireland's chief nursing officer Rachel Kenna. Ms Kenna was giving one of the keynote addresses at the recent Nurse Practitioner/ Advanced Practice Nurses Network Conference held in Dublin.

Hosted by the INMO and the Irish Association of Advanced Nurse and Midwife Practitioners in collaboration with the International Council of Nurses, the three-day event was the largest ever international gathering of advanced nurse practitioners.

The theme for the event – which was the 12th time the conference had been held – was *Advanced Practice Nursing: Shaping the Future of Healthcare,* with the main focus of the event placed on learning and innovation.

Ms Kenna's told those assembled in UCD's O'Reilly Hall that as "we learn, we innovate and we advance" and she encouraged nurses to "reach up, reach in and reach out" as they progress through their careers.

She gave an outline of the chief nursing officer role and how it was key to the Irish health service – being a senior leadership role that operates at decision-making level within the Department of Health. She said that having such a role to influence health policy was vital to the professions.

Such influence, she said, would help to further strengthen the capacity of the nursing and midwifery workforce to deliver and co-ordinate excellence in healthcare design and delivery, while fulfilling their "potential as primary caregivers to the full extent of their education and training". In turn, she said this would enable the full economic value of nurses and midwives' contribution to care to be realised, stressing that this was particularly relevant in the area of advanced practice.

Ms Kenna emphasised to attendees that due to nurses and midwives' level of education and professional training, as well as their strength in number and proximity to the patient, they had "opportunity and real power to lead and bring the needed changes in health services."

She said that advanced practice had increased patient access to expert care and services and simultaneously helped to develop career pathways within the professions. She added that nursing had significant reach across all the different patient groups and care areas from a leadership perspective. While advancing in their careers, Ms Kenna underlined that one challenge for nurses was how to stay "high touch in a high-tech world".

She added that it was also important for advanced practice nursing and midwifery policy to shape and support the development of evidence-based practices.

Ms Kenna gave an overview of Ireland's advanced practice policy journey from the early 2000s when Valerie Small was the first ANP appointed, to the current situation where we have 517 advanced nurse and 17 advanced midwife practitioners appointed.

While she acknowledged that we were still very early on in the development of advanced practice in Ireland, Ms Kenna said that every single practitioner was already having an effect in delivering safe, effective care that benefits patients.

"Advanced practice roles are so important, fulfilling the overall aim of Sláintecare – delivering the right care at the right time in the right place," she added.

Ms Kenna pointed to evidence showing that advanced practice has reduced waiting times, lessened the avoidance of ED attendance, provided more services in the community and reduced hospitalisation. For these reasons, advanced practice was central to the Department of Health's nursing and midwifery policies across the different disciplines.

Pandemic

The chief nurse acknowledged the role that advanced practice played throughout the Covid crisis, citing the "innovation and re-imagining" of service delivery alongside the adoption of technology "in ways that we've never seen before" as a "significant driver" in the maintenance of services.

"One of the biggest lessons from Covid is that we need to work together and that together we are stronger. Collaboration is going to be so important, not just for the context of the increase in threats that we're all facing, but also in relation to the workforce challenges," she said.

She added that the pandemic put a spotlight on the professions, providing an opportunity to showcase their contributions which "didn't disappoint".

Looking to the future, Ms Kenna said that leadership from the patient's side to the policy table was required and that advanced practitioners were well placed to achieve this.

"Leveraging our role as leaders and advocates, clinicians, researchers, multidisciplinary actors in a complex system will help us to achieve successful health and a successful health system," she said.

Trail blazer

Ireland's first advanced nurse practitioner Valerie Small says that from its humble beginnings in 1997, the role is now a vital and growing part of our health service. **Alison Moore** reports

Valerie Small
Photo Lisa Moyles

IT IS said that necessity is the mother of invention and while waiting times in Irish emergency departments (ED) have never been a cause of celebration, one good thing they have brought about was the origin of advanced practice.

Valerie Small was the nurse who blazed that trail in Ireland. As she recalled, it was 1996, the population was about 4.2 million, the European Working Time Directive was starting to have an effect on junior doctors' working hours, and low acuity ED presentations were increasing while waiting times were rising in tandem.

As a nurse trained in the area of emergency medicine, Ms Small described how, informed by the advanced practice experiences of both the US and the UK, they began to look into the nurse practitioner role for the ED in St James's Hospital in Dublin where she was working.

Ms Small credited Peta Taaffe, a former director of nursing at the hospital and who became Ireland's first ever chief nursing officer in 1997, for her "forward thinking".

"She very much embraced the notion that an experienced, trained nurse could manage cases of low acuity. For the most part we were training the junior doctors as they came along every six months, we stood at their shoulders and said 'You know, I wouldn't do that if I were you'," she said, to much mirth among the attendees at the recent Nurse Practitioner/Advanced Practice Nurses Network Conference in Dublin.

With the help of the director of nursing, Ms Small set about writing a job description and a scope of practice for a nurse practitioner role in the ED.

"I suppose this was really ground breaking. There were no such roles at the time and we had to negotiate with our stakeholder partners in radiology and orthopaedics to be involved in this role, by accepting referrals from nurses," she said.

Ms Small also underlined that lack of opportunity for education and training for nurses who wished to advance their clinical careers, which this new advanced role would later provide. The scope of practice was approved by the hospital board and became the initial framework on which advanced practice roles were developed.

St James's Hospital entered into an academic partnership with Trinity College Dublin to provide a formal education process via a master's of science degree course in nursing in 1997, under the faculty of medicine. "I very quickly came to the conclusion that if advanced practice was to be taken seriously, we needed to be educated to master's level," said Ms Small, who embarked on this programme herself in 1997.

In 1999 she wrote a thesis evaluating the role and the scope of advanced practice. Her evidence showed that the role delivered safe practice and patient satisfaction and should be expanded.

She explained that the main driver in bringing about such an expansion was the Report of the Commission on Nursing in 1998 which, among other things, examined promotional, training and educational opportunities within the profession.

Ms Small's earlier scope of practice document for the advanced practice role in St James's was one of the many submissions made to the Commission. "Up to that point, there were no onward career pathways for nurses who wanted to stay in the clinical area. The report was the catalyst for change, providing new pathways for clinical nurse specialists and advanced nurse and midwife practitioners."

The report also led to the regulatory changes which saw An Bord Altranais become the Nursing and Midwifery Board of Ireland (NMBI) and the establishment of nursing and midwifery degree courses in 13 universities across Ireland.

Under the health reform programme 2001-2010, funding was made available to fund the Commission of Nursing Report and subsequently when the HSE was set up in 2005, its policies included growing the ANP role to improve service efficiency.

Ms Small discussed how the role went through a period of research and development under the National Council for Professional Development of Nursing and Midwifery from 1999-2010 after which point the responsibilities of the office were subsumed by the NMBI.

Under the various health reform plans since 2010, advanced practice has very much been embedded in the planned models of care. She said that the Nursing and Midwifery Act of 2011 underlined the era of advanced practice with the creation of a separate register for accredited practitioners.

Under Sláintecare, Ms Small said that advanced practice roles will become yet more pivotal to our health service with the planned move to more community-based care. She observed that the rate of growth has seen the number of practitioners grow from one in 1997 to 656 in 2022 would only increase in the future, and that there would soon be additional opportunities in private healthcare.

Time to deliver

Howard Catton
Photo: Lisa Moyles

Nurses in leadership positions represent our best chance in the fight against global health crises, says ICN CEO Howard Catton. **Max Ryan** reports

HOWARD Catton, chief executive of the International Council of Nurses (ICN), told attendees of the Council's 12th Nurse Practitioner/Advanced Practice Nurses Network Conference in Dublin that now was the time to invest in nurse-led models of care, stating that "we need to come together to lead".

Delivering the keynote on day four of the conference in UCD's O'Reilly Hall, Mr Catton said that nurses were the solution to many of the health crises that continued to plague the global health landscape.

"We need to have our eyes on the current international health agenda and how we as nurses and ANPs are key to the solution," Mr Catton told the conference. It's not just about advocating for our individual roles, it's about advocating for models of care."

Set against the backdrop of the Covid-19 pandemic, the conflict in Ukraine and the growing prevalence of mental illness worldwide, Mr Catton said that where many saw crises, he saw opportunities for nurse-centred solutions.

"I see nursing work: I see incubation, I see vaccination, I see nursing care plans, I see primary healthcare and I see access to mental healthcare."

Leaders in design

Mr Catton spoke about a publication that he and colleagues at the ICN worked on last year, in collaboration with WHO chief nursing officer Elizabeth Iro, and the recommendations it made about the future direction of nursing in a post-Covid era. Published in the *BMJ* in 2021, the paper recommended that "nurses should be leaders in the design of healthcare systems", not merely involved in the delivery of care. It demanded that not only health be considered in every government policy, but that senior nurses be present "at the top of all health system organisations".[1]

These recommendations, in combination with those pertaining to workforce planning and investment in nursing jobs and education, made a compelling case for the widespread implementation of nurse-led models of care, Mr Catton said.

"Everybody knows that we're great at delivery, but we often get left out in terms of design," Mr Catton said. "You have to have us at the table for those design decisions. You're not going to have strong health systems if you don't have us there. We need to have nurses in all countries in government positions."

Another critical development in the involvement of nurses in global health strategy came in 2018, said Mr Catton, who cited the WHO's *Time to Deliver*[2] report on non-communicable diseases (NCDs), which made specific reference to the role of advanced nurses in addressing the burden of NCDs globally.

"The previous ICN president Annette Kennedy was a commissioner [of the report] and it was down to her work that there are explicit references in *Time to Deliver* about the critical role that nurses and advanced nurses play in addressing the NCD burden right the way around the world. The report advocates for and recommends nurse-led models of care."

A little less conversation

Mr Catton told the conference that it wasn't enough to have nurses in leadership roles. He said, for example, that although two-thirds of ICN member states had chief nurse positions, many of these roles did not have the authority to advise at a strategic level.

"If you get the roles, there's no guarantee that they're going to be utilised, involved and included in decision-making. So we have to make sure we support our colleagues who are in these positions to have a voice, to be effective and to do what they are there to do."

Mr Catton said that throughout his career he has found it frustrating to witness the promising strategies that have been agreed on at global health summits not being implemented following their agreement.

"Ministers will come from around the world and will agree a strategy. However, what happens is some kind of amnesia on the flight home because we then see very little implementation," he said.

Nurses are key to making sure that commitments made globally to healthcare are "translated on the ground", he said.

Mr Catton concluded his address by likening nurses to "the linchpin that holds the axle on the wheel." Without nurses, he said, "the wheels would literally fall off".

References
1. Catton H, Iro E. How to reposition the nursing profession for a post-Covid age. BMJ 2021; 373:n1105
2. World Health Organization 2018. Time to deliver: report of the WHO Independent high-level commission on noncommunicable diseases. WHO

Cardiology ANP Shirley Ingram proves that a career of practice advancement can pay off for patients and stakeholders. **Max Ryan** reports

Making the case

Shirley Ingram
Photo: Lisa Moyles

CASELOAD expansion was the focus of Shirley Ingram's address to the recent Nurse Practitioner/Advanced Practice Nurses Network Conference in Dublin. Ms Ingram, who is an ANP in Cardiology at Tallaght University Hospital, outlined the story of her own practice advancement through the lens of the six key competencies of advanced practice nursing: autonomy, accountability, clinical supervision, professional development, collaboration and caseload.

Ms Ingram has more than 30 years of clinical experience in cardiology nursing, from coronary care and cardiac rehabilitation to chest pain assessment, an area in which she has worked for the past 12 years. She pioneered the ANP-led chest pain service in Tallaght University Hospital and has expanded her caseload from the acute ED setting into the community. She told the conference that ANPs are not just clinical practitioners, they are "experts, healthcare leaders and researchers" who use their own professional scholarship competencies to expand the scope of their practice.

Ms Ingram credited a stint working in the Australian outback early in her nursing career as a launchpad for the level of autonomy she enjoys in her practice today.

"I worked in the outback in Australia in a tiny little place called Halls Creek. In a way they were far ahead of their time because you were fairly autonomous, because it was a very small and remote town."

On her return to Ireland, Ms Ingram and a colleague fought in the Labour Court, with the support of the INMO (then the INO), to be recognised as clinical nurse specialists (CNS). Having achieved this recognition, she helped to establish the first CNS-led cardiac rehabilitation centre in Tallaght University Hospital, which is now internationally recognised. After seven years in the cardiac rehab centre, Ms Ingram moved into the area of chest pain assessment, first in the ED in Tallaght and later in a primary care centre, where she works to this day. Her current caseload comprises non-acute chest pain patients referred by their GP.

"I aim to see these patients, depending on if they're low, medium or high risk, within one to two weeks. Some patients I will see the next day if I'm concerned."

During her time as a CNS in cardiac rehab, Ms Ingram conducted an audit of returning patients to the general cardiology outpatient clinic and pioneered a nurse-led pre-assessment tool to address the lengthy waiting times and expedite the process of identifying patients who were eligible for discharge. Ms Ingram told the conference that the success of this pre-assessment tool paved the way for the introduction of further nurse-led services within the hospital's cardiology department.

"We began to see what cohorts of those clinics a nurse-led service could remove. So I started the post-PCI (percutaneous coronary intervention) clinic in Tallaght Hospital in May 2011.

"Telling people what you do is important, in this case publishing the audit and publishing the results of the post-PCI clinic have been really important."

Ms Ingram said that where a clinical problem is identified in a patient, her first and second responses are to gather the data and establish whether or not there is a nursing solution. Invariably, however, she said the decision boils down to money, and that's when collaboration becomes important.

"The theme here is making friends, communicating and negotiating with people, and showing them what you can do to add to the service for the patient.

"In a time of tight economics, it's about the money. I can stand there and say 'I can educate a patient' but really people want to know how much money it's going to cost, how many hours it's going to take and what kind of numerical savings can be made for the patient. Then you make the case, make the case, make the case," she continued.

"What comes with experience is tenacity and not being afraid to speak your voice. I have sat outside the CEO's office for five hours, building relationships in the corridor and sharing what we do, because when you're a respected professional, people will listen to what you have to say."

Ms Ingram said that the introduction of the chronic disease management programme has resulted in "far more growth and development in the community in an integrated-care fashion," but added that "I like to think that myself and my heart failure colleagues got there first".

‘CPD vitally important’ – ICN chief nurse

Dr Michelle Acorn shared her career path with the conference

THE importance of continuing professional development and the value of postgraduate education in advanced nursing practice were made clear by Dr Michelle Acorn in her address to the Advanced Practice Nurse Network Conference.

Dr Acorn, who previously worked as chief nursing officer with the Ontario Ministry of Health, described her ascent from registered nurse at the age of 20 to inaugural chief nurse of the International Council of Nurses (ICN), the position she has held since May 2021.

She told the conference: “At that age I realised I had so much intent to learn, and the more I learned the more I realised I didn’t know.”

Dr Acorn said her decision to continue to learn and expand her practice was driven by a desire to “not just care for the patient, but for the profession”.

She said: “I just continued down a purposeful path of knowledge because I wanted to ensure I was safe in my practice and I was confident.”

Dr Acorn shared her global outlook on nursing, which is central to her role as the ICN chief nurse. She told the conference, however, that she has always looked beyond her local-level practice throughout her 25-year nursing career.

“I actually became the chief nurse by going back and doing my postdoc. I knew I was local because I was a provincial chief nursing officer and I was president of the Nurse Practitioners Association; I knew I was national because I was tied with our national principal nurse advisors as well, but I didn’t really feel confident in my global aspect.”

To address this perceived deficit, Dr Acorn said she undertook an international nursing certification as a global nurse consultant before working with the ICN on its code of ethics as part of her postdoctoral research.

Dr Acorn also shared her insights into recruitment and retention practices, drawing on research she conducted into the impact of Covid-19 on nursing in Canada. Offboarding, she said, is a crucial part of understanding why people leave the profession.

ICN chief nurse Dr Michelle Acorn

“I have colleagues who have reached out to me because they want to leave. They were at the end of their tether. We shouldn’t have to get to that point. We need to promote our wellbeing, both physical and psychological, for patient safety and for professional safety.

“We need to remove barriers to truly enable, empower and support, and to utilise all our advanced practice skills.”

Florence Nightingale medalist recounts remarkable career working in conflict zones

HER first placement with Irish NGO Concern saw her stationed in Cambodia in 1992 during the brutal Khmer Rouge regime, but Irish nurse Vivien Lusted’s overseas adventures did not end there.

Ms Lusted described her atypical nursing journey in an inspirational address to the recent Advanced Practice Nurse Network Conference, which took in sobering tales from her work in conflict zones in Iraq, Palestine, Myanmar, Nigeria, Liberia, Zimbabwe and Sudan.

Ms Lusted told the conference that resources in Cambodia were severely lacking as the health service was on the verge of collapse. Her work there began with implementing a vaccination campaign, which involved travelling daily to remote villages and sterilising used syringes in a pot on an open fire. This was the least of the dangers, according to Ms Lusted.

“Unfortunately, the countryside was littered with landmines, and for someone who had never seen a fresh mine injury, it was a real shock. For people who lived in the rural community, the risk was huge on a daily basis,” she said.

Following her experience in Cambodia, Ms Lusted joined the Irish Red Cross, which took her to Sudan. Her work there primarily involved vaccinations, but due to a shortage of staffing and resources, she said it also involved driving mothers in obstructive labour to hospital and “delivering babies in the back of a vehicle”.

Ms Lusted told a harrowing story that took place while she and her colleagues were carrying out first aid training with combatants in Darfur: “I met some of these young men a few months later in the bush while they were holding up our vehicles at gunpoint and trying to steal them.

Vivien Lusted

“Because of the training, they were nice enough just to take one of the vehicles. Their logic was they needed one vehicle to pick up their wounded and we needed one to continue coming to the first aid training.”

Ms Lusted told the conference that despite the extraordinary nature of her career in nursing, she shares the same set of values that every nurse brings to their practice.

“I realise that whatever level we are as nurses, whether we’re starting out in our careers or having reached the level of APN, we are all bound by the same values: the care of people and communities, compassion, communication and courage. There is a place for all of us,” she said.

See also the March 2020 issue of WIN for an extended feature on Ms Lusted’s career with the Irish Red Cross.

Training in reproductive coercion lacking

HEALTHCARE professionals, including nurses and midwives, are not trained to recognise or address cases of reproductive coercion, in Ireland or internationally, according to Brídín Bell, a clinical nurse specialist forensic clinical examiner.

Ms Bell was presenting at a fascinating breakout session at the recent Advanced Practice Nurse Network Conference in Dublin. Her presentation entitled 'Nurses and providers' experiences of reproductive coercion within intimate partner violence: qualitative evidence synthesis' focused on the need for healthcare providers to reduce the risk of harm to those affected.

Ms Bell, who recently completed her master's degree in advanced practice, noted that while coercive control was now a recognised crime under Irish legislation, the very specific gender-related abuse of forcing someone to get/not get pregnant via the use of termination or by forcing or preventing the use of birth control, was not specifically covered under the legislation.

Following a literature review of intimate partner violence studies in Ireland, she noted that the area of reproductive coercion was not mentioned at all and in an international context the research was also very limited, despite it being "the single most gender specific abuse towards girls and women."

She discussed the need for healthcare practitioners in Ireland to understand the factors influencing reproductive coercion and the need to create awareness in the Irish context of the criminal, psychological and physical implications of such behaviour.

If healthcare practitioners do not know exactly what sexual or reproductive coercion is then how do they approach it, or even recognise it in the first instance, asked Ms Bell, who said that the clear lack of training in this area must be addressed urgently.

She suggested that incidence of sexual or reproductive coercion was likely similar to that of other domestic violence at a rate of one in four or five, and she gave some details of such cases that have been seen in the country.

"We had a case of a young person under the age of 18 who was locked in a room and given 10 abortion tablets to force her to have a termination. She nearly ruptured her uterus.

"We had another woman whose contraceptive was removed three weeks before without her knowledge. That case actually has recently gone through the courts as there was also strangulation involved but it never mentioned the reproductive coercion," she recalled.

Ms Bell said that training should be given to staff in EDs and orthopaedics, due to the number of fractures that this cohort would suffer. She also highlighted maternity clinics for staff training asking how many practitioners in the room had seen patients admitted postnatally with ruptured stitches, only to be afraid to ask questions.

"It's all because we have no training and are so afraid to make it worse. So I think there is an amount of work to be done," she added.

Challenge of evaluating impact of advanced practice

MEASURING the impact of advanced practice on the health service is complex as the role is multifactorial. This was according to Leanne Madigan, a project officer at the HSE's Nursing & Midwifery Planning & Development Unit (NMPDU).

Dr Madigan (*pictured right*) was speaking at a breakout session at the Advanced Practice Nurse Network Conference held in UCD recently. Her presentation discussed capturing the impact of advanced practice nursing in Ireland and the need to inculcate culture and resources into practice.

She explained that a working group within the Office of the Nursing and Midwifery Services Director wanted to develop a tool to enable ANPs to demonstrate their role, with the ultimate aim of gathering data that could be used to optimise performance.

She told the meeting that the Expert Review Body in nursing and midwifery had recommended that such evaluation was necessary to gain a better understanding into how the role was impacting the key deliverables of improving access, reducing waiting lists and hospital avoidance, as well as demonstrating the positive effects on patient care.

Dr Madigan explained that they carried out a broad-based literature review on data collection tools to measure the impact of advanced practitioners.

They looked at data and literature nationally and internationally, and noted that there was a variety of ways data was being collected both qualitatively and quantitatively, highlighting the need for more systematic approaches to be adopted. The literature review findings however did not offer tangible solutions to the problem of identifying key monthly indicators to objectively demonstrate the impact of the role, she explained.

Dr Madigan said that barriers to the capture of good data included time, resources and the gathering process putting excessive burden on already busy practitioners.

"We ourselves have found challenges in capturing meaningful data and the questions to go with this, so it's important to recognise it's not enough to collect data for the sake of it, it needs to be meaningful."

She explained how the NMPDU had developed a cloud-based digital portal to capture the impact of ANPs using monthly surveys, which can be used on a handheld device or a computer. Participants and their managers can then download their data from the portal in real time and use it to inform practice.

The NMPDU has also created a repository of the various data collection tools that were in use nationally, which they will draw on in order to design a standardised tool in the future.

Q and A Bulletin Board

With INMO director of industrial relations Albert Murphy

Public holiday entitlement

Q. I am a staff nurse who works in a job share in OPD. I am required to work every Monday in a specialist clinic and I am wondering about my public holiday entitlement, as the employer gives me four and a half days every year

As you work in a location that is Monday to Friday, the following public holiday entitlements apply to nurses who work part time or job share. If the public holiday falls on a day you are normally scheduled to work, then you receive a paid day off. Job sharing nurses and midwives who work Monday to Friday and who are not scheduled to work on the day on which the public holiday falls are entitled to one-tenth of their normal fortnightly pay for the public holiday. Part-time nurses and midwives who work Monday to Friday and who are not scheduled to work on the day on which the public holiday falls are entitled to one-fifth of their normal weekly pay for the public holiday. Nurses and midwives employed in the public health service who work a five over seven (seven-day week) roster receive additional annual leave in lieu of their liability to work on public holidays, ie. 10 days in the case of a full-time nurse and five days in the case of part-time nurses. In addition, they also receive double pay in respect of any public holiday on which they are required to work. This, in effect, gives them treble time in respect of a public holiday worked, while the legal minimum is double time.

Maternity leave

Q. I am a staff midwife working in the public health service. I had planned to start my maternity leave at week 37 of my pregnancy, two weeks before the end of the week when my baby was due. However, my baby came seven weeks before I planned to go on maternity leave. This would mean that I start my maternity leave earlier than expected. I believe that there have been some changes in the maternity legislation in relation to premature births.

If your baby was born before the date when you were due to start maternity leave, your maternity leave lasts for 26 weeks from the date of your baby's birth. For premature births on or since October 1, 2017, maternity leave is extended for an extra period after the end of this 26 weeks with maternity benefit payable for this extra period. The duration of this corresponds to the time period between your baby's actual birth date and the expected start date of your maternity leave. To make a claim for any additional period due to a premature birth, you will need to contact the Maternity Benefits Section of the Department of Employment Affairs and Social Protection to inform them of the premature birth. This must be done before the end of the first 26 weeks of maternity benefit.

Workplace assault

Q. I work for the HSE and was assaulted in my workplace and am currently out on sick leave as a result. I was advised by my employer that I would be paid sick leave under the normal sick pay scheme, is this correct?

This is incorrect. If an employee has been physically assaulted at work they are paid sick leave under the Serious Physical Assault at Work scheme, which is six months' full pay including premium pay and if needed this may be extended twice, three months' full pay and another three months' basic pay. Medical expenses incurred may also be recouped as follows:

- A refund of expenditure in respect of treatment provided by the Irish public health service, general practitioner, emergency, outpatient and consultant visits, and prescription charges
- Where employees have medical insurance they must claim where appropriate, with the employer paying the excess
- Where there are long waiting times for treatment or where treatment is not available in the public health service, private treatment costs in these exceptional circumstances will be refunded.

Where you believe you meet the criteria to be included under this scheme and your employer denies this, there is an appeals procedure that the INMO has referred a number of similar cases to and had successful outcomes. If you are in this situation please do not delay in contacting the INMO official with responsibility for your area and your case will be reviewed to seek the best outcome.

Know your rights and entitlements

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

Contact Information Officers Catherine Hopkins and Catherine O'Connor at
Tel: 01 664 0610/19
Email: catherine.hopkins@inmo.ie, catherine.oconnor@inmo.ie
Mon to Thur 8.30am-5pm; Fri 8.30am-4.30pm

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

Section focus

INMO Professional

Jean Carroll, Section Development Officer

Pension issues top Retired Section's agenda

INMO director of industrial relations Albert Murphy told a recent meeting of the INMO Retired Section that pension increases which have been due since last October would be paid in September 2022 and backdated to October 2021.

Mr Murphy also highlighted the statutory requirement under the Pensions Act to pay pensions within three months of application. He asked that members who are experiencing delays in their pension payments bring this to the union's attention, as the INMO is meeting the head of pensions on a regular basis and many individual cases have been progressed through this forum.

The meeting, which saw more than 80 members attend either online or in person at the Richmond Education and Event Centre, also heard updates from the Irish Senior Citizens Parliament, the ICTU and the section's social committee.

Upcoming conference

The section will host its bi-annual conference on Tuesday, November 28. Please email education@inmo.ie to book your place or contact us on 01-6640618/01-6640641. The cost of attendance is €20 and booking is essential. It will not be possible to join the conference online.

Social outings

The next social outing for the Retired Section is scheduled for Thursday, October 6 at the Richmond Barracks, which can be accessed via the Drimnagh stop on the Luas red line. Arrangements are in place for meeting at 12pm for coffee and a self-guided tour. At 1pm there will be a guided tour of the cemetery. Please contact Mary Giblin on 086-3970239 with any queries.

Pictured on a recent visit to historic Kilkenny were members of the Retired Nurses Section (l-r): Catherine O'Connell , Catherine Gillanders, Bridie Lalor, Ann Gee, Myra Garahan, Cecilia Fox, Ann Igoe and Mary Giblin

A four-night getaway to Buncrana, Co Donegal is planned for next May, leaving from Dublin on Monday, May 1, 2023. Accommodation will be booked in the Inishowen Gateway Hotel. Bookings will be open from early January.

Section membership

Members who are approaching retirement are reminded that membership of the Retired Section is only open to previous members of the INMO who have been in membership for at least the 12 months immediately preceding the date of retirement.

Please don't let too much time lapse, make sure you get involved in the section as soon as you retire.

National Orthopaedic conference

NURSES working in orthopaedics will be interested to know that the 22nd National Orthopaedic Conference will take place on October 19, 2022 at the Carlton Hotel in Blanchardstown, Dublin.

INMO Orthopaedic Nurses Section committee and INMO staff will be in attendance to answer any queries.

Registration is free for nurses working for HSE Section 38-funded hospitals. For bookings contact Rosemary Masterson by email to: rosemary.masterson@nohc.ie

Have you booked a place at these upcoming events?

October

- Occupational Health Nurses Section Conference, Richmond Education and Event Centre, Thursday 6
- Operating Department Nurses Section Conference, Limerick, Saturday 8
- CPC Section seminar, Richmond Education and Event Centre, Wednesday 19

November

- PHN Section webinar, Saturday 12
- All-Ireland Midwifery Conference, Thursday 17
- Assistant Directors Section Webinar, Thursday 24
- National Children's Nurses Section webinar, Saturday 26
- Retired Nurses Section seminar, Monday 28

To book your place, Email: education@inmo.ie or Tel: 01-6640618/41

INMO Professional

Continuing professional development for nurses and midwives

INMO EDUCATION PROGRAMMES

In the pull-out this month…

Tracheostomy Care Study Day

Oct 10

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

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

PEG Feeding – Caring for Adults and Paediatrics who have a PEG Tube in the Hospital/Community Setting

Oct 11

This short online programme is aimed at all nurses working within the hospital and community setting caring for adults and paediatrics who have a percutaneous endoscopic gastrostomy (PEG) tube. It will address the clinical indications and requirements for PEG feeding in the home and hospital setting.

€30 INMO members; €65 non-members

Overview of Nursing Assessment and Management of Stroke

Oct 11

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

€30 INMO members; €65 non-members

INMO Professional

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Webinars & Conferences for Nurses and Midwives

Webinars and Conferences 2022

ONLINE AND IN-PERSON EVENTS

All conferences and webinars are Category 1 approved by NMBI

Thursday 6 OCTOBER — Occupational Health Nurses Section Conference

Saturday 8 OCTOBER — Operating Department Nurses Section Conference

Saturday 12 NOVEMBER — Public Health Nurses Section Webinar

Thursday 17 NOVEMBER — All Ireland Midwifery Conference

Saturday 26 NOVEMBER — National Childrens Nurses Section Webinar

Thursday 24 NOVEMBER — ADON Section Webinar

SCAN for more information

For further details go to
www.inmoprofessional.ie/conference
or contact jean.carroll@inmo.ie

INMO Professional

Education Programmes

Tel: 01 6640618/41
Email: education@inmo.ie

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Time: 10am-1pm

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Oct 7 **Paediatric Asthma – Understanding the Basics**

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

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

Oct 12 **Risk Management and Incident Reporting**

This new online programme outlines the core principles of best practice in managing risk, underpinned by philosophy and care needs. At the end of the session participants will be enabled to: understand key terms and definitions related to risk management in healthcare; outline the stages of the risk management process based on the international standard and framework for risk management; outline the five steps of risk assessment; understand the purpose and maintenance of a risk register and complete accurate records of incidents for incident reporting. Ultimately, this programme promotes best practice with risk management and patient safety.

Oct 14 **Tools for Safe Practice** *(free for INMO members)*

This course provides safe practice tools to protect the nurse and midwife. This is an awareness session to ensure all staff have an understanding of the process involved regarding patient alerts, clinical incidents and thorough assessment. The programme addresses patient safety and staff safety and provides five key tools on areas of documentation, clinical incident reporting, safety statements, best practice guidelines regarding assessment and communication practices in a complex multifaceted healthcare arena.

Oct 18 **Promoting Informed Consent and Positive Risk in Nursing Persons with an Intellectual Disability**

The aim of this programme is to outline principles of practice for supporting clients' autonomy through the promotion of informed consent and positive risk taking in person centred planning. The aim of this programme is to outline principles of practice for supporting clients' autonomy through the promotion of informed consent and positive risk taking in person centred planning.

Oct 19 **Introduction to Treating and Preventing Pressure Ulcers**

This short online course will advise participants on pressure ulcer prevention. Topics covered on the day include; causes of pressure ulcers, risk assessment, and prevention of pressure ulcers.

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

Oct 20 **Delegation Principles and Practices**

This short programme is aimed at all nurses, midwives and clinical nurse and midwife managers who work with health care assistants. It explores the issues surrounding delegation and decision making, including appropriate clinical supervision for delegated functions. Participants will learn the difference between clinical and managerial delegation and how delegation differs from assignment of a task.

Oct 21 **The Know How of Inhaler Technique**

This short programme will address issues around inhaler technique. The programme will introduce the nurse and midwives to current best practice in relation to inhaler technique and assist in the understanding of the role of inhaled medication with the correct use of inhalation devices.

Oct 26 **Complaints Management for Healthcare Staff (Acute or Residential Healthcare Setting)**

This programme is aimed at senior nurse managers within the acute or residential healthcare settings. It will provide them with the key skills of communication tools to minimize the negative impact complaints can have in their workplace.

Oct 27 **Falls Reduction, Assessment and Review**

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

Nov 4 **Tools for Safe Practice** *(free for INMO members)*

This course provides safe practice tools to protect the nurse and midwife. This is an awareness session to ensure all staff have an understanding of the process involved regarding patient alerts, clinical incidents and thorough assessment. The programme addresses patient safety and staff safety and provides five key tools on areas of documentation, clinical incident reporting, safety statements, best practice guidelines regarding assessment and communication practices in a complex multifaceted healthcare arena.

Nov 8 **Understanding and Developing Care Plans for Nurses and Midwives**

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

Nov 8 **Best practice for Clinical Audit for Nurses and Midwives**

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

Nov 9 **Become More Assertive**

This short online programme is designed to help nurses and midwives develop their skills to be more assertive and help them make decisions with conviction; to deal with difficult situations and people and to influence others positively.

Nov 9 **Leg Ulcer Assessment and Management**

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

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

Nov 16 **Medication Management Best Practice Guidance for Nurses and Midwives**

This education programme supports nurses and midwives in providing safe, evidence-based practice in the area of medication management thus preventing medication errors and near misses. The programme will cover key topics such as: the key principles of medication management, the medication management cycle, management of controlled drugs and medication safety.

Nov 16 **Person-centred Care Planning**

The aim of this online programme is to outline the nurses' role in the process of person-centred assessment and care planning for service users within a legal and professional framework. This programme is relevant to management and frontline staff, who work in residential care and disability services.

Nov 17 **An Introduction to the Management of Chronic Disease in Primary Healthcare**

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

Nov 23 **End of Life Care in Residential Care Settings for Older Persons**

This online programme outlines information specific to the care and support of residents and their families in end of life care. The course aims to recognise signs and symptoms of deterioration, and will assess, monitor and review, physical, psychological, social and spiritual areas of care at end of life for the person. Participants will be able to identify and apply effective interpersonal communication with families of a loved one at end of life during this difficult period. Furthermore the outline of debriefing of staff and bereavement care for residents and relatives is addressed.

Nov 23 **Wound Management**

This short online course will advise participants on wound care management. Topics covered on the day include; wound healing, wound bed preparation and treatment options, and dressing selections.

Nov 24 **Diabetes CBT and General Wellbeing**

This online course is for nurses and midwives who have an interest in the management of a patient with diabetes. The literature would suggest that diabetes, chronic disease management and the self-care that is associated with it brings high incidence rates of depression, anxiety, and negative thoughts. The use of different strategies, cognitive behavioural therapy (CBT) and clinical trials look at the area of wellbeing and theories and models to help clients and healthcare providers try and formulate plans to look at these issues.

Nov 25 **Healthcare Provider CPR** *(in person at the Richmond Education and Event Centre, Dublin)*

This course will equip the participants with the necessary theory and skills for the provision of CPR (cardiopulmonary resuscitation) and AED (automated external defibrillation) use in emergency situations, in line with the latest guidelines recommended by the American Heart Association. The care of the adult, child and infant will be included. The certificate awarded on completion of the course has a life span of 2 years. After this time it will then be necessary for nurses and midwives to re-certify. Times: 9-10.30am, 11-12.30pm or 1-2.30pm. Fee: €135 INMO members; €175 non members.

Nov 30 **Introduction to Treating and Preventing Pressure Ulcers**

This short online course will advise participants on pressure ulcer prevention. Topics covered on the day include; causes of pressure ulcers, risk assessment, and prevention of pressure ulcers.

Dec 1 **Infection Control Regulation 27: Guide to Thematic/Focused Inspections in your Facility**

This course is for staff who are interested in infection prevention and control standards. It will identify key areas relevant to the new focused HIQA infection control guidelines/inspections (October 2021). This programme will provide information and outline the actions required by registered providers to ensure that procedures, consistent with the national standards for infection prevention and control in community services, published by HIQA, are implemented by staff.

INMO Professional

INMO
Irish Nurses and Midwives Organisation
Working Together

Webinars & Conferences for Nurses and Midwives

Annual Operating Department Nurses Section Conference

Saturday, 8 October 2022

Venue: **The Limerick Strand Hotel, Limerick**

Fee:
€85 INMO members;
€120 non members

Morning Session, Chairperson – Karen Eccles INMO ODN Section

09.00 *Registration and trade exhibition*

10.00 **Opening Address, Karen McGowan, INMO President**

10.10 **Nurse-led Corneal Cross-linking**
Speaker: Diana Malata, ANP, Royal Victoria Eye & Ear Hospital

10.30 **Promoting workplace health and wellbeing through culture change: An evidence review**
Speaker: Dr Kathryn Lambe, Research Officer, Health Research Board

11.00 **Leading healthcare in the post pandemic era**
Speaker: Steve Pitman, INMO Head of Education

11.30 *Trade exhibition and coffee*

Mid Morning Session, Chairperson - Sandra Morton, INMO ODN Section

12.00 **Major haemorrhage**
Speaker: Catherine Nix, Consultant Anaesthetist Intensivist, University Hospital Limerick

12.30 **Motivational Speaker – 'My Journey to the End of the World'**
Speaker: Nuala Moore, Extreme Swimmer

1.15 *LUNCH and trade exhibition*

Afternoon Session, Chairperson - Liz Waters INMO ODN Section

2.30 **Breast Surgery Innovations in UHL**
Speaker: Claire Keane, Theatre Department, University Hospital Limerick

2.40 **Awake / Asleep Fibre Optics**
Speaker: Sheila Clancy, Theatre Department, University Hospital Limerick

2.50 **Menopause & Shift Change**

3.30 **Panel Discussion**

4.15 Evaluation and competition winners

To book
www.inmoprofessional.ie/conference
or call 01 6640641/18

Book Now

Dec 2 **Tools for Safe Practice** *(free for INMO members)*

This course provides safe practice tools to protect the nurse and midwife. This is an awareness session to ensure all staff have an understanding of the process involved regarding patient alerts, clinical incidents and thorough assessment. The programme addresses patient safety and staff safety and provides five key tools on areas of documentation, clinical incident reporting, safety statements, best practice guidelines regarding assessment and communication practices in a complex multifaceted healthcare arena.

Dec 6 **Risk Management and Incident Reporting**

This new online programme outlines the core principles of best practice in managing risk, underpinned by the philosophy and care needs. At the end of the session participants will be enabled to: understand key terms and definitions related to risk management in healthcare; outline the stages of the risk management process based on the international standard and framework for risk management; outline the five steps of risk assessment; understand the purpose and maintenance of a risk register and complete accurate records of incidents for incident reporting. Ultimately, this programme promotes best practice with risk management and patient safety.

Dec 7 **Peripheral Intravenous Cannulation** *(in person at the Richmond Education and Event Centre, Dublin)*

This programme provides guidance to participants in the skill of peripheral intravenous cannulation. Instruction will be provided on the sites used for peripheral intravenous cannulation, identifying criteria for evaluating a vein and the principles of an aseptic technique. The aim is for participants to be able to carry out the procedure in a competent and safe manner. While this course will provide the necessary knowledge and skills to undertake peripheral intravenous cannulation, it will be necessary for each nurse and midwife attending to ensure that they abide by their local policy on peripheral intravenous cannulation in their place of work. Fee: €90 INMO members; €145 non members.

Dec 7 **Introduction to Management and Leadership Skills for Nurses and Midwives**

The aim of this short online programme is to identify key managerial and leadership competencies for front line nursing/midwifery managers and to explore how these are applied in practice. The programme will include management theory, effective leadership and team working as well as delegation and clinical supervision.

Dec 8 **Restrictive Practices in Residential Care Settings for Older People**

Restrictive practices in the residential care is a half-day webinar programme that encourages participants to reflect on interventions that could be seen as restraining residents if viewed from a resident's perspective. Many interventions within healthcare environments can restrict movement of older people. They are unintentional and can be argued as in the best interest or for the protection of residents, for example, a nursing home locked at night to protect residents and staff from intruders.

INMO
Irish **Nurses** and **Midwives** Organisation
Working Together

TOOLS FOR SAFE PRACTICE

FREE Practical Advice Workshops on the following critical issues;

- **Clinical Risk**
- **Report and Statement Writing**
- **Documentation**
- **Incident Reporting**
- **Fitness to Practise Complaints**

3 CEUS

FREE Online Sessions

OCTOBER
Friday, 14 October

NOVEMBER
Friday, 4 November

Time: 10am - 1pm

€65 for non INMO members

NOTE: PLEASE QUOTE YOUR MEMBERSHIP NUMBER when booking your place

The INMO is providing a nationwide series of 3 hour workshops in your workplace to provide information and guidance to members in a challenging climate.

This workshop is Approved by Nursing and Midwifery Board of Ireland (NMBI) with **3 Continuing Education Units (CEUs)**

TO BOOK YOUR PLACE
Email: **deborah.winters@inmo.ie** or Call: **01 6640618**
For further information please contact your Industrial Relations Officer.

SCAN ME

INMO library services – a resource for all members

This month we offer an overview of the resources available to members through the INMO library

Whether you are commencing studying this autumn, or if you are just looking to update your knowledge on a topic, the INMO Library provides a range of services and resources to support you through your professional career.

We aim to provide a person-centred service to you not only as a formal student, but also for your continuing professional development as you progress through your career.

The information below describes the services and information provided by the Library and its professional staff.

Library Services

Literature searches

The library offers a literature searching service which is available to members. The library staff will discuss the search requirements and email you a list of references. This can be useful if you are having difficulty finding relevant articles or if you do not have enough time to complete your search yourself.

Remote search consultations

If you require assistance with searching techniques the library staff can now facilitate remote consultation. Please contact the library to make an appointment.

Reference desk queries

Are you looking for an incomplete reference for a bibliography or finding it difficult to locate an article? The Library's reference desk service will be able to assist in solving those tricky situations.

Introduction to Effective Library Searching Skills (3 CEUs)

The Library staff run an online education programme on library searching techniques and managing information. Facilitated by the Librarians, this programme provides essential skills on searching for evidence to assist with policy development, clinical guidelines as well as evidence-based nursing and midwifery. The programme forms part of the INMO Professional's suite of education programmes and is worth 3 CEUs. Please contact us for more information on course dates, visit **www.inmoprofessional.ie**. or see below.

Nurse2Nurse

Nurse2Nurse is an electronic library and portal containing a wealth of e-resources and a wide range of hand selected materials covering all aspects of nursing and midwifery. The chief aim is to assist in the education and professional development of nurses and midwives with relevant, credible and current information available seamlessly through one website.

Nurse2Nurse journals

This menu provides simple access to over 1,300 journals available electronically and in print format from the Library. Below is a current sample listing of the core nursing and midwifery journals held.

- *British Journal of Community Nursing*
- *British Journal of Midwifery*
- *British Journal of Nursing*
- *Emergency Nurse*
- *Cancer Nursing Practice*
- *Midirs Midwifery Digest*
- *Nursing Children and Young People*
- *Nursing Older People*
- *Nursing Management*
- *Nursing Standard*
- *Nursing Times.*

Trial to new database: Cinahl Ultimate

The INMO Library is currently trialling a new database Cinahl Ultimate. It is available through www.nurse2nurse.ie on the Search Databases page and Cinahl link. We would like to invite you to check it out and let us know what you think of it. We would also like to know if there are other resources that you find helpful for your studies. Please contact library@inmo.ie with your comments.

Contact the Library

If you require any assistance to access www.nurse2nurse.ie or would like to make an appointment to visit in person, you can contact us at library@inmo.ie or Tel: 01 6640614/25. Opening hours: Monday to Thursday, 8.30am-5.00pm; Friday, 8.30am-4.30pm.

Online – Introduction to Effective Library Search Skills

Next course date: Monday, October 17, 2022

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

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

INMO Professional

RCM i-learn

THE ROYAL COLLEGE OF MIDWIVES

Facilitating active birth

A new i-learn module looks at the theory and practice around supporting women to use different positions during labour

BEING upright in labour has endless advantages and while this is well documented, it raises the question: why are women still giving birth on their backs, on a bed?

There is clear and important evidence that walking and upright positions in the first stage of labour reduce the length of time in labour, the risk of Caesarean birth and the need for epidural. Based on the current findings, it is recommended that women in labour should be informed of the benefits of upright positions and encouraged and assisted to adopt positions in which they feel comfortable.[1]

The skill of the midwife is in using their knowledge of anatomy and physiology in day-to-day practice to recognise the presentation, position and degree of flexion of the foetus and suggest positions that may assist rotation and increase the woman's level of comfort.

This updated module explores the theory and practice around supporting women using different positions throughout labour and birth, including:

- An overview of the relevant anatomy and physiology
- A relevant historical discussion and inclusion of research and evidence that supports good practice
- The midwife's role in supporting and providing information to women
- Some of the positions that can be used.

This will help you in suggesting to women to use different positions during labour and birth in order to manage pain and encourage physiological labour and birth.

This module will take approximately two hours to complete.

Why it matters

In a Royal College of Midwives audit in 2010, it was demonstrated that midwives did encourage many women to adopt different positions during labour and birth but nearly a third still used the more traditional recumbent position during labour and nearly 50% of women gave birth in the recumbent position.[2] It was not clear whether the lack of use of different positions was related to feelings of a lack of confidence or knowledge or whether the birthing environment itself affected the positions suggested and used.

Role of the midwife

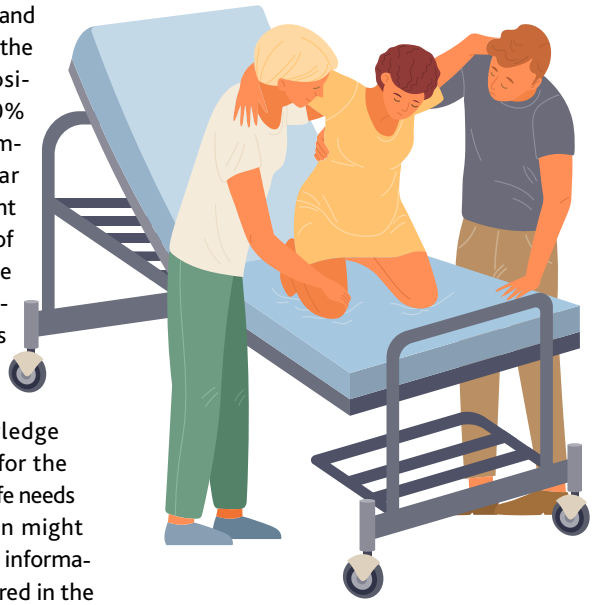
The midwife and their knowledge is the most important support for the woman and her family. The midwife needs to think about what the woman might need in terms of preparation and information and what needs to be prepared in the birth environment. It is also important to provide student midwives with a good role model and a demonstration of how evidence is applied to real-life practice.

It is also important to support the woman in her choice and, where required, act as her advocate if she is not being supported by others. For example, if she needs continuous monitoring, this does not mean she cannot change position.

Learning outcome

After completing this module you will:

- Be able to describe the relevant anatomy and physiology relevant to positions during labour and birth
- Be able to describe the normal mechanism of labour and the effect of position on this
- Be familiar with the key research and evidence regarding positions and mobility during labour and birth
- Feel more confident in suggesting different positions that a woman can adopt during labour and birth



- Consider the differences that you, as a midwife have to put into place in supporting a women adopting a more active approach to labour and birth.

References

1. Lawrence A, Lewis L, Hofmeyr G, Styles C (2013) Mothers' positions and mobility during the first stage of labour. https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD003934.pub4/full

2. Royal College of Midwives (2010) Royal College of Midwives Survey of Positions used in Labour and Birth Final Report, in RCM Audit of Practice, Munro J, Editor. 2010, Royal College of Midwives: London

RCM i-learn access for INMO midwife members

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

Spotlight on leadership

Clinical leadership

WITH a focus on clinical leadership, this article provides a brief overview of this style of leadership and its importance in the context of nursing and midwifery and the broader health service.

Although there is a growing body of literature on clinical leadership, there remains a lack of consensus over a common definition.[1] Similarly, many of the papers exploring clinical leadership refer to a vast array of characteristics or attributes. However, some of the common attributes include: clinical competence/good clinical practice; effective communicator; supportive; values/beliefs focused; and a focus on clinical excellence/quality care.[2]

Like other styles of leadership, clinical leadership was initially associated with more formal leadership roles or positions. However, with an increasing need to improve effectiveness and efficiencies of care in the health service, clinical leadership is increasingly associated with the roles of nurses and midwives of all grades and levels.[3]

Although, clinical leadership skills can be acquired and developed in the workplace, there is a need for education programmes to enhance the learning experience. In particular, early-career nurses and midwives, may not always recognise the skills they have or may undervalue the role they are playing in terms of clinical leadership. Therefore, education is essential for the development of these skills.[4] Specifically, there is a need to ensure the development of the pre-registration curricula to include clinical leadership skills.[5]

Several barriers to clinical leadership have been explored in the academic literature. Stanley et al summarise some of the common barriers that are identified in research studies over the years.[6] For example, some research points to conflict that can arise in health professionals due to the need for them to remain clinically focused while also taking on management functions.

The absence of a clear definition of clinical leadership can lead to a lack of understanding of the term. An Irish study examining the self-perceived barriers to clinical leadership found that: "Clinical leadership development can be constrained by barriers associated with interdisciplinary working and in particular, by the perceived and actual influence that nurses and midwives have in both clinical and wider organisational decision-making."[7]

Adding to the wealth of academic literature, over recent years several reports – both national and international – have identified leadership and clinical leadership as being central to patient safety and improved outcomes. High-profile enquiries into patient safety also identified this. In the UK the Morecombe Bay Investigation recommended a review of governance for clinical leadership in obstetrics and midwifery.[8] The Francis Report investigating the failures at Mid Staffordshire Hospital recommended that in order prioritise patient safety, leadership must be established at all levels "from ward to the top of the Department of Health".[9]

Similarly in Ireland, clinical leadership has emerged over the past number of years as a necessity within health service for nurses and midwives. A needs analysis study undertaken by the HSE stated that for nurses and midwives "clinical leadership involves influencing and motivating others to deliver clinically effective care by demonstrating clinical excellence, and providing support, and guidance to colleagues through mentorship, supervision and inspiration".[9]

Clinical leadership also allows the professions to demonstrate their voice within the multidisciplinary team. The clinical leadership centre for nursing and midwifery in the ONMSD is responsible for delivering a national approach to the development of clinical leadership skills offering programmes, workshops, pathways and a national competency framework for nurses and midwives. Further information on the programmes they run can be found on the office's website: the following link: **healthservice.hse.ie/about-us/onmsd/**

While the research on clinical leadership is still emerging and some barriers exist in terms of its implementation, it is a crucial component for practising nurses and midwives. It is also central to delivering a change agenda to provide responsive, quality improvement initiatives.

Contributing to this series

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

Niamh Adams is head of library services and Steve Pitman is head of education and professional development

References

1. Mannix J, Wilkes L, Daly J. Attributes of clinical leadership in contemporary nursing: an integrative review. Contemp Nurse. 2013;45(1):10-21. doi:10.5172/conu.2013.45.1.10

2. Stanley D, Stanley K. Clinical leadership and nursing explored: A literature search. J Clin Nurs. 2018;27(9-10):1730-1743. doi:10.1111/jocn.14145

3. Ogrin R, Barrett E. Clinical leadership and nursing. Aust Nurs Midwifery J. 2015;23(2):45

4. Evans N. How you can develop your clinical leadership skills. Nurs Manag. 2022; 29(2): 14-15

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8. Francis R. Report of the Mid Staffordshire NHS Foundation Trust public inquiry: executive summary, 2017; The Stationary Office

9. Health Service Executive. The national nursing and midwifery clinical leadership needs analysis study. 2009; Dublin: HSE

Making progress

Róisín O'Connell welcomes new students and urges recent graduates who are starting out in their careers to become full INMO members

WELCOME back to all our student nurses and midwives. Over the next few weeks, I will be travelling to all the 13 colleges and universities of nursing and midwifery across the country to encourage the first-year students to sign up with the INMO. Those who miss these opportunities can easily join online at **www.inmo.ie** Membership is free for students, so please let your fellow students and friends know about this. Perhaps you could put it on your Instagram page.

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.

Applying for membership

Congratulations to those of you who are graduating. This is such an exciting time. Don't be afraid to branch out into different aspects of the professions and to take all the opportunities that come your way. Don't be afraid to ask questions and if you are unsure of something always seek advice, as nurses and midwives we are always learning.

Until now you would have enjoyed our free student membership. But as you are graduating from a student nurse/midwife to a staff nurse/midwife it is time for you to look into applying for full membership. You will receive further correspondence from the INMO prior to this.

I encourage you to continue to protect your registration by becoming a full member of the INMO. There are great benefits to being part of this union including:

- Ensuring access to expert support, advice, and guidance with regard to all employment and industrial relations issues
- Having a say in one of the largest professional organisations in the health sector
- Ensuring appropriate support and representation, if required in the event of a fitness to practise hearing with the NMBI
- Access to relevant courses, both online and in-person, to assist with your further professional development obligations at discounted rates for INMO members
- An array of special offers and discounts exclusively available to INMO members at **www.inmo.groupscheme.com**
- Free access to the INMO library and information office services, including access to up-to-date relevant developments, important to you as nurses/midwives
- Access to the INMO Rewards Scheme, supported by Cornmarket, where members can get discounts on car insurance, home insurance and health insurance.

Class photos

Many of you will be graduating from college over the coming weeks. It would be great to get a collection of the graduating or last day photos of newly qualified nurses and midwives. Please send photos to: roisin.oconnell@inmo.ie along with where the picture was taken. Hopefully we can publish them in *WIN*.

Get involved as a rep

Now more than ever, it is essential for each class to have a student rep to link in with me. If your group does not have an INMO student rep, please discuss this among yourselves and nominate one rep per year, discipline and placement area, if you are spread across multiple sites. Note that INMO student reps are distinct from student union reps as the INMO is the professional body representing nurses and midwives dealing with matters relating to the workplace. Being a rep doesn't mean taking on lots of work and solving your class's problems by yourself. A rep is someone who lets me know their group's collective issues so that I can either address these or bring them to the attention of senior management so that your voice can be represented at national negotiations. If you are interested in learning more, please do not hesitate to contact me at roisin.oconnell@inmo.ie

A new-graduate's experience of Tallaght's critical care programme

AS A student nurse I always admired the experienced nurses I was fortunate enough to work with and wondered how I would ever get to that stage. The transition from student to graduate felt like a huge challenge. With so much to learn and the step up in responsibility, it was daunting. In my case, this emotion was amplified by accepting my first staff nurse role in the intensive care unit at Tallaght University Hospital (TUH). It was hard to comprehend that in a few short months you could go from student nurse to ICU staff nurse, but you can, and I did.

Being part of the first cohort of new-graduate nurses to train within TUH ICU I was very excited and it was a challenge I was eager to take on. With a 12-week new graduate programme tailored to ICU nursing I felt supported in this environment. Through both theoretical learning and high fidelity simulation as part of the blended learning programme, I started to feel confident in my new role. I began working within the experienced ICU team and with the support of the clinical facilitators, in an environment centred on the value of education, I knew I had made the best choice for my career development.

Previously, clinical experience would have been required before working in the critical care environment, however the opportunity to start from day one and learn the fundamentals of ICU nursing is now available to new graduates. The benefits of this career pathway from new graduate to advanced practice, including the ongoing support and focus on education, is why I chose a career in ICU.

In my short ICU career to date, I have already had so many opportunities and new experiences. I am commencing the National Foundation Education Module in Critical Care Nursing and had the opportunity to be involved as a co-creator on a new-graduate nurse in critical care support app that won the Dublin regional finals of the Spark Ignite Innovation Programme Awards.

If I look back and acknowledge how far I've come from my first 12 weeks in ICU, when everything felt foreign, it has really been an amazing year. I look forward to the challenges and opportunities to come. I hope to continue my education to postgraduate level and become the nurse I aspired to be as a student.

A further 15 new graduate nurses are ready to start the programme in October 2022.

Shauna Vandendries was one of the first four new-graduate nurses to commence the New-graduate Nurse in Critical Care Programme in TUH in October 2021

Workplace welfare

With European Week for Safety and Health at Work taking place this month, **Karen Eccles** emphasises the importance of nurses and midwives feeling safe, supported and protected in the workplace

THE Covid-19 pandemic has significantly changed the standards required for the health and safety of workers, heightening health and safety awareness and bringing weaknesses in current practice and design to our attention. Improving workplace health and safety standards where modern technologies and processes are being introduced is an ongoing challenge and new risks will continue to emerge.

The European Agency for Safety and Health at Work (EU-OSHA) is an established leader in the promotion of safer, healthier and more productive workplaces throughout Europe. Its expertise in the collection, assimilation and sharing of reliable workplace health and safety data is aimed at advancing knowledge and increasing workplace health and safety awareness. Central to its role is the promotion of a culture of risk prevention.[1]

EU occupational safety and health (OSH) legislation, its regulations and codes of practice are essential to protect the health and safety of the almost 170 million workers in the European Union. They set out minimum standards for safety and health in the workplace which are then implemented through our national legislation, one such example is the current EU Sharps Directive.

The EU-OSHA places such importance on workplace health and safety that it assigns the 43rd week of each year as European Week for Safety and Health at Work. During this week, which falls from October 24-28 this year, it continues to promote current health and safety campaigns such as 'Healthy Workplaces Lighten the Load 2020-2022', which is aimed at tackling work-related musculoskeletal disorders.

Musculoskeletal disorders affect three in every five workers and can have an adverse effect on psychosocial health and wellbeing, which underlines the importance of work-related stress risk assessments in the management of this risk.

Despite progress we must not be complacent, the health and social work sector in Ireland reports approximately 1,400 injuries each year, accounting for 20% of all workplace injuries reported to the Health and Safety Authority (HSA) annually. Reported incidents indicate three main accident triggers in the healthcare sector:

- Manual handling (patient handling and handling of inanimate loads)
- Slips, trips and falls (on the level)
- Work related shock, fright and violence.[2]

The HSA Strategy Statement 2022-2024 also supports the safety representative role where it currently states it will prioritise all aspects of the role of safety representatives and increase health and safety compliance through inspection, surveillance and enforcement.

High-quality worker involvement and consultation in the identification and control of risks is recognised as an essential component of any safe workplace. In recognition of this the INMO – through the current national, safety and health and welfare at work strategy, utilising the Safety, Health and Welfare at Work Act (2005) (sections 25 and 26) and recent agreements reached with the HSE – aims to recruit and train INMO safety representatives in all work locations.[3]

It is essential that we as nurses and midwives challenge health and safety concerns in our workplace collaboratively with the employer. Early interventions can reduce both the immediate and cumulative long term ill health effects that increase absenteeism and work-related stress, and impact on career longevity, especially in the midst of a globally recognised nursing workforce crisis.

Hazard identification is central to the management of workplace risk. During this awareness week, nurses and midwives can take the opportunity to increase and share their knowledge and understanding of:

- Workplace safety statement
- Workplace risk assessments
- Workplace occupational health and safety policies such as:
  - HSE integrated risk management policy parts 1-3, 2017[4]
  - HSE policy on the prevention and management of stress in the workplace, 2018[5]
  - HSE policy on the prevention and management of work-related aggression and violence, 2018.[6]

The HSE has put in place comprehensive policies and procedures established by the Health and Safety Function Unit (HSFU) and the Workplace Health and Wellbeing Unit supporting the occupational health and safety of nurses and midwives in the workplace. You can contact the HSFU helpdesk for support at Tel: 1800 444925.

If you would like further information on the safety representative role and training, please contact me at: karen.eccles@inmo.ie

Karen Eccles, INMO national safety, health and welfare at work representative. email: Karen.eccles@inmo.ie

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A column by Maureen Flynn

Quality & Safety

Walk and Talk Improvement – a new podcast

IN THIS month's column we introduce a new way of hearing about quality and patient safety. In the wake of the Covid-19 pandemic, podcasts have seen a tremendous growth as a media channel, with 45% of listeners across the UK and Ireland joining within the past 12 months.[1]

We chose a podcast because audio format is agile and more flexible, accessible anytime and anywhere. As a response to this growing shift in communications, the National Quality and Patient Safety Directorate (NQPSD) in collaboration with the Health and Social Care Services Quality Improvement, Northern Ireland (HSCQI NI) team have co-designed an all-Ireland podcast titled *Walk and Talk Improvement: Ideas for Safe Quality Care*.

Aim

We aim to use the podcast to share ways to improve patient care by capturing the personal stories of people who work in and use health services regarding patient safety and quality improvement, and make these conversations available through a new communication platform.

The initial project scope includes the development of six episodes, based around the six themes of the HSE Patient Safety Strategy (PSS), 2019-2024.[2] Each episode focuses on one of the themes of the PSS. Central to development of the episodes is the inclusion of an all-Ireland 'voice' to provide more than one health systems perspective on the ranging topics within the PSS.

Who is involved?

We use a co-design approach, testing and learning from the experience of producing each episode. Key to our success is the participation of patient partners, who are members of the project group, and feature both as guests and hosts in the podcast.

Benefits and outcomes

Podcasts are a great way to capture people's attention as it is more conversational than a document, article or webinar and can bring stories to life. The podcast was launched on September 13, with the first four episodes now available to listen to as part of communication plan for World Patient Safety Day last month. *See box for episode details*.

Get involved

When you are next planning your walk or stepping challenge why not listen to the podcasts and share your reflections at your next team meeting or journal club. You can find the series by searching for "Walk and Talk Improvement" on Spotify, Amazon Prime, YouTube, or Google Podcasts.

Maureen Flynn is the director of nursing ONMSD, QPS Connect lead, HSE National Quality and Patient Safety Directorate

Acknowledgements
Thank you to my colleague Sheema Lughmani, digital communications officer for assistance in writing this column. An enormous thank you to our podcast hosts and participants, Clifford Mitchell, Dave Milliken, Carol McCullough, Linda Craig, Bernie O'Reilly, Dr John Fitzsimons, Dr Mary Browne, Caroline Lennon Nally, Elaine Fallon, Dr Leonard Douglas, Dr Athinyaa Shiraviraj, Lucy Nugent, Roisin Egenton, Yvonne Young, Christine Sheehan, Dr Brian McCloskey, Dr Gemma Moore, Gemma Willis, Mr Keith Synnott, Damian McGovern, Grainne Cosgrove and Prof Deirdre Madden

Walk and Talk Improvement: Ideas for Safe Quality Care episodes

Episode 1: Empowering and enabling patients: The importance of patient partners
Summary: This episode focuses on partnering with patients, service users and carers. You'll hear more about how to capture patient stories and why they matter to our healthcare services. Topics include: learning and applying quality improvement, capturing the voice of service users and how patients, service users, carers and their families can become active participants in improving health services

Episode 2: Empowering and Engaging staff: What is staff engagement?
Summary: In this podcast episode, you'll hear from five healthcare colleagues on what staff engagement means to them, and how colleagues within teams are using it to provide peer to peer support. We also hear from leaders on the value of staff engagement, and how and why they support it

Episode 3: Reducing harm in healthcare: Recognising the deteriorating patient
Summary: In this episode, we're exploring improvement efforts to address one of the most common causes of patient harm: recognising and responding to the clinically deteriorating patient. Topics include the importance of clinical judgement; communication between staff as well as communication with patients and families; safe systems and safe culture; as well as personal experiences and examples of successful improvement efforts that have made a difference

Episode 4: Using data to improve: "No data without stories, no stories without data"
Summary: In this episode, we cover how data can be used for assurance and improvement. You'll hear how combining different types of data presented in the right way can help boards and committees in leading and overseeing healthcare organisations in quality and patient safety. We'll also hear the importance and value of board and committee members engaging with people's lived experiences of using and working in healthcare

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Irish Nurses and Midwives Organisation
Working Together

Royal College of Midwives

All Ireland Annual Midwifery Conference

Midwives - Visible and Valued

Thursday, 17 November 2022

Venue: **Slieve Russell Hotel, Co Cavan**

IN PERSON EVENT

MORNING SESSION:

09.00 Trade exhibition, poster display

09.30 Registration

09.45 **Mindful movement -** Aparka Shukla, Mindfulness, MBSR & Yoga Teacher

10.00 **Opening - KEYNOTE**
Angela Dunne, HSE, National Lead Midwife women & Infant Health Programme, HSE

10.20 **Humanising Birth**
Mary Curtin, Assistant Professor/Lecturer in Midwifery, UCD

10.50 **Home birth - Southern Trust Home birth team**
Mary Cronin, Self Employed Community Midwife

11.30 Morning break and trade exhibition

11.50 **All Ireland MLU Network**
Maria Healey, Senior Lecturer in Midwifery Education, QUB and
Patricia Leahy Warren, Professor in Maternal and Infant Health, UCC

12.20 **Concurrent Workshops**

The Re:Birth Project: developing a shared language around birth
Lia Brigante, Policy and Practice Advisor, RCM

Caring for You - Making a difference
Lynn Collins, Director of Field Services, RCM

INMO

RCM

AFTERNOON SESSION:

13.00 Lunch

14.00 **Workshops repeated**

14.40 **Burnout**
Jean Doherty, CPC Holles Street, MSc , BSc Midwifery, Diploma Hypnobirthing

15.10 **Panel Discussion - All Speakers**

15.45 Evaluation and close

BOOKING INFORMATION

INMO:
www.inmoprofessional.ie/conference
or email: **education@inmo.ie**
or call **01 6640641/18**

RCM:
https://www.rcm.org.uk/rcm-events/2022/all-ireland-midwifery-conference

Engagement: Improving the patient experience

Orla Kenny urges nurses and midwives to consider how they could increase patient engagement in their day-to-day practice

PATIENT engagement is a simple way of improving patient experience and patient safety, yet it is not always practised in the healthcare setting. Hospitals receive many formal complaints each year that could have been avoided by staff using a patient engagement approach to care.

Patient engagement involves the active participation of a patient in their own care. The patient and their family should be supported, encouraged and empowered by staff to take a central role in the decision-making process concerning their healthcare. With this support the level and depth of active involvement should be set by the patient and their family in line with their own preferences.

Patient engagement is not only the responsibility of frontline healthcare staff, it is equally important that the senior management team embraces a patient engagement agenda and embeds it in the culture of the hospital so it becomes a 'that's the way we do it here' ethos.

There are multiple levels of patient engagement from consultation to partnership.[1] A truly engaged patient shares leadership and partnership with healthcare staff in their direct care, in the governance structure of the organisation and in policy making. A consultation-approach to patient engagement involves the patient being provided with information about their clinical care, given the opportunity to provide feedback on their experiences and invited to partake in focus groups.

While this approach is both proactive and inclusive, it remains surface level to the engagement continuum and yet still proves to be a challenge in the healthcare setting today. The end goal for patient engagement is to achieve meaningful partnership with our patients in decision making and shared leadership at governance level. This involves patients having equal representation at committee and board level.

Patient engagement contributes to better quality healthcare by improving patient outcomes and patient experiences.[2,3] Engaging patients in the design of services and the planning of care demonstrates a commitment to person-centred care.[4] Involving the patient and their families ensures that care is appropriate to their needs and is in keeping with their personal preferences. Embracing patient engagement builds a culture that accepts feedback and improves services accordingly.

Meaningful engagement focuses on delivering outcomes that matter to patients and their families. There are however factors that impede patient engagement. From a patient viewpoint these factors include, but are not limited to, capacity, willingness to engage, beliefs about the patient role and health literacy. From a healthcare viewpoint, such factors include organisational culture and senior management buy-in.

Healthcare staff can promote patient engagement within services by acknowledging that patients are partners in planning their own care. In practical terms, to ensure that engagement is both realistic and meaningful, staff can for example maintain clear, concise and regular communication with the patient and their families. Staff can care for patients and their families with dignity, respect and kindness, ensuring these values are afforded to those in receipt of healthcare.

Staff can strive to provide care that is co-ordinated and multidisciplinary. In real terms that means using joined up thinking, clear communication across the multidisciplinary team and caring for the patient holistically.

Staff can support patients and families to develop their knowledge, skills and confidence to make informed decisions. This could be achieved by staff providing verbal, written and access to electronic information to patients, not only about diagnosis and treatments but also about healthcare processes such as admission, transfer and discharge.

Patients and their families can be empowered by staff to participate in service design and policy development through involvement at focus group, committee and board level. This aspect of engagement provides a platform for the patient voice within healthcare organisations, therefore staff should strive to support the patient and family to provide their feedback and lived experiences of a service.

This feedback can then be used to inform change through recommendation development and quality improvement (QI) implementation. Active involvement in engagement driven QI will afford healthcare staff, particularly those at the frontline, the opportunity to partake in positive change in their own services that will be meaningful to staff and patients alike.

There are many examples of successful engagement driven QI across our healthcare services to improve communication, reduce risk and improve patient experience.

Perhaps at the next reflective practice or brainstorming session with your colleagues, try to determine what elements of patient engagement you can apply to improve your healthcare services and patient experience.

Orla Kenny is the patient engagement manager for the RCSI Hospital Group

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Evolution and progress

Diana Malata looks back at 125 years of nursing in Dublin's Royal Victoria Eye and Ear Hospital

I ARRIVED in the Royal Victoria Eye and Ear Hospital (RVEEH) from the Philippines on a beautiful day in October 2004. It was sunny but cool. I was fascinated by the beauty of the red brick Victorian building against the blue sky and I felt lucky that I had the opportunity to work there.

In 2022, I still pass the entrance hall daily, where I am greeted by the bronze memorial of Sir Henry Swanzy, one of the founders of the hospital. As I make my way up the granite staircase passing the stained glass window and the bust of Sir William Wilde, I always wonder what nursing here was like when the hospital opened in 1897.

Sir Wilde described the duties of the nurse in the hospital's annual report in 1857. As that time it was known as St Mark's, before its amalgamation with the National Eye Hospital to become the RVEEH.[1] His descriptions included the washing of linens and towels, maintenance of cleanliness and accountability of items in the hospital under the nurse's care.[1] He does not mention caring for patients or any sort of technical knowledge.[1]

It was in the late Victorian period when Florence Nightingale started revolutionary reforms that transformed nursing; she formalised nursing education to establish science-based nursing care.[2] Nursing was established as a reputable and highly respected profession by the beginning of the 1900s.[3]

The RVEEH nurse training school was established in 1944 by Mary Frances Crowley who joined the hospital as assistant matron and a nurse tutor, becoming the director of nursing studies in 1947.[1] The RVEEH was recognised by the Irish General Nursing Council for nurse training in 1945.[1]

In 1948, recognising the demand for specialist trained nurses, Ms Crowley went on to establish the first ophthalmic nurse training school in Ireland. This course was extended to the Moorfields Eye Hospital in London in 1950, becoming the Ophthalmic Nursing Board Certificate of Great Britain and Ireland.[4]

(Main photo) RVEEH heritage picture of nurses at the hospital in the early 20th century; (above left) Some of the current nursing staff at the RVEEH pictured outside the hospital; (far right) Mary Reynolds (née O'Connor) pictured in 1965; and (left) Hilda Bolton who has had two corneal transplants at the hospital, in 1978 and again in 2016

Widely recognised internationally, the development of nursing education at the RVEEH conferred notable prestige on Ms Crowley and the hospital. In 1974, she established the Faculty of Nursing in the Royal College of Surgeons in Ireland (RCSI), the first of its kind in Ireland and the UK, in which she was appointed the first dean.[4]

Marie Reynolds (*pictured above*) did her nurse training in RVEEH in 1965 and remembered Ms Crowley as her tutor. She recalled that Ms Crowley was strict but "very inspiring". Ms Reynold's fond memories of her time in RVEEH shone through as she told me the story of her training.

She remembered her blue uniform with starched apron and hat, with black socks and black shoes. She recalled Ms Crowley in the classroom as she lectured, not just about nursing but other subjects such as ethics too. She'll never forget Ms Crowley telling them that "improvisation is the mother of invention".

As a nurse trainee, she stayed in the second-floor accommodation of the hospital where they had to be in bed by 10pm. I listened in awe, as she told me that patients had to lie flat on their backs for six weeks after their cataract operation. The nurses had to feed them and make sure that they were comfortable. She loved chatting to patients and hearing their stories.

Ms Crowley's legacy lives on as the RVEEH, jointly with RCSI, is still very much involved in postgraduate nursing programmes. The programme is designed to facilitate nurses to acquire advanced theory-based education using a modular structure to provide specialist nursing care in a variety of clinical settings in the hospital.

In 2005, the increasing demand in nurse-led services encouraged RVEEH to support nurses to take on extended roles. The hospital appointed a clinical nurse specialist (CNS) in ophthalmic emergency department (ED) and a CNS in ear, nose and throat (ENT) ED to improve patient care, reduce waiting times and optimise medical capacity. Over the years there have been many improvements in nursing

in RVEEH and nurse-led services were set up to improve access and enhance patient care (*see Table*).

Surgical techniques have also developed with the help of technology and have improved patient experience. Hilda Bolton was 24 years old when she had corneal transplant in her left eye in 1978. She was a young teacher at that time and was struggling with her vision due to keratoconus, a condition that produces a cone like progressive bulge of the cornea causing the vision to deteriorate.

Corneal transplant was a pioneering procedure in Ireland in the 1970s and was only done in RVEEH. Ms Bolton stayed in the RVEEH for four weeks after the surgery, lying flat and had to be fed by nurses. She was told not to read, not to bend, not to do anything. It was a traumatic experience for her as she was newly married and was just starting her career as a teacher. Her tape recorder playing music in the ward helped.

"I felt isolated and cut off from my family. What helped me was chatting with other patients and the nurses who were very caring and compassionate," she explained.

Some 38 years later, in January 2016, Ms Bolton returned to the RVEEH for a second corneal transplant in the same eye, as her vision had deteriorated. I met her in the ward, and although I reassured her that the recovery would be better compared to the first transplant, she was still very anxious.

This time she stayed in the hospital for just three days and it was a much better experience for her.

"So much has changed in RVEEH, the surgical technique had improved so that I did not have to stay in the hospital for weeks, but the culture of care had not changed. There's a great sense of community and warmth in the hospital, the nurses were very kind and helpful to me," Ms Bolton added.

Looking at the history of nursing in the RVEEH, I can see the lengths the nurses went through to ensure that patients received the quality of care they needed. It was not an easy journey as there were many difficulties along the way. Such experiences however, helped to build the foundation of RVEEH nursing.

On behalf of the RVEEH nurses, we pay tribute to those who have gone before us, laid the foundations of nursing in ophthalmology and ENT, and opened doors for us to expand nursing services and improve patient care. We acknowledge the nursing management for their support and appreciation. We also acknowledge the doctors who have always supported us.

My message to all RVEEH nurses is to be immensely proud of our contribution to this great institution that has stood the test of time and continues to provide specialist care and promote values of care and compassion. The RVEEH has influenced the world of nursing in Ireland and beyond, and I know that the future is bright for nursing here in the next 125 years.

Table: Nursing achievements and services set up in RVEEH

2005	• CNS in Ophthalmology ED and CNS in ENT ED appointed to reduce patient waiting time in ED
2005	• Nurse-led chalazion/cyst clinic was set up
2007	• Oncology liaison nurse appointed in ENT OPD. The service works closely with head and neck consultants and is involved in the weekly Rapid Access Head and Neck clinic. The service involves support and advocating for the patients along their cancer journey and liaises with MDT staff in the RVEEH, St James's Hospital and St Luke's Hospital, Rathgar
2008	• First nurse-led ear micro-suction clinic in Ireland
2010	• A dedicated ocular oncology service was established in the RVEEH in conjunction with St Luke's Hospital, with a CNS in ocular oncology. Prior to this, all patients were referred to St Paul's Eye Unit in Liverpool for the radiological management (brachytherapy) of uveal melanoma
2012	• CNS glaucoma service set up to manage stable glaucoma
2015	• Ann O'Sullivan accredited as first ANP in ophthalmology in Ireland
2016	• Ireland's first nurse-led corneal cross-linking service for the treatment of keratoconus started. The service was shortlisted at the HSE Excellence Awards in 2017 and won the INMO CJ Coleman Research Award in 2017. It was featured in New Zealand's *Eye on Optics* December 2021 issue • Nurse-led medical retina clinic was set up, resulting in the establishment of the first nurse-led intravitreal injection procedure lists in the Republic of Ireland. This initiative was shortlisted for review by the HSE Excellence Awards in 2017
2017	• Nurse-led post-cataract clinic was set-up • A dedicated stand-alone cataract unit was established and opened to meet the growing demand for cataract surgery that could not be met within the existing eye theatres
2018	• Staff nurses in eye OPD were upskilled and started running the glaucoma assessment clinic, performing slit lamp examination, intraocular pressure measurement, stereoscopic imaging and visual field testing. This was the first such glaucoma clinic service in Ireland and has since been replicated in the community setting
2019	• Nursing staff in the ward looked after complex time sensitive head and neck surgery cases over an eight-week period, providing opportunity to upskill • New nurse-led telephone triage was evaluated as a method of prioritising essential visits to the ED. This ensured appropriate referral, reduced patient flow time and optimised medical capacity while offering an opportunity to treat patients at home in line with Sláintecare • Deirdre Carroon CNM2 ED awarded the first Ophthalmic Nurse of the Year Award • Nurse-led keratoconus clinic and post-operative cataract clinics were set up pioneering Tpro (video consultation software) as a virtual platform • Nurse-led virtual rhinology clinic set up
2020	• ANP in glaucoma appointed to manage stable complex glaucoma • The macular treatment centre opened and the first intravitreal injection foundation course for nurse injectors was held, the first of its kind in Ireland, resulting in four new CNSs who are now competent in delivering 45% of all intravitreal injections. This unit is paperless
2021	• Seven staff nurses from RVEEH supported colleagues in St Vincent's University Hospital ICU for four weeks, having a catalyst effect in the hospital group resulting in further support from other organisations • ENT liaison nurse specialist appointed • Fellowship of the Faculty of Nursing and Midwifery (FFNMRCSI) by examination awarded to ANP Diana Malata
2022	• RVEEH nurse tutor/practice course co-ordinator Sabrina Kelly appointed honorary clinical lecturer in RCSI in recognition to her contribution to nurse education • CNS in oculoplastic appointed

Diana Malata is an advanced nurse practitioner in ophthalmology, cornea and anterior segment at the Royal Victoria Eye and Ear Hospital, Dublin

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End-of-life care during Covid

Restrictions imposed by Covid-19 made the end-of-life care of children infinitely harder for families and healthcare professionals, writes **Tyrone Horne**

THE care of a dying child and their family is never easy for healthcare professionals, but this emotional aspect of caring for children became even more challenging during the Covid-19 pandemic. Children's lives were turned upside down by the pandemic, with severe disruptions to schooling, interaction with friends and family, and social isolation.

During the pandemic, children with pre-existing and life-limiting conditions still required care. Providing end-of-life care (EOL) during this period was extremely challenging. The population was mandated to social distance, isolate and wear face masks. To protect patients and healthcare staff and reduce the spread of the virus, the use of personal protective equipment (PPE) and restrictions on visiting within healthcare settings were a necessity. Some of these measures remain within healthcare and have created stress and an additional burden for children and their families, as well as for the healthcare professional delivering care.

The need to wear facemasks and PPE has posed a particular challenge for nurses in relation to communication with children and their families. Humans rely on facial expressions to help them to read emotions during social interactions. The requirement to wear face masks has made conversations and communication more challenging and this challenge is heightened during difficult conversations, such as communicating a poor prognosis or telling a family that their loved one is going to die.

Delivering bad news

In recent years Ireland has introduced a greater degree of training around the best practice for delivering bad news, but unfortunately Covid-19 made implementing this very challenging for healthcare providers.

Since the beginning of the pandemic, I have been involved in several 'breaking bad news' conversations. Near the start of the pandemic, with one particular family I was involved with over a short period at the end of their loved one's life, I participated in several conversations on my own and as part of the team with several consultants and other members of the multidisciplinary team (MDT).

All of these interactions were extraordinary; the first was my initial meeting with the patient's mother and grandparents in a small room where I had to push myself into the corner to keep my distance and where we all wore masks. I could not see their faces and they could not see mine. It was difficult to express the usual warmth you try to show towards families in this position. I wanted them to know I was there to support them at what would be the worst time of their lives, as it looked like their child/grandchild would not survive. In a normal conversation like this you might acknowledge what they are saying by quietly responding "I know", "I understand" or with a little smile when they recall a happy memory, but they could not hear or see this behind the mask.

For the healthcare professional, it was challenging to get a feel for what stage of acceptance or understanding the family members were at. The small non-verbal facial expressions, like the biting of the lip to hold back tears, were difficult to look out for. Often families in this situation speak softly or while crying, which makes it hard to catch, even if they are not wearing a mask.

The second meeting I recall was a large group comprising six family members and five members of staff. This took place in a large family room, everyone again donning masks, unlike any family meeting that any of the professionals would have been involved with previously. We spread awkwardly around the room, not making eye contact with each other, so the little nods we would often give each other to jump into the conversation or to indicate that we had something to add could not take place. Even something very simple like having a tissue to slide discreetly to a family member became more cumbersome.

In addition to masks creating a barrier between the healthcare professional and the child and their family, social distancing posed a problem when dealing with parents at the end of their child's life. Many colleagues have expressed how difficult it is not to put your hand on a family member's shoulder as an expression of consolation. Instead, we had to learn to stand back at such an emotional time in these families' lives.

Grieving families often need tactile interaction, but during the pandemic many parents had relatives who were cocooning or they themselves were cocooning, so the support they would usually have was not available. When a child dies in a hospital

setting, families often want to embrace a staff member as they leave, as they have just shared a special, albeit it sad, experience with them. To stand back and say "sorry I can't" did not feel normal. Often a hug can also be exactly what a staff member needs following an event such as the death of a child under their care.

As per national guidelines, many healthcare settings were following strict protocols on visitation. Unfortunately, this included at the end of life in some cases. Even for children, only parents were allowed to be present at his awful time. In some instances, nurse managers had to use clinical judgement based on compassionate grounds to provide much needed support for parents who may have been otherwise alone at such a distressing time.

Delayed grief

Much has been written about the delayed grief that many will face following this pandemic, from not being with their loved ones at the end of their life to grieving alone or without support.

The mental health of healthcare professionals has also suffered, as we have been unable to be physically close and have often been hidden behind our PPE. We have also had to be the only people present for parents and families to cry and share a sad laugh with.

Another significant change during the pandemic has been the families' post-death experience. Often before a child dies, the healthcare professional will prepare families for what will happen, including how funerals can look. Often families are told there are no rules for a child's funeral, eg. releasing balloons or playing modern pop songs in church, etc. However, during the pandemic, the number of people allowed at funerals was extremely limited, particularly in the first year of Covid-19 when the maximum funeral attendance was capped at 10.

Children's funerals are often packed with communities showing their support. How often have we heard the saying that Ireland does death, dying and funerals well? Most families have far more than 10 people who want or need to attend.

That support that bereaved parents and close family normally receive was often absent during the pandemic, but even before getting to a funeral, other aspects changed. In hospitals, parents often take their deceased child home themselves, but this was often not possible during the pandemic.

Long-term impact

Covid-19 had a detrimental effect on those involved in the end-of-life care of children. The way we provided care had to be adapted. Although adaptation is an everyday part of healthcare, usually it is done in an attempt to improve situations. In this scenario, things only got worse. It left many healthcare professionals feeling like we had been cold to families. The families themselves longed for the comfort of their loved ones and craved the support of their community.

We are yet to discover the impact that delayed grief and suffering from the loss of loved ones during the pandemic might have on families in the coming years, as well as on the staff who cared for these children at the end of their lives.

Tyrone Horne is a clinical nurse co-ordinator for children with life-limiting conditions at Cork University Hospital

The 5th All-Ireland Children's Palliative Care Conference will take place on November 17 and 18, 2022 at the Titanic Hotel, Belfast. Register via ***www.cpcc.ie***

Impact of ageism and stereotyping on old age

More awareness around ageism and how it can negatively affect the health of older people is needed, writes **Tope Omisore**

STEREOTYPES of old age and ageism are major challenges that face the delivery of care to older people and their health.[1] This article discusses ageism and stereotypes of old age, common ageist views and stereotypes of old age, the facts about old age and older people, the impact of ageism on their health as well as some solutions to ageism in our society.

Ageism and stereotypes

Each person ages in a unique and individualised manner, yet ageing is stereotyped.[2] Ageism is defined as making discriminatory over-generalisation about individuals or a group based on their age.[3] Ageism involves an assumption about how an older person will act or react and what they will experience without recourse to the uniqueness and individual characteristics of the older person.[4]

Stereotypes of ageing usually portray older age and ageing in a negative light, associating them with poor physical and mental health, and a decline in cognitive and physical functions.[2,4] Stereotypes of ageing can be positive; for instance, when the older person is seen as knowledgeable, fit and rich.[2,4]

A negative ageist view entails seeing an older person as a passive recipient of care, one who does not need to contribute or make a decision about his or her care,[5] having a belief that an older person is too weak to contribute in their care, whether as an individual or as a group.[6]

Ageism is socially tolerated, unchallenged and subtle. It is often institutionalised. It can manifest in the form of jokes or writing that is discriminatory against older people. Ageist views can also be held by older people themselves and healthcare workers, including nurses, without being aware of them.

Table 1. Common ageist views and stereotypes of old age[1]

• Old age is a stage of life to be afraid of because it is associated with disability and death
• Old adulthood is associated with depression, and so, older people should withdraw from their roles in society
• Old people cannot learn new complex skills
• Health promotion is not necessary for cohorts of older people who live with two or more chronic health conditions
• Some level of senility is expected in old age
• Urinary incontinence is a normal part of ageing which is best managed with the use of a continence appliance
• Unavoidable decline in intellectual abilities is associated with old age

The facts

Historically older people have been seen as passive members of society who are to be facilitated and aided. However, there is evidence now to challenge this narrative. Evidence, as presented below, has shown older people as givers and contributors, whether at an individual level, family level, community level or even at a national level.[7]

The Irish Longitudinal Study on Ageing (TILDA) found that a good proportion of older people who still have parents assist their parents with activities of daily living such as cleaning, bathing and some people give financial aid to their parents.[8]

Many older people are now involved in making friends online or through in-person adult classes, and fostering relationships within the family settings.[7] Several older people are involved in sporting activities and eating out, where they make friends/relationships. They are also actively involved in activities in religious settings, and non-governmental organisations through which they make social connections.[8]

According to the TILDA third wave (2019), older people whose parents are still alive make regular contact with their parents. Also, more than five out of 10 older people participate in active and social activities once a week and more than four in 10 participate in organised group activities once a week.[8] One other area where older people are actively involved in social networks is through the use of social media such as Facebook and LinkedIn. An increasing number of older people are making use of these social media platforms to maintain social ties with friends, family members and neighbours.[9]

Older people participate in community activities such as voting, and many of them are also being voted for. For example, the presidents of Ireland and the US are examples of older people in politics. Older people are seen as active and important in the electoral process so much so that politicians specifically target this group.[10,11]

Impact of ageism

Ageism influences the perception of others about older people, as well as older people's self-perceptions.[4] Negative self-perception of ageing has been associated with low self-confidence, which impacts on emotional and physical health, including the immune and the cardiovascular systems.[12,13,14] Furthermore, in a systemic review and meta-analysis involving academic papers from 45 countries and involving more than seven million older people by Chang et al, the analysis showed negative effects of ageism at individual and institutional levels.[15] Ageism had effects on 11 health themes in all 45 countries. As such, this illustrates the global challenge of ageism and the need for swift action to enlighten the public about the contributions that older people can and do make to our society.

Way forward

Common in the literature among the barriers to the older people continuing their roles as active social agents in terms of lifestyle, social networks and community activities are illness/disability, lack of accessibility to transport system, lack of opportunities to perform roles, death of friends and loved ones, fear of social rejection and ageism.[16,17,18] The global Covid-19 pandemic has also been a major barrier, as many older people had to cocoon away from friends and family. Also, there are ongoing restrictions on visitors for older people residing in long-term care settings, thereby reducing the level of social connectedness of the older people.

To facilitate older people continuing to be active at family, community and national levels, there must be political will on the part of government at all levels to formulate enabling policies for older people. Social amenities must be put in place to facilitate older people leading a socially productive life. In addition, individuals and groups have to be educated about the existence of ageism and the associated impacts on older people.[1]

Table 2. Summary of facts about older people to counteract ageism[1]

- Most older people live independently and have a high level of self-reported health
- It is untrue to say that health promotion is not effective in the cohort of older people living with chronic diseases
- Although depression is common among older people, it is treatable and preventable
- 'Senility' is an inaccurate term used to describe symptoms of dementia which is a pathological condition
- In most situations, identifiable causes of incontinence can be found and treated in older people using interventions such as bladder training, and pelvic floor exercises
- Older people are capable of learning new skills, though the speed with which they learn may reduce
- Older people may experience some decline in some cognitive abilities but other abilities increase

Nurses need to be aware of any ageist view they may hold and counter them with facts through training and education. Older people need to be seen with the eyes of wellness. There is a need to give holistic care to older people, the care that takes cognisance of their body, spirit and mind. More emphasis needs to be placed on the strengths of the older person rather than on their disability, through care planning focused on wellness.

Conclusion

Contrary to the view that older people are passive and unhealthy members of society, older people are active contributors to their families, communities and the nation at large. In many countries, politicians see the older demographic as a strong force to be reckoned with.

There is an increasing worry that older people are beginning to experience role overload as many of them can have many role expectations. Continuing to see older people as passive, and other age stereotypes, can negatively impact the health of the older person.

Therefore, there is a need for public enlightenment about the existence of ageism and its negative implications. Finally, more concerted efforts are needed to eliminate or reduce the minimum, barriers to older people's social productivity and healthy ageing.

Tope Omisore is a staff nurse at Aras Mhathair Phoil, Castlerea, Co Roscommon

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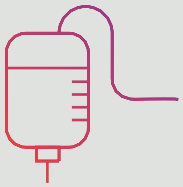
1. Check

all patients with HF regularly for anaemia and ID[1]



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For full prescribing information refer to the Summary of Product Characteristics (SmPC)

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Presentation: Solution for injection/infusion. Available as a 10mL vial (as 500mg of iron) and 20mL vial (as 1000mg of iron).
Indication: Treatment of iron deficiency when oral iron preparations are ineffective or cannot be used or if there is a clinical need to deliver iron rapidly. The diagnosis must be based on laboratory tests.
Dosage and Administration: The posology of Ferinject follows a stepwise approach:
Step 1: Determination of the iron need;
The individual iron need for repletion using Ferinject is determined based on the patient's body weight and haemoglobin (Hb) level. The table in the SmPC should be used to determine the iron need.
Step 2: Calculation and administration of the maximum individual iron dose(s);
Based on the iron need determined, the appropriate dose(s) of Ferinject should be administered:
A single Ferinject administration should not exceed:
• 15 mg iron/kg body weight (for administration by intravenous injection) or 20 mg iron/kg body weight (for administration by intravenous infusion)
The maximum recommended cumulative dose of Ferinject is 1,000 mg of iron (20 mL Ferinject) per week.
Administration rates for intravenous injection:
For iron doses of 100mg to 200mg, there is no prescribed administration time. For doses >200mg to 500mg, Ferinject should be administered at a rate of 100mg iron/min. For doses >500mg to 1,000mg, the minimum administration time is 15 min.
Administration of intravenous drip infusion:
For iron doses of 100mg to 200mg, there is no prescribed administration time. For doses >200mg to 500mg, Ferinject should be administered in a minimum of 6 mins. For doses >500mg to 1,000mg, the minimum administration time is 15 mins.
Ferinject must be diluted in 0.9% m/V NaCl but not diluted to concentrations less than 2 mg iron/mL.
Step 3: Post-iron repletion assessments
Contraindications: Hypersensitivity to Ferinject or any of its excipients. Known serious hypersensitivity to other parenteral iron products. Anaemia not attributed to iron deficiency. Iron overload or disturbances in utilisation of iron.
Special warnings and precautions: Parenterally administered iron preparations can cause potentially fatal anaphylactic/anaphylactoid reactions. The risk is enhanced for patients with known allergies, a history of severe asthma, eczema or other atopic allergy, and in patients with immune or inflammatory conditions. There have been reports of hypersensitivity reactions which progressed to Kounis syndrome (acute allergic coronary arteriospasm that can result in myocardial infarction). Ferinject should only be administered in the presence of staff trained to manage anaphylactic reactions where full resuscitation facilities are available (including 1:1000 adrenaline solution). Each patient should be observed for 30 minutes following administration. If hypersensitivity reactions or signs of intolerance occur during administration, the treatment must be stopped immediately. Symptomatic hypophosphataemia leading to osteomalacia and fractures requiring clinical intervention has been reported. Patients should be asked to seek medical advice if they experience symptoms. Serum phosphate should be monitored in patients who receive multiple administrations at higher doses or long-term treatment, and those with existing risk factors. In case of persisting hypophosphataemia, treatment with ferric carboxymaltose should be re-evaluated. In patients with liver dysfunction, parenteral iron should only be administered after careful risk/benefit assessment. Careful monitoring of iron status is recommended to avoid iron overload. There is no safety data on the use of single doses of more than 200mg iron in haemodialysis-dependent chronic kidney disease patients. Parenteral iron must be used with caution in case of acute or chronic infection, asthma, eczema or atopic allergies. It is recommended that treatment with Ferinject is stopped in patients with ongoing bacteraemia. In patients with chronic infection a benefit/risk evaluation has to be performed. Caution should be exercised to avoid paravenous leakage when administering Ferinject.
Special populations: A single maximum daily dose of 200 mg iron should not be exceeded in haemodialysis-dependent chronic kidney disease patients. The use of Ferinject has not been studied in children. A careful risk/benefit evaluation is required before use during pregnancy. Ferinject should not be used during pregnancy unless clearly necessary and should be confined to the second and third trimester. Foetal bradycardia may occur during administration of parenteral irons, as a consequence of hypersensitivity. The unborn baby should be carefully monitored during administration to pregnant women. **Undesirable effects:** Common (≥1/100 to <1/10): Hypophosphataemia, headache, dizziness, flushing, hypertension, nausea, injection/infusion site reactions. Rare (≥1/10,000 to <1/1,000): Anaphylactoid/anaphylactic reactions. Frequency not known: Kounis syndrome, hypophosphataemic osteomalacia. Please consult the SmPC in relation to other undesirable effects.
Legal category: POM
MA Number: PA0949/004/001
Date of Authorisation: 19.07.2007
MA Holder: Vifor France, 100-101 Terrasse Boieldieu, Tour Franklin La Défense 8, 92042 Paris La Défense Cedex, France

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Document number: IE-FCM-2200020
Date of preparation: 02/2022

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Adverse events should also be reported to Vifor Pharma UK Ltd. Tel: +44 1276 853633. Email: medicalinfo_UK@viforpharma.com

ESC: European Society of Cardiology; **HF:** heart failure; **ID:** iron deficiency; **IV:** intravenous; **LVEF:** left ventricular ejection fraction.

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IE-FCM-2200067 Date of preparation: July 2022

VIFOR PHARMA

Updated guidelines on iron deficiency anaemia

The British Society of Gastroenterology recently updated its guidelines on the management of iron deficiency anaemia in adults

IRON deficiency anaemia (IDA) is common and a major cause of morbidity and burden of disease worldwide. Its many causes include poor dietary intake and malabsorption of dietary iron, as well as a number of significant gastrointestinal (GI) pathologies, including cancer. Therefore, where there is no obvious explanation for IDA, GI investigations should be considered urgently in newly diagnosed adults.[1]

IDA may present in primary care or across a range of specialties in secondary care. Because of the insidious nature of the condition, the British Society of Gastroenterology (BSG) recently updated its guidelines for the management of iron deficiency anaemia in adults in the light of more recent evidence and developments.[1]

Because blood is iron-rich, IDA can result from chronic blood loss. Therefore a common underlying cause for the development of IDA may be, for example, menstrual or GI blood loss. Approximately one-third of men and postmenopausal women presenting with IDA have an underlying pathological abnormality, most commonly in the GI tract. Therefore optimal management of IDA requires iron replacement therapy (IRT) in combination with appropriate investigation to establish the underlying cause.[1] The BSG states that unexplained IDA in all at-risk individuals is an indication for fast-track referral to secondary care because GI malignancies can present in this way, often in the absence of specific symptoms.

Definition

The WHO defines anaemia as a haemoglobin (Hb) concentration of:

- < 130g/L in men over 15 years of age
- < 120g/L in non-pregnant women over 15 years of age
- < 110g/L in pregnant women in the second and third trimester.[2]

The updated BSG guidelines recommend that iron deficiency should be confirmed by iron studies prior to investigation. Serum ferritin is the single most useful marker of IDA, but other blood tests, such as transferrin saturation, can be helpful if a false-normal ferritin is suspected.[2]

Following diagnosis by blood testing, iron deficiency anaemia can be treated by iron replacement therapy using the oral or intravenous route. The BSG strongly recommends that a good response to iron therapy (Hb rise ≥ 10g/L within two weeks) in anaemic patients is highly suggestive of absolute iron deficiency, even if the results of iron studies are uncertain. The recommended initial investigation of confirmed IDA should include urinalysis or urine microscopy, screening for coeliac disease and in appropriate cases, endoscopic examination of the upper and lower GI tract.[1]

Age, sex, Hb concentration and mean cell volume are all independent predictors of risk of GI cancer in IDA, and need to be considered as part of a holistic risk assessment, according to the BSG, which pointed out that the cancer risk in iron deficiency without anaemia is low. Bidirectional GI endoscopy is the standard diagnostic approach to examination of the upper and lower GI tract. In those not suitable for colonoscopy, CT colonography can be considered.

Hb levels normalise with IRT in most cases of IDA, but iron deficiency recurs in a minority of these on long-term follow-up. The BSG recommends consideration of long-term IRT when the cause of recurrent IDA is unknown or irreversible. After the restoration of Hb and iron stores with IRT, it is recommended to monitor the blood count periodically to detect recurrent IDA.

In those with negative bidirectional endoscopy of acceptable quality and either an inadequate response to IRT or recurrent IDA, the BSG recommends further investigation of the small bowel and renal tract to exclude other causes.

Treatment of iron deficiency anaemia

Iron replacement therapy should not be deferred while awaiting investigations unless a colonoscopy is imminent. The BSG recommends that the initial treatment of IDA should be with one tablet per day of ferrous sulphate, fumarate or gluconate. If not tolerated, a reduced dose of one tablet every other day, alternative oral preparations or parenteral iron should be considered.

Limited transfusion of packed red cells may on occasion be required to treat symptomatic IDA, in which case IRT will be necessary post-transfusion. The BSG recommends that patients should be monitored in the first four weeks for an Hb response to oral iron, and treatment should be continued for approximately three months after normalisation of the Hb level, to ensure adequate repletion of the marrow iron stores. Parenteral iron should be considered when oral iron is contraindicated, ineffective or not tolerated.

Special situations

The BSG guidelines on special considerations for certain cohorts, including:

- Young women, in whom major contributory factors for IDA include menstrual losses, pregnancy and poor dietary intake
- Older people: Iron deficiency is common in older people and is often multifactorial in aetiology
- People with specific comorbidities, including advanced chronic kidney disease (CKD), chronic heart failure (CHF), inflammatory bowel disease (IBD) and following GI surgery (such as resection or bypass surgery involving the stomach and/or small bowel, including bariatric surgery). Parenteral IRT may be indicated in some of these cases.

– Tara Horan

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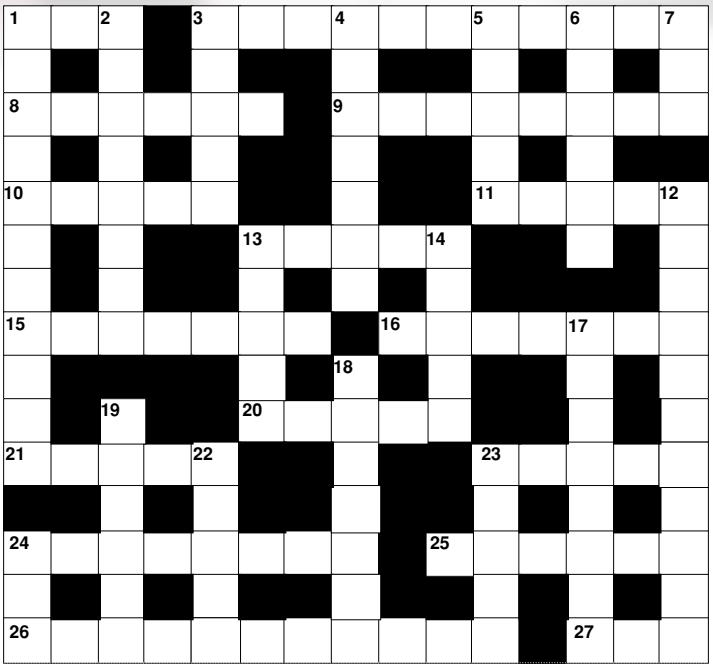
CROSSWORD Competition

Across

1 Peaked headgear (3)
3 Rules for arranging genial tours (11)
8 From which to sip your elevenses (6)
9 One of the skills practised by a tiler (8)
10 Walked cross-country (5)
11 Disciple of an Asian religion (5)
13 Parasites get the correct marks! (5)
15 Struck by a vehicle lacking in energy? (3,4)
16 Fee paid in a restaurant to have your own wine bottle opened (7)
20 Black birds, or castles in chess (5)
21 Age, era (5)
23 Female adult (5)
24 Might one skip half a convenient container for alcohol? (3,5)
25 Tropical American lizard (6)
26 Navel (5,6)
27 Dine (3)

Down

1 Distinctive repeated statement about peach starch (11)
2 These creatures comprise the diet of many whales (8)
3 & 13d Defensive building associated with monasteries (5,5)
4 Condition of pressing importance (7)
5 Durable, rugged (5)
6 Skinny vegetables! (6)
7 Droop (3)
12 How to make Neptune rant, not being minded to feel sorry (11)
13 See 3 down
14 Demonstrates (5)
17 A nickname for water (5,3)
18 Set of implements for a tradesman or DIY enthusiast (4,3)
19 Force one to make the elm cop out (6)
22 Not quite mountainous (5)
23 Town in Greater Manchester (5)
24 Type of cooker (3)



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September crossword solution

Across: 1 Rip 3 Complainant 8 Damson 9 Clean out 10 Quick 11 Event 13 Vixen 15 Rancour 16 Also-ran 20 Trots 21 Lotus 23&3d Alarm clock 24 Foolscap 25 Honshu 26 Tagliatelle 27 Doh

Down: 1 Red squirrel 2 Pump iron 4 Pickaxe 5 Irate 6 Atoned 7 Tat 12 Trench mouth 13 Vault 14 Niles 17 Relapsed 18 Pork pie 19 Strong 22 Sushi 23 Alone 24 Fit

The winner of the September crossword is: Jane Gunn, Donnycarney, Dublin

ICN welcomes WHO workforce report

WHO director describes global shortages as "ticking time-bomb"

THE International Council of Nurses (ICN) has welcomed the publication of the WHO's latest workforce report, which reveals shortages that WHO regional director for Europe Hans Kluge has described as a "ticking time-bomb".

The ICN said that the *Health and Care Workforce in Europe: Time to Act* report highlights many of the issues the Council has raised since the start of the pandemic, including the findings of the *Sustain and Retain* report.

Those issues include the ageing nursing workforce, the uneven distribution of nurses throughout the region, failure of governments to train enough indigenous nurses rather than rely on international recruitment, and the 'Covid effect,' which the ICN said has led to greater sickness-related absences, increased burnout and mental health problems among nurses and higher levels of intention to leave the profession.

Speaking at the recent launch of the report, Mr Catton said: "This report provides baseline information about the health and care workforce across Europe and should be replicated across all of WHO's regions. It highlights the many severe pressures and demands that nurses and other healthcare workers are under at this time.

"The ICN fully endorses the report's findings, including its 10-point plan, which is an urgent call for governments to act immediately to grow their own nursing and healthcare workforces so that they can be self-sufficient in meeting their populations' needs.

"The report recognises the obligation nations have in increasing access to healthcare, but we will only be able to maintain and retain the nursing and healthcare workforce if we support their training and education, and enable them to advance their careers," Mr Catton continued.

"This cannot wait. We need action now, not some five or 10-year plan that never comes to fruition. It is a call to action that must be put in place now: to do otherwise would be to risk that ticking time-bomb blowing up in our faces."

Mr Catton stressed that the WHO must regularly monitor progress on the 10-point plan and report on its delivery.

WHO 10-point plan:

- Align education with population needs and health service requirements
- Strengthen professional development to equip the workforce with new knowledge and competencies
- Expand the use of digital tools that support the workforce
- Develop strategies that recruit and retain health workers in rural and remote areas
- Create working conditions that promote a healthy work-life balance
- Protect the health and mental wellbeing of the workforce
- Build leadership capacity for workforce governance and planning
- Improve health information systems for better data collection and analysis
- Increase public investment in workforce education, development and protection
- Optimise the use of funds for innovative workforce policies.

Lung health groups urge HSE to address delays in 'crucial' breathing tests

The Irish Lung Health Alliance, a coalition of charities promoting lung health, has called on the HSE to address delays in the provision of pulmonary function tests, which are crucial in the diagnosis of a number of lung diseases. The call came ahead of World Lung Day, which took place on September 25. A survey of 19 pulmonary function laboratories revealed widespread staff vacancies and many patients having to wait months or years in some cases for pulmonary function tests. As part of its lung health awareness campaign, the alliance also urged the public to adopt its 'Top Five Steps to Love Your Lungs' by availing of flu, pneumonia and Covid-19 vaccines, quitting smoking, limiting exposure to air pollution, eating a balanced diet and being physically active

Alzheimer Society launches new dementia guidance

NEW guidance to help healthcare professionals and community groups to support people with young-onset dementia has been launched.

Around 64,000 people are currently living with dementia in Ireland and this figure is expected to double within the next 20 years. Young-onset dementia refers to people who develop the condition under the age of 65. Currently in Ireland, up to 4,300 people are affected.

The guidance provides evidence-based recommendations on how dementia service providers can support people with this form of dementia and their families in the community.

See: **www.alzheimer.ie** to read the guidance document.

October

Thursday 6
OHN Section conference. Richmond Education and Event Centre

Saturday 8
ODN Section conference. Limerick Strand Hotel. Bookings essential

Wednesday 19
CPC Section seminar. Richmond Education and Event Centre. Booking essential.

Wednesday 19
22nd National Orthopaedic Nurses Conference Carlton Hotel, Blanchardstown. Contact rosemary.masterson@nohc.ie for further details

Monday 24
National Children's Nurses Section meeting. 11am on Zoom

November

Thursday 3
International Nurses Section meeting. 5pm, Richmond Education and Event Centre

Saturday 12
PHN Section webinar. See *page 54* for further details

Thursday 17
All-Ireland Midwifery Conference Cavan. See *page 38*

Saturday 19
School Nurses Section online meeting. Talk on indemnity cover

Thursday 24
Assistant Directors Section webinar. 11am. Booking essential. Contact education@inmo.ie

Saturday 26
National Children's Nurses Section webinar. 11am. Booking essential. Contact education@inmo.ie

Monday 28
Retired Nurses Section seminar. Richmond Education and Event Centre. Contact education@inmo.ie or call 01-6640618 /41

Wednesday 30
CPC Section meeting. 11am

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

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C	**Private nursing homes**	€228
D	**Affiliate members** *(non-practising)* *Lecturing (employed in universities & IT institutes)*	€116
E	**Associate members** *Not working*	€75
F	**Retired associate members**	€25
G	**Student members**	No Fee

Condolences

- The INMO extends its deepest sympathies to the family and friends of Eamon McMahon. Eamon was a passionate trade unionist and founder of Trade Union Friends of Palestine. As secretary of TUFP (North), Eamon was the driving force behind boycott, divestment and sanctions campaigns within the trade union movement. He was a member of both UNISON and NIPSA throughout his career as a dedicated health professional. He will be sorely missed by all who knew him. *Ar dheis Dé go raibh a h'anam*.
- The Clare and Limerick Branches of the INMO are deeply saddened to hear of the death of Marichu Almazan, ANP in University Hospital Limerick and Ennis General Hospital. We offer condolences to her loving children, her mother and her brothers and sisters. She will be very much missed as the bright light that she was to everyone who knew her and for those that she cared for.

Cork University Hospital Annual Nursing Conference 2023

- The CUH annual nursing conference 2023 will take place on Tuesday, February 28, 2023 in the main auditorium, Cork University Hospital. It will also be streamed live. The theme is 'A Turning Tide: Nurses Influencing the Future'. Keynote speakers will include Geraldine Cunningham, associate director of culture change and wellbeing, Barts NHS Trust London; Sheila McClelland, CEO, NMBI; Jolanta Burke, clinical psychologist and senior lecturer, RCSI; and Derval O'Rourke, Olympian and wellness expert. Submission deadline for abstracts and posters: 5pm, Friday, October 28, 2022.

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To apply, please submit your CV by email to hr@caredoc.ie or for informal enquiries contact a member of the Nursing Management Team on 059 9138199 during office hours

Integrated Care in Inclusion Health Conference & Report Launch

Thursday, 27 October 2022

Topics and speakers include:

- **Keynote 1 Integrated healthcare** - Siobhán Ní Bhriain, National Lead for Integrated Care, Clinical Design and Innovation, Office of the CCO
- **Keynote 2 Integration in Inclusion health** - Cliona Ni Cheallaigh
- **Launch RCQPS study** – (Nurse led-COVID-19 interventions in homelessness) Rachel Kenna and Maureen Flynn

Supported by
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IN PERSON EVENT

9.15am - 4.00pm

The Richmond Education and Event Centre, Dublin

Registration is €20

Book Now

For bookings go to https://www.eventbrite.ie/e/419087621357 or scan the QR code above.

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- Control over your appointments – you'll have complete control over booking your appointments, giving you the flexibility to manage your Inuvi work around other work and personal commitments.
- Training and support – you'll receive full procedural training and access to our dedicated team of specialist advisors.

Contact Julie Collett by email: recruitment@inuvi.co.uk or Tel: (0)1 447 5172

Irish Cancer Society Night Nursing Manager

The Irish Cancer Society are seeking an experienced nursing leader, passionate about palliative care, to lead our night nursing service, ensuring high-quality patient centred care, and managing the effective operation of the service.

- Job description on **www.cancer.ie**
- Email CV and queries to **recruitment@irishcancer.ie**

Irish Cancer Society Night Nurses

The Irish Cancer Society are seeking Registered General Nurses who can provide a minimum of 6 nights per month and have some palliative experience. Training will be provided.

- Job description on **www.cancer.ie**
- Email CV to **recruitment@irishcancer.ie**
- Informal enquiries to Amanda on 01-231 0532

Irish Nurses Rest Association

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

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

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If you are interested in joining the Emergency Department Nursing Team at University Hospital Kerry please contact:

Mairead O'Sullivan, ADON Emergency Department.
T: +353 (0)87 343 1003 • E: mairead.osullivan4@hse.ie

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- **Opportunity to complete ED Foundation Programme / Sponsored Post-graduate Programme*.**

* subject to meeting the relevant criteria

UHK is continually welcoming nurses in **Medicine, Surgery, Orthopaedics, Paediatrics, Theatre, Critical Care, Oncology & Dialysis.** For details on these vacancies please contact: **Joanne Evans,** CNM3 Nursing HR, T: +353 (0) 87 4006751 • E: joanne.evans@hse.ie

Staff Midwife & Community Midwife positions available - great opportunities for family-friendly hours, education and promotion. Contact **Sandra O'Connor**, Director of Midwifery, T: +353 (0)66 7184023 • E: sandra.oconnor@hse.ie

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Webinars & Conferences for Nurses and Midwives

Public Health Nurses Section Webinar

Saturday, 12 November 2022

Time: 11.00am to 1.00pm

Title: Public Health Nursing into the future

FREE LIVE ONLINE EVENT
FOR INMO MEMBERS

Topics will include, amongst others:

- **Health action training**
- **NMBI review of PHN staff requirements**
- **Safe staffing framework in the community**
- **Minding your health and wellbeing**

For further details go to
www.inmoprofessional.ie/conference
or call 01 6640641/18

Book Now

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National Children's Nurses Section WEBINAR

SAVE THE DATE

Saturday, 26 November 2022

From 11am - 1.30pm

FREE LIVE ONLINE EVENT
for INMO members

Topics will include, amongst others

- **Nursing and Midwifery Board of Ireland - Educational Update**
- **Hybrid Higher Diploma in Children's Nursing Programme**
- **All-Island Congenital Heart Disease (CHD) Network**
- **Irish Paediatric Acute Transport Service (IPAT)**
- **Non Accidental Injury – ED Nursing Perspective**

For further details go to
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or call 01 6640641/18

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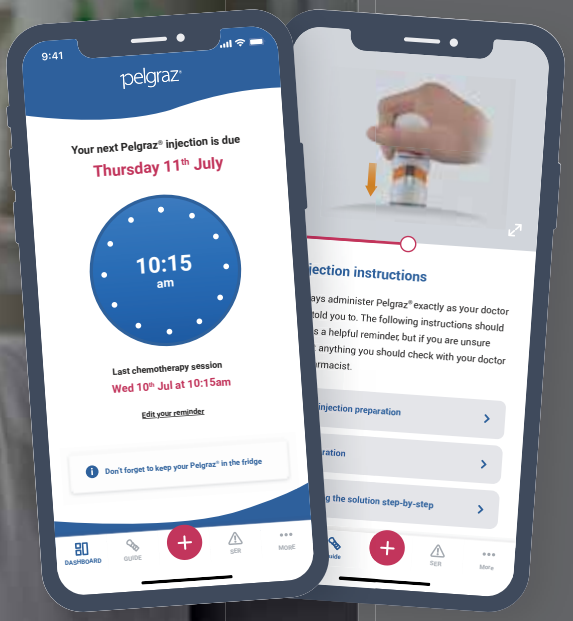

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ABBREVIATED PRESCRIBING INFORMATION

Please refer to the Summary of Product Characteristics (SmPC) before prescribing **Pelgraz▼** (pegfilgrastim) **6 mg solution for injection in pre-filled syringe or pre-filled injector. Presentation:** Each pre-filled syringe or pre-filled injector contains 6 mg of pegfilgrastim* in 0.6 mL solution for injection. The concentration is 10 mg/mL based on protein only**. *Produced in *Escherichia coli* cells by recombinant DNA technology followed by conjugation with polyethylene glycol (PEG). ** The concentration is 20 mg/mL if the PEG moiety is included. **Indications**: Reduction in the duration of neutropenia and the incidence of febrile neutropenia in adult patients treated with cytotoxic chemotherapy for malignancy (with the exception of chronic myeloid leukaemia and myelodysplastic syndromes). **Dosage and Administration**: Pelgraz therapy should be initiated and supervised by physicians experienced in oncology and/or haematology. Posology: One 6 mg dose (a single pre-filled syringe or pre-filled injector) of Pelgraz is recommended for each chemotherapy cycle, given at least 24 hours after cytotoxic chemotherapy. Safety and efficacy of Pelgraz in children and adolescents has not yet been established and no recommendation on a posology can be made. No dose change is recommended in patients with renal impairment, including those with end-stage renal disease. **Method of administration:** Pelgraz is for subcutaneous use. The injections should be given subcutaneously into the thigh, abdomen or upper arm. See SmPC for instructions on handling of the medicinal product before administration. **Contraindications**: Hypersensitivity to pegfilgrastim or any of the excipients in Pelgraz. **Warnings and precautions**: To improve the traceability of biological medicinal products, the trade name of the administered product should be clearly recorded. The long-term effects of pegfilgrastim have not been established in acute myeloid leukaemia (AML); therefore, it should be used with caution in this patient population. Granulocyte-colony stimulating factor (G-CSF) can promote growth of myeloid cells *in vitro* and similar effects may be seen on some non-myeloid cells *in vitro*. The safety and efficacy of pegfilgrastim have not been investigated in patients with myelodysplastic syndrome, chronic myelogenous leukaemia, and in patients with secondary AML; therefore, it should not be used in such patients. Particular care should be taken to distinguish the diagnosis of blast transformation of chronic myeloid leukaemia from AML. The safety and efficacy of pegfilgrastim administration in *de novo* AML patients aged < 55 years with cytogenetics t(15;17) have not been established. The safety and efficacy of pegfilgrastim have not been investigated in patients receiving high dose chemotherapy. This medicinal product should not be used to increase the dose of cytotoxic chemotherapy beyond established dose regimens. Pulmonary adverse reactions, in particular interstitial pneumonia, have been reported after G-CSF administration. Patients with a recent history of pulmonary infiltrates or pneumonia may be at higher risk. The onset of pulmonary signs such as cough, fever, and dyspnoea in association with radiological signs of pulmonary infiltrates, and deterioration in pulmonary function along with increased neutrophil count may be preliminary signs of adult respiratory distress syndrome (ARDS). In such circumstances pegfilgrastim should be discontinued at the discretion of the physician and the appropriate treatment given. Glomerulonephritis has been reported in patients receiving filgrastim and pegfilgrastim. Generally, glomerulonephritis resolved after dose reduction or withdrawal of filgrastim and pegfilgrastim. Urinalysis monitoring is recommended. Capillary leak syndrome has been reported after G-CSF administration and is characterised by hypotension, hypoalbuminaemia, oedema and haemoconcentration. Patients who develop symptoms of capillary leak syndrome should be closely monitored and receive standard symptomatic treatment, which may include a need for intensive care. Generally asymptomatic cases of splenomegaly and cases of splenic rupture, including some fatal cases, have been reported following administration of pegfilgrastim. Spleen size should be carefully monitored (e.g. clinical examination, ultrasound). A diagnosis of splenic rupture should be considered in patients reporting left upper abdominal pain or shoulder tip pain. Treatment with pegfilgrastim alone does not preclude thrombocytopenia and anaemia because full dose myelosuppressive chemotherapy is maintained on the prescribed schedule. Regular monitoring of platelet count and haematocrit is recommended. Special care should be taken when administering single or combination chemotherapeutic medicinal products which are known to cause severe thrombocytopenia. Pegfilgrastim in conjunction with chemotherapy and/or radiotherapy has been associated with development of myelodysplastic syndrome (MDS) and acute myeloid leukaemia (AML) in breast and lung cancer patients. Patients treated in these settings should be monitored for signs and symptoms of MDS/AML. Sickle cell crises have been associated with the use of pegfilgrastim in patients with sickle cell trait or sickle cell disease. Therefore, use caution when prescribing pegfilgrastim in patients with sickle cell trait or sickle cell disease, monitor appropriate clinical parameters and laboratory status and be attentive to the possible association of this medicinal product with splenic enlargement and vasoocclusive crisis. White blood cell (WBC) counts of 100×10^9/L or greater have been observed in less than 1% of patients receiving pegfilgrastim. No adverse reactions directly attributable to this degree of leukocytosis have been reported. Such elevation in WBCs is transient, typically seen 24 to 48 hours after administration and is consistent with the pharmacodynamic effects of this medicinal product. Consistent with the clinical effects and the potential for leukocytosis, a WBC count should be performed at regular intervals during therapy. If leukocyte counts exceed 50×10^9/L after the expected nadir, this medicinal product should be discontinued immediately. Hypersensitivity, including anaphylactic reactions, have been reported with pegfilgrastim. Permanently discontinue pegfilgrastim in patients with clinically significant hypersensitivity. Do not administer pegfilgrastim to patients with a history of hypersensitivity to pegfilgrastim or filgrastim. If a serious allergic reaction occurs, appropriate therapy should be administered, with close patient follow-up over several days. Stevens-Johnson syndrome (SJS), which can be life-threatening or fatal, has been reported rarely in association with pegfilgrastim treatment. If the patient has developed SJS with the use of pegfilgrastim, treatment must not be restarted at any time. As with all therapeutic proteins, there is a potential for immunogenicity. Rates of generation of antibodies against pegfilgrastim is generally low. Binding antibodies do occur as expected with all biologics; however, they have not been associated with neutralising activity at present. Aortitis has been reported after filgrastim or pegfilgrastim administration in healthy subjects and in cancer patients. The symptoms experienced included fever, abdominal pain, malaise, back pain and increased inflammatory markers (e.g. C-reactive protein and WBC count). In most cases aortitis was diagnosed by CT scan and generally resolved after withdrawal of filgrastim or pegfilgrastim. The safety and efficacy of Pelgraz for the mobilisation of blood progenitor cells in patients or healthy donors has not been adequately evaluated. Increased haematopoietic activity of the bone marrow in response to growth factor therapy has been associated with transient positive bone-imaging findings. This should be considered when interpreting bone-imaging results. The additive effect of concomitantly administered products containing sorbitol (or fructose) and dietary intake of sorbitol (or fructose) should be taken into account. Pelgraz contains less than 1 mmol sodium (23 mg) per 6 mg dose, that is to say essentially 'sodium-free'. The needle cover contains dry natural rubber (a derivative of latex), which may cause allergic reactions. **Pregnancy and Lactation**: Pegfilgrastim is not recommended during pregnancy and in women of childbearing potential not using contraception. A decision must be made whether to discontinue breastfeeding or to discontinue/abstain from pegfilgrastim therapy taking into account the benefit of breastfeeding for the child and the benefit of therapy for the woman. **Adverse Events include: Adverse events which could be considered serious include: Common:** Thrombocytopenia. **Uncommon:** Myelodysplastic syndrome, acute myeloid leukaemia, sickle cell anaemia with crisis, capillary leak syndrome, glomerulonephritis, hypersensitivity reactions (including angioedema, dyspnoea, anaphylaxis), splenic rupture (including some fatal cases), Sweet's syndrome (acute febrile neutrophilic dermatosis), pulmonary adverse reactions including interstitial pneumonia, pulmonary oedema and pulmonary fibrosis have been reported. Uncommonly cases have resulted in respiratory failure or ARDS which may be fatal. **Rare:** Aortitis, pulmonary haemorrhage, Stevens-Johnson syndrome. **Other Very Common adverse events:** Headache, nausea, bone pain. **Other Common adverse events:** Leukocytosis, musculoskeletal pain (myalgia, arthralgia, pain in extremity, back pain, musculoskeletal pain, neck pain), injection site pain, non-cardiac chest pain. See SmPC for details of other adverse events. **Shelf Life:** 3 years. Store in a refrigerator (2∞C – 8∞C). Pelgraz may be exposed to room temperature (not above 25°C ± 2°C) for a maximum single period of up to 72 hours. Pelgraz left at room temperature for more than 72 hours should be discarded. Do not freeze. Accidental exposure to freezing temperatures for a single period of less than 24 hours does not adversely affect the stability of Pelgraz. Keep the container in the outer carton in order to protect from light. **Pack Size:** One prefilled syringe or prefilled syringe injector with one alcohol swab, in a blistered packaging. **Marketing Authorisation Numbers: Pre-filled syringe:** EU/1/18/1313/001, **Pre-filled injector:** EU/1/18/1313/002. **Marketing Authorisation Holder (MAH):** Accord Healthcare S.L.U, World Trade Center, Moll de Barcelona, s/n, Edifici Est, 6a planta, Barcelona, 08039 Spain. **Legal Category:** POM. Full prescribing information including the SmPC is available on request from Accord Healthcare Ireland Ltd, Euro House, Little Island, Co. Cork, Tel: 021-4619040 or www.accord-healthcare.ie/products. **Adverse reactions can be reported to Medical Information at Accord Healthcare Ltd. via E-mail:** medinfo@accord-healthcare.com **or Tel:** +44(0)1271385257. **Date of Generation of API:** May 2021. IE-01426

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Adverse events should be reported. Reporting forms and information can be found on the HPRA website (www.hpra.ie), or by e-mailing medsafety@hpra.ie. Adverse events should also be reported to Medical Information via email; medinfo@accord-healthcare.com or tel:0044 (0) 1271 385257

July 2021. IE-01663