€5.75 Vol 26 No 7 September 2018

WIN

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

World of Irish Nursing & Midwifery

Latest INMO CPD education programme
Page 29

Poor pay causes staffing shortfall
page 8

INMO wins on government's fake nursing figures
page 10

10 tips for new students
page 24

Latest CPD: When children fail to thrive
page 39

NEWS & VIEWS

FEATURES

CLINICAL

LIVING

JOBS & TRAINING

WIN – World of Irish Nursing & Midwifery is distributed by controlled circulation to **more than 35,000** members of the INMO. It is published monthly (10 issues a year) and is registered at the GPO as a periodical. Annual Subscription: €155 incl. postage paid. Editorial Statement: *WIN* is produced by professional medical journalists working closely with individual nurses, midwives and officers on behalf of the INMO. Acceptance of an advertisement or article does not imply endorsement by the publishers or the Organisation.

guaranteed irish™

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

(ISSN: 2009-4264)
Volume 26 Number 7
September 2018

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

medmedia publications

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

Production & news editor Tara Horan

Sub-editor Sonja Storm

Designers Fiona Donohoe, Paula Quigley

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

Publisher Geraldine Meagan

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

INMO
Irish Nurses and Midwives Organisation

Editor-in-chief: Phil Ní Sheaghdha

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

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

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

www.facebook.com/irishnursesandmidwivesorganisation

twitter.com/INMO_IRL

Preparing for action on pay

WE ENTER September 2018 without a funded workforce plan for 2018 – yes, that's 2018! The HSE and the Department of Health have not yet agreed the funding that will be made available to grow the nursing and midwifery professions in 2018.

The funded plan is now nine months behind the date set in an agreement with INMO and SIPTU nursing in 2017. It will simply not be possible to develop or grow nursing/midwifery services at this late stage, and this failure is particularly serious in the context of the recruitment and retention difficulties that already exist.

This fundamental breach of the 2017 agreement was scheduled to be addressed at the INMO emergency Executive Council meeting on August 28 – as we go to press – and it is very likely that you, as members will be called upon to publicly show the government and your employers that continued co-operation cannot be one sided.

Agreements brokered in good faith between trade unions on behalf of their members and employers require both parties to honour commitments given. The prospect of facing another winter with staff shortages and an escalating overcrowding problem is simply unthinkable.

As we prepare for Budget 2018 it is disappointing that the Department of Public Expenditure and Reform officials have concluded that the low pay of nurses and midwives is sufficient to retain staff and to recruit more, and that there has been growth in the nursing and midwifery workforce. The INMO has communicated with the Department contesting their conclusions as set out in correction letters to them which you can read on the news pages of this issue of *WIN*, see *pages 10-11*. It is important that we all contest and correct this misrepresentation of the real workforce shortages faced daily by nurses and midwives which has led to high risk practice and increasingly intolerable working conditions.

On your behalf a comprehensive pre-budget submission (full details are available on **www.inmo.ie** and covered on *page 9* of this issue of *WIN*) has been issued to the Minister for Finance. The INMO has held, and continues to hold, a series of meetings with political parties at a national level and is now broadening this to local level in order to emphasise the issues of importance to nurses and midwives that must be addressed in this budget.

We need you as members to get involved in this lobbying campaign. Industrial relations officers (IROs) and Executive Council members will be leading this lobbying effort and will be asking members to join them at meetings with public representatives.

Please contact the IRO with responsibility for your area and join in this campaign to get the message from the frontline to the politicians inside and outside government.

The current position of the Department of Public Expenditure and Reform must be contested by all of us working together to set the record straight: nursing and midwifery are low paid professions and the numbers are simply not sufficient to meet the current demands on the health service.

It is important that all members actively seek opportunities to articulate to public representatives, the real effect of these shortages on the nursing and midwifery professions and the services they provide to all sectors of our community.

It is now time to get your voice heard as part of this campaign: our politicians must be advised that low paid nurses and midwives will not accept a failure to address the real issues they face in their professional lives.

Details of meetings are available from INMO regional offices and IROs.

Phil Ní Sheaghdha
General Secretary, INMO

Your priorities with the president

Martina Harkin-Kelly, INMO president

Time ticking on Pay Commission report

SUMMER seems to have sped by in the blink of an eye. We've just seen the annual Leaving Cert results frenzy, bringing with it the emotional, financial and accommodation challenges that many of our members who are parents will face. All of you will know that the Leaving results aren't the be all and end all, and what's for you will not pass you – despite the education system's often poor preparation for real life. But they aren't the only results nurses and midwives will be watching out for this summer; the Public Sector Pay Commission was, at the time of print, due for publication in late August. It's up to us, the union of midwives and nurses, to judge how we respond in the four-week period following publication. We know all too well that our ventilated health service is barely hanging on only thanks to the sacrifices made by our nursing and midwifery members.

Telling the story – EFN, ICN and Nursing Now

IT CAN sometimes be difficult to see the impact our international nursing organisations have on daily working life but, as your president, I've seen firsthand how important these affiliations are, especially to share the experience of nurses and midwives in Ireland on European and global levels. For example, the general secretary and I recently attended the ICN Triad meeting in Geneva and were able to set the record straight on the much-quoted and misleading OECD figures that exaggerate the number of nurses working in Ireland.

On a European level, the INMO is affiliated with the European Federation of Nurses (EFN). We've been involved since 1971, standing with over three million nurses in 34 European countries. The EFN's primary job is to influence EU policy, ensuring that nurses' views are heard. At every level – international, European or right here in Ireland – nurses need to be recognised as partners in value-based healthcare. The health challenges of the 21st century cannot be overcome without strengthening nursing – as was acknowledged in the recently launched Sláintecare implementation plan. This is where the Nursing Now Campaign comes in. It's a campaign aiming to raise the status and profile of nursing globally, running until 2020 – Florence Nightingale's 200th birthday. The campaign runs with partners such as the International Council of Nurses (ICN) and the WHO. The campaign was set up following a report from the UK parliament, which found that developing nursing improves not only health, but gender equality and economic growth too. You can read more here: **bit.ly/2eWHVhI**

The INMO is fortunate to have the expertise of Elizabeth Adams, the elected president of the EFN, as a board member on the Nursing Now Campaign. We also have Annette Kennedy, ICN president, who will ensure the global impact of the campaign's vision and its continuity long after the initial campaign period. As INMO president, I will be launching this campaign with members of the management team and the National Executive of the INMO. We want to support nurses and midwives to be agents of change. This campaign will make them a key part of the solution to today's health challenges – if nurses and midwives are properly deployed, valued and included in healthcare decisions, true transformation can occur.

Global Nurses United meeting

OUR first-vice president, Catherine Sheridan and Limerick IRO Mary Fogarty, represented the INMO at the Global Nurses United event in July. I would like to thank both of them for their very capable representation in round table discussions on topics such as pay, conditions, staffing, ratios, violence, environmental crises and universal healthcare. Catherine and Mary both reported back on how engaging with the public and media was a key theme of the NSW Nurses and Midwives' Association Annual Conference which they also attended.

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

Quote of the month

"The pessimist sees difficulty in every opportunity, the optimist sees the opportunity in every difficulty."

Report from the Executive Council

AS WE went to press, it was decided to hold an emergency meeting of the National Executive on August 27-28. This will allow us to consider our response to the Public Sector Pay Commission report. Under a previous agreement, we have four weeks to formally respond and begin engaging with the Department of Public Expenditure and Reform.

We will also be discussing the HSE's continued breach of our agreement on a national funded workforce plan. This plan sets out how many extra nursing and midwifery posts the HSE will fund in 2018. We are more than half way through the year and the plan has not materialised, even after several meetings and a referral to the Workplace Relations Commission. As I said in a press release on August 16, it is simply unacceptable to go on like this. We will update members on these issues following the August emergency meeting.

Our next normal Executive Meeting is set for Sept 17-18. This will be one of the first meetings with our new Executive members. I look forward to working with them, and we plan to introduce each of them in the next issue of *WIN*.

Reminder for members: if you are working in conditions where you cannot provide safe care, please complete the disclaimer forms. This will be your only safeguard in the event of a near miss or an incident.

Get in touch

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

Poor pay and short staffing driving nurses and midwives out of Ireland

BURNOUT is now commonplace in nursing and midwifery and unless pay is addressed the recruitment and retention crisis will get worse, the INMO warned TDs and senators recently.

INMO representatives told the Oireachtas Joint Committee on Health that nurses face massive overcrowding in emergency departments, with a record high of 714 admitted patients being cared for on trolleys on one day this year. In addition, there have been nearly 10,000 attacks on acute hospital staff in the past decade, over 70% of which were against nurses.

Due to these conditions and low pay:

- It now takes an average of six months to recruit just one nurse
- Some ED vacancies which arose in 2016 are still unfilled
- Many nurses on maternity leave are not being replaced
- The HSE failed to recruit the required numbers of nurses and midwives in last year's workforce plan and has failed so far to produce a plan for this year.

Speaking after the committee meeting, INMO general secretary Phil Ní Sheaghdha said: "Ireland's health service is in crisis, with nursing staff put under extreme pressure, even in summer. Winter is coming, and I worry that more nurses will either burn out or look for better-paid work overseas.

INMO general secretary Phil Ní Sheaghdha addressing the Oireachtas Joint Committee on Health

Table 1. Comparison of purchasing power of nurses working in public sector hospitals

Country	PPP (€)
Canada	54,536
US	46,834
Australia	42,446
Japan	40,951
Denmark	37,537
Sweden	34,025
New Zealand	33,502
Ireland	32,718

Table 2. Pay scale of staff nurse working in Irish public service

Grade	Salary (€)	% increase
After 1 year	30,802	
After 5 years	36,023	16.95%
After 10 years	42,644	38.45%
After 15 years	45,248	46.90%

"A decade ago, the health minister declared nearly 500 people on trolleys as a 'national emergency'. Yet we've seen days with over 700 people on trolleys in 2018, with little or no political urgency.

"The time for reports and reviews is over. Patients deserve hospitals which are appropriately staffed by properly paid nurses. That will not happen without real investment in the health service."

Responding to the Fianna Fáil health spokesperson Stephen Donnelly's claim that Irish nurses and midwives were well paid compared to other countries, Ms Ní Sheaghdha said: "Irish nursing wages simply aren't at the races when it comes to the international job market. Compared to other recruiting health systems, Irish nurses work longer hours for lower pay. The proof is in the pudding – nurses would not be looking at opportunities overseas if pay and conditions were worse there. Without a pay increase, the health service will not be able to maintain existing capacity, never mind the growth required for a growing and ageing population".

International pay comparison

The INMO provided figures to demonstrate the fact that Irish nurses and midwives are better off financially if they move overseas. The International Council of Nursing has collected data on the purchasing power parity of nurses working in the public-sector hospitals in eight countries including Ireland *(see Table 1)*.

Refuting Stephen Donnelly's argument that similarly-qualified workers in the private sector would have lower starting salaries than nurses and midwives, the INMO pointed to figures *(see Table 2)* that show that even after long service, a staff nurse's pay remains relatively modest.

Sligo reps play their roles:
A role-play exercise featured as part of the rep training course which took place in the Fórsa Offices in Sligo recently. The course was organised by Albert Murphy and Maura Hickey and members were also addressed by INMO president Martina Harkin-Kelly. Pictured during the course were (back, l-r): Albert Murphy, Ciara Eagan, Lorraine Maxwell, Noreen Geraghty and Tracey O'Fiach, (front, l-r) Sharon Murphy, Breege Creaven, Martina Harkin-Kelly and Hardiman Bayle

Budget a 'litmus test' for Ministers on health service

THE government can fix the recruitment and retention problems in the health service and kick-start funding for Sláintecare, the INMO argued in its pre-Budget submission last month.

Citing a projected economic growth of 4% in 2019, the INMO is recommending the government give nurses and midwives the pay rise they have earned, in order to resolve the recruitment and retention crisis in the health services.

There are currently 2,664 fewer nurses and midwives working in the Irish public health service than there were in 2007. There are more than 200 nursing vacancies in emergency departments alone and 207 midwife posts vacant nationally.

The INMO blames these vacancies on low salaries, which have resulted in an inability to recruit and retain these vital professionals.

The government's Health Service Capacity Review found that an additional 1,200 beds are immediately required to meet demand, but the INMO says that such an expansion will not be possible until more nurses and midwives are recruited.

The INMO's submission also recommends that the next Budget includes initial funding for Sláintecare, the proposed universal healthcare system with cross-party backing. The proposed system comes with a recommended transitional fund, €63.5 million of which is to increase hospitals' acute capacity.

Other recommendations include:

- Increasing the number of undergraduate nursing and midwifery training places
- Increasing the number of public health nurses, who provide care in the community
- Significantly expanding primary care services as recommended in the Sláintecare report.

INMO general secretary Phil Ní Sheaghdha said: "Our health service simply doesn't have enough staff. Nurses and midwives remain the lowest paid healthcare professional and the combination of low pay and poor working conditions are driving away nurses and midwives, many of whom are forced to move overseas or leave the profession. If this continues the HSE will not be able to maintain services, let alone consider service expansion.

"Ireland's population is growing, but our health service isn't keeping pace. The Budget is an opportunity for the government to prioritise the introduction of measures that will address the recruitment and retention crisis in nursing and midwifery. If they fail to address nurses' and midwives' pay, they will have missed an opportunity to protect the health service into the future.

"This Budget is a litmus test to see if ministers are serious about fixing the health service. Without funding, Sláintecare risks becoming just another report gathering dust on a shelf."

End of summer and HSE has still failed to produce a workforce plan for 2018

THE HSE is still refusing to confirm how many extra nurses and midwives it plans to hire in 2018, according to the INMO.

Last month the HSE again delayed publication of its funded workforce plan for 2018, which sets out how many nursing and midwifery posts would be funded in this calendar year.

This means that nine months into the year, the HSE would still be deciding the number of nurses and midwives to hire in 2018.

Publication of the funded workforce plan in November 2017 was part of an agreement secured by the INMO on recruitment and retention. The INMO has referred the issue as a dispute to the Workplace Relations Commission to enforce the agreement, yet there has been no progress after several meetings.

INMO general Secretary Phil Ní Sheaghdha said: "Delay tactics like this pose high risks for patient care. We're more than halfway through 2018, and the HSE still hasn't confirmed how many new nurses and midwives it plans to hire this year. This is simply the opposite of best practice."

INMO president Martina Harkin-Kelly said: "This continued breach of a national agreement by the HSE, combined with the delay in the Public Sector Pay Commission's special report, would form part of an emergency INMO Executive Council meeting on August 28. It is simply unacceptable to go on like this."

World news

Nurses and midwives in action around the world

Australia

- State invests $8.1 million to recruit a further 80 nursing, midwifery and support positions according to HNEH
- Nurses united in fight for better working conditions

Canada

- New deal for Ontario nurses
- Staffing issues at long-term care homes known to province for years, Wettlaufer inquiry hears

Honduras

- Health Ministry suspends payroll deductions for union dues

Mexico

- A 30-40% shortage of doctors and nurses in Baja California

New Zealand

- Nurses accept fifth pay offer, ending a year of negotiations

Portugal

- Nurses' union united in "forms of struggle" beginning in September

South Africa

- Nurses threaten to swap uniforms for pyjamas if allowances not paid

Spain

- There is not enough nursing staff to cover leave and vacations

UK

- Fears for NHS as apprenticeships fail to plug gaps left by Brexit brain drain
- Proper breaks and access to drinking water is the law

US

- Union power is on the rise, from Missouri to West Virginia
- Nurse staffing levels impact quality of care, study finds

INMO questions govt spending review

Health expenditure report on nursing/midwifery contains inaccuracies

The INMO has called on the Minister for Finance, Public Expenditure and Reform, Paschal Donohoe, to formally and publicly confirm that the views presented in a recent government report on health expenditure relating to nursing and midwifery are not those of the Department or of the Minister himself.

In a letter to the Minister, INMO general secretary Phil Ní Sheaghdha set out in detail several inaccuracies in the *'Spending Review 2018 – Health Expenditure: Nursing and Midwifery'* report, that was drawn up by the Irish Government Economic and Evaluation Service (IGEES).

Nursing capacity

The report stated that a combined increase in agency nurses and additional hours reflects an increase of 397 WTE nurses/midwives on quarter four, 2007.

Ms Ní Sheaghdha pointed out that seeking "to convert additional nursing hours provided for under the Haddington Road Agreement to inflate the WTE nursing workforce is disingenuous in circumstances where there was no provision/intention for such a conversion under the HRA in the first instance, and where no other grade within the civil and public service has had their WTE numbers inflated in such a manner."

On agency staff, Ms Ní Sheaghdha said: "The straightforward comparison in nursing numbers between 2007 and the end of March 2018 shows that there are 2,664 fewer directly employed nurses in the health system than there were in 2007" (39,006 down to 36,342).

She pointed out that the HSE has admitted that since January 2018, it had been double counting the student nurse number and that, following a Workplace Relations Commission process, this had been corrected and the correct number would be reflected in the July census. However, she stressed that the student numbers should be discounted in full as recruitment and retention applies to qualified nurses, not nurses in training.

Even where the estimated agency nurse complement is taken into consideration, there were still considerably fewer nurses employed in the health service at end of March 2018 than in 2007 *(see Table 1)*.

In addition to the above figures, as pointed out in the INMO submission to the Public Service Pay Commission, the February 2017 agreed Nursing and Midwifery Workforce Plan provided for a total increase of 1,224 WTE, of which 1,020 are at staff nurse grade. "Therefore, at the end of 2017 there should have been a total of 25,798 WTE staff nurses", Ms Ní Sheaghdha pointed out. "The HSE statistics show that this target was not met and at the end of 2017, 25,313 staff nurses were employed in the health service, a shortfall of 485 on the 2017 agreed figure. By the end of March 2018, the staff nurse WTE figure had again decreased to 25,246, representing a shortfall of 552 on the agreed 2017 figure."

Ms Ní Sheaghdha said: "The figures indicate that rather than the nursing and midwifery workforce increasing, it is decreasing and vacancies are growing across all services.

Productivity improvements

Ms Ní Sheaghdha also pointed out inaccuracies in the report relating to blood transfusion and IV fluid balance.

Table 1. Number of nurses employed in health service in 2007 compared to March 2018

Year	Direct	Agency *(estimate)*	Total
2007	39,006	761	39,767
2018	36,342	1,400	37,742
Number of fewer directly employed and agency nurses in 2018 compared to 2007			2,025

Healthcare assistants

Ms Ní Sheaghdha refuted the report's claim that HCAs are undertaking many of the tasks historically performed by nurses and midwives. While a national review of HCAs is underway and is due to report in September 2018, she said: "The initial finding of this report is that while titled HCA, many of the grades are, in fact, incorrectly titled. The function range of HCAs is multi-task from catering, cleaning to direct patient care and this is the matter under review."

Advanced, specialist and senior staff nurse

While there has been a modest increase in the number of specialist grades in nursing and midwifery, Ms Ní Sheaghdha said in fact there has been no great move from those already practising at specialist level in 1999, when the Commission on Nursing recommended the grade of clinical nurse specialist (CNS).

"Since then the numbers appointed as CNS remain at a very low level, 1,504 across all disciplines of nursing. The Department of Health has sought that advanced nurse practitioners make up 2% of the nursing population and that would be 700, based on today's full-time equivalent figures. However, currently, that target has not been met with 272 WTE advanced nurse/midwife practitioners employed in the public health service," she said.

"This year alone reflects a drop of 100 funded posts since last year from 130 ANP candidates in 2017 to 30 in 2018. This indicates that this growth will not be achieved over the next decade. Therefore, the statement in the IGEES report that *'there has been significant compositional shift towards advanced and specialist grades'* is completely erroneous. There has not been a major shift, there has a been a re-titling of posts at CNS level in 1999 and no real growth since. The reality is that the targets set by the Department of Health for the development of the CNS and ANP, in reality, have fallen well short of projected requirements.

It is important to note that the grade from which ANPs and CNSs are recruited is usually the staff nurse grade which, as evidenced above, has recruitment difficulties.

International comparisons

In relation to the OECD table in the report, illustrating the number of active nurses per 1,000 population, Ms Ní Sheaghdha said it was "inconceivable how such a comparison could be given any credibility at all".

Nursing turnover

Ms Ní Sheaghdha said that a comparison of turnover rates between countries was another tactic employed by the authors of the IGEES report to suggest that Ireland does not have a nursing/midwifery recruitment and retention problem. "Measuring and comparing the costs and rates of turnover is difficult because of differences in definitions and methodologies."

Starting salary

The report compares the starting salary of nurses and midwives with other areas of graduate recruitment to the public service and with the average starting salary for a graduate in the private sector.

"Both of these comparisons are completely inappropriate in circumstances where you have direct comparators in the allied health professional (AHP) grades who work alongside nurses and midwives on a daily basis and where the same level of education is required to graduate in the relevant profession," said Ms Ní Sheaghdha.

"The grades of physiotherapist, speech and language therapist, occupational therapist, etc. all commence their working career with the same employer as that of the grade of nurse and midwife. The annual starting salary of the AHP grade, however, is significantly higher at €35,319 compared to the staff nurse/midwife grade at €28,768 (€30,802 following 16 weeks employment), a difference of €6,551 (or €4,417 following 16 weeks employment). The difference is greater when you take into account the hourly rate: AHP – €18.29 compared to staff nurse/midwife – €14.15 (€15.14 after 16 weeks).

"The starting salary of a teacher is also relevant and appropriate for comparison purposes at €35,958 per annum. In addition, the starting salary of a Garda is €29,699. Of the four grades, the starting salary of the staff nurse/midwife is considerably lower."

Premium payments

The IGEES authors thought it important to point out that nurses and midwives have access to premium payments of approximately 20% and that this should be taken into consideration when comparing their pay with the basic pay of other graduates in the public and private sectors. "Again, such a comparison is entirely inappropriate since it does not compare like with like. Nurses and midwives have a contractual obligation to work unsocial hours, they have no choice in the matter. They are required to work at night, on Saturdays, Sundays, public holidays, Christmas Day, St Stephen's Day and to be on-call," said Ms Ní Sheaghdha, backing up this point with research evidence regarding the negative effects of night and shift work.

"All grades, including nurses/midwives and AHP grades, employed in the public service who are required to work unsocial hours are compensated for the potential risks to their health and massive disruption to their lives."

Career advancement

The IGEES authors point out that an estimated 13,613 staff nurses/midwives are on basic pay over €40,000 – point 9 is actually €40,080. However, the authors failed to point out that "AHP grades are on basic pay in excess of €40,000 at point 4 of their scale, teachers reach the €40,000 mark at point 5 of their scale and gardaí reach it at point 6. At point 9, the AHP grades are on €45,843, a teacher is on €46,432 and a member of the gardaí is on €48,271," said Ms Ní Sheaghdha.

International pay comparisons

The INMO also pointed out how the IGEES report used several OECD comparisons on nurses' remuneration but said these figures cannot be relied on as the comparisons are not on a 'like for like' basis.

DPER reply and subsequent correspondence

Despite the extensive arguments set out above, the secretary general at the Department of Public Expenditure and Reform, replied to the INMO's letter refusing to accept a range of criticisms.

The DPER stated that the *'Spending Review 2018 – Health Expenditure: Nursing and Midwifery'* report was one of a number of reports published as part of this year's spending review. "The spending review has a key role in promoting and informing debate about important public expenditure issues as part of the annual budget process and embedding a culture of critical evaluation in the public service that is based on evidence."

The secretary general went on to respond on a number of key points, including:

- Nursing numbers
- Student nurses
- Productivity and capacity
- Advanced senior, specialist and managerial staff
- Pay
- Turnover rates
- International comparisons.

INMO general secretary Phil Ní Sheaghdha responded directly to this letter from the secretary general, reiterating and reaffirming the contents of the INMO's original letter. She addressed once again the issues of pay recruitment and retention, pay specialist grades and staff turnover rates.

She concluded by saying: "There is no doubt that the HSE, the Department of health and government parties across the Houses of the Oireachtas understand that there is now a crisis in the recruitment and retention of nursing and midwifery grades, and that the collective, desired, expansion of the health service, through the Capacity Report, will be severely compromised if this issue is not addressed proactively and immediately.

"It is incumbent on the DPER to assist in resolving this crisis, considering the effects of this shortage, and to join in the public acknowledgement of this crisis by the Minister of health."

The real challenge for Sláintecare is funding, says INMO

THE INMO has responded to the government's publication of the Sláintecare Implementation Strategy, and is awaiting an early meeting with the Minister for Health and the Sláintecare office.

The Organisation wants to see a focus on solving the recruitment and retention problems in nursing and midwifery, as well as assistance in developing nursing and midwifery-led services.

INMO general secretary Phil Ní Sheaghdha said: "We have always been strong advocates for Sláintecare and want to see the report implemented in full. More information is needed on the government's plans than was announced last month, and we have sought an early meeting with government.

"But the real challenge for Sláintecare is funding. There are already hundreds of nursing and midwifery vacancies across the country, which the HSE simply can't fill.

"Unless the government focuses on solving the recruitment and retention crisis in nursing and midwifery, the expanded services in Sláintecare simply won't become a reality. The inadequate pay of nurses and midwives has to be addressed. And while ministers are right to allocate extra capital spending for the health service, that will be money down the drain unless new facilities are properly staffed."

Appointments welcomed

Meanwhile, the INMO expressed relief at the long overdue appointments at the new Sláintecare office. Laura Magahy has been appointed as the first executive director and Dr Tom Keane has been appointed as chair of the Sláintecare advisory council.

"More than a year after the Sláintecare report, we are glad to see the government has finally appointed people to these key roles. We look forward to working with Laura Magahy to deliver much-needed reforms and end Ireland's two-tier health system," said Ms Ní Sheaghdha. "Having worked with Dr Tom Keane previously on the cancer programme, I know he is dedicated to quality public healthcare and recognises the pivotal work of nurses and midwives. The INMO, as the voice of nurses and midwives, should be represented on the advisory council.

"Sláintecare is an opportunity for patients and staff alike, which could open up nursing-led primary care in communities across the country. This will be particularly important for the management of chronic disease. But for Sláintecare to be more than an academic exercise, ministers need to commit to fully funding its implementation. We are waiting for the government to publish a realistic funding plan for it, starting with this year's budget."

EDs short over 200 nurses in summer

"HSE sleepwalking into yet another winter crisis"

IRELAND'S emergency departments (EDs) were at least 216 nurses short of the number required to care for all admitted patients in July, according to HSE figures obtained by the INMO at the Workplace Relations Commission.

The HSE figures showed there were 159 unfilled vacancies, while it estimated that an additional 57 nurses were required within EDs to care for admitted patients for whom there were no available beds.

The INMO said that low pay and poor working conditions were making it near impossible to recruit and retain sufficient nurses in EDs. Across all services, the nursing census shows 2,500 fewer employed nurses and midwives than in 2007, and vacancies are growing.

At a recent meeting with the HSE at the WRC, the INMO demanded immediate talks on curtailment of services to ensure safety of nurses and midwives when at work.

INMO trolley/ward watch figures for July counted 7,069 admitted patients were on trolleys across Ireland, 21 of whom were under 16. This is an increase of 11% on 2017, and the most overcrowded July since records began. The highest numbers of trolleys were in:

- University Hospital Limerick (897)
- Cork University Hospital (614)
- Midlands Hospital Tullamore (494)
- University Hospital Galway (457).

INMO general secretary Phil Ní Sheaghdha said: "Overcrowding is now a constant feature of our hospital system, even in summer. Low salaries for nurses and midwives mean that vacancies simply aren't being taken up and health service capacity can't grow. Without realistic pay correction for nurses and midwives, this problem won't be fixed.

"The HSE still hasn't set out its funded workforce plan for 2018 for nursing and midwifery. The HSE is sleepwalking into yet another winter crisis. We have sought discussions on which services will be curtailed this winter, so that nursing staff can work in safe environments."

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

Hospital	July 2006	July 2007	July 2008	July 2009	July 2010	July 2011	July 2012	July 2013	July 2014	July 2015	July 2016	July 2017	July 2018
Beaumont Hospital	270	489	701	810	549	605	489	627	580	643	364	357	78
Connolly Hospital, Blanchardstown	189	219	283	179	408	321	313	540	295	442	203	197	303
Mater Hospital	251	480	497	361	503	236	424	103	262	325	368	455	330
Naas General Hospital	152	18	84	424	201	285	136	146	169	310	145	338	164
St Colmcille's Hospital	70	65	81	258	162	175	227	101	n/a	n/a	n/a	n/a	n/a
St James's Hospital	26	38	199	259	66	158	168	85	216	188	117	102	55
St Vincent's University Hospital	418	611	537	521	509	497	502	111	167	161	173	125	186
Tallaght Hospital	307	314	359	305	657	419	127	290	266	432	442	237	440
Eastern total	**1,683**	**2,234**	**2,741**	**3,117**	**3,055**	**2,696**	**2,386**	**2,003**	**1,955**	**2,501**	**1,812**	**1,811**	**1,556**
Bantry General Hospital	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	0	20	27	12	29
Cavan General Hospital	125	232	153	107	264	254	125	169	36	48	38	22	3
Cork University Hospital	407	211	247	509	470	388	187	358	228	307	375	318	614
Letterkenny General Hospital	215	25	30	38	27	27	21	79	382	175	147	237	449
Louth County Hospital	1	27	2	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Mayo University Hospital	136	58	111	110	149	9	74	n/a	96	73	137	109	73
Mercy University Hospital, Cork	89	145	138	159	143	138	173	135	164	81	156	161	135
Mid Western Regional Hospital, Ennis	17	4	20	7	131	291	115	244	291	295	498	439	288
Midland Regional Hospital, Mullingar	42	21	44	17	46	88	18	71	109	162	228	219	290
Midland Regional Hospital, Portlaoise	3	1	3	13	13	111	84	201	208	176	333	309	494
Midland Regional Hospital, Tullamore	66	56	20	55	14	2	5	4	n/a	19	10	n/a	4
Monaghan General Hospital	21	3	23	2	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Nenagh General Hospital	n/a	n/a	n/a	n/a-	n/a	n/a	n/a	n/a	n/a	1	n/a	4	4
Our Lady of Lourdes Hospital, Drogheda	201	113	173	304	202	671	482	340	648	769	452	102	36
Our Lady's Hospital, Navan	17	48	29	41	53	13	40	57	38	33	49	204	79
Portiuncula Hospital	9	8	1	50	59	78	46	42	84	29	44	38	80
Roscommon County Hospital	11	7	12	28	50	27	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Sligo University Hospital	44	31	38	107	113	106	93	45	129	172	111	70	246
South Tipperary General Hospital	31	32	134	20	32	30	234	284	118	58	304	388	330
St Luke's Hospital, Kilkenny	n/a	n/a	n/a	n/a	n/a	118	55	134	186	393	348	325	282
University Hospital Galway	76	145	317	269	282	343	213	295	446	654	447	202	457
University Hospital Kerry	85	43	18	17	32	25	73	25	71	98	144	134	289
University Hospital Limerick	92	18	123	176	371	238	300	260	475	495	649	662	897
University Hospital Waterford	n/a	n/a	125	66	113	78	168	218	86	94	353	358	323
Wexford General Hospital	89	73	194	228	391	286	52	160	38	62	77	229	111
Country total	**1,777**	**1,301**	**1,955**	**2,323**	**2,955**	**3,321**	**2,558**	**3,121**	**3,833**	**4,214**	**4,927**	**4,542**	**5,513**
NATIONAL TOTAL	**3,460**	**3,535**	**4,696**	**5,440**	**6,010**	**6,017**	**4,944**	**5,124**	**5,788**	**6,715**	**6,739**	**6,353**	**7,069**

Comparison with total figure only:

Increase between 2017 and 2018: 11%
Increase between 2016 and 2018: 5%
Increase between 2015 and 2018: 5%
Increase between 2014 and 2018: 22%

Increase between 2013 and 2018: 38%
Increase between 2012 and 2018: 43%
Increase between 2011 and 2018: 17%
Increase between 2010 and 2018: 18%

Increase between 2009 and 2018: 30%
Increase between 2008 and 2018: 51%
Increase between 2007 and 2018: 100%
Increase between 2006 and 2018: 104%

EDs facing worst winter on record

INMO warns HSE its members will not shoulder burden of responsibility

THIS winter is likely to be the worst on record for hospital overcrowding, given that the majority of hospitals failed to implement the nationally-agreed de-escalation policy during the unprecedented levels of overcrowding experienced in the summer months. This was the INMO's stark warning to the HSE and the Department of Health at the Workplace Relations Commission on July 31, 2018.

The Organisation also stressed to the HSE that INMO members working in emergency departments (ED) will not shoulder the burden of responsibility for another winter. Therefore, I called on the HSE to devise an appropriate plan that will curtail the services to match the resources available.

Discussions at the WRC highlighted that there is currently a shortage of up to 216 nursing posts within EDs, due to the inability of the HSE to fill vacancies and also to provide additional staff to care for admitted patients.

A further meeting was due to take place with the HSE to discuss the staffing deficits on August 10, 2018, however, this was postponed by the HSE, which citied the reason that some of its key managers were unavailable due to annual leave. The INMO accused the HSE and the Department of Health of failing to take the ED overcrowding crisis seriously, and also failing to adhere to the WRC agreement of 2015/2016. The vacancies outlined by the HSE appear to be an underestimation of the level of deficits within the services.

The INMO outlined that trolley numbers had been significantly improved in a number of hospitals which had gained an operational grip of their ED overcrowding and patient flow. However, the Organisation pointed out that other hospitals are blatantly disregarding the WRC agreement and that national HSE management appears to be powerless in addressing this with local hospital management.

The HSE is demonstrating a reckless disregard for the health, safety and wellbeing of staff working within the service but also with the patients who are left in inhumane and intolerable conditions. The HSE has been advised that it has a window of opportunity to devise appropriate plans to address the ED overcrowding issues before the next meeting at the WRC on September 7, 2018.

– Tony Fitzpatrick, INMO director of industrial relations

New key appointments at the INMO

TONY FITZPATRICK has been appointed director of industrial relations with the INMO, following an open competition for the position.

Tony has been acting as director of industrial relations since last autumn, when the position was vacated by Phil Ní Sheaghdha.

Previously, Tony was an industrial relations officer with the INMO since 2002 covering the Old South Eastern Health Board and the Dublin North East areas.

Tony trained as a registered nurse in Our Lady's of Lourdes Hospital, Drogheda and after travelling to Australia for a year, returned to work in the emergency department of Beaumont Hospital, Dublin.

Tony holds a higher diploma in emergency nursing from RCSI and has a MBA from the University of Wales.

Tony is currently leading on national negotiations around staffing and skill-mix in services for older persons.

Tony Fitzpatrick:
INMO director of industrial relations

Michael Pidgeon:
INMO media relations officer

MICHAEL PIDGEON is the new INMO media relations officer, taking over from Ann Keating, who retired recently.

Michael joins the INMO from a stint in the Mayor of London's press office and several years working in digital campaigns and media at the Trades Union Congress in the UK. He has also worked in Brussels for the European Commission and Friends of the Earth.

"I'm delighted to take up the new role at the INMO," Michael said. "I have big shoes to fill since Ann's departure, but I'm looking forward to meeting lots of members, and working with the fantastic communications team we have here. We're working as best we can to ensure that nursing and midwifery issues, especially on pay, are top of the agenda and get the coverage that they deserve, in print, broadcast or online media. I'm especially keen to hear any fresh ideas you might have to improve our media work, journal or digital output. Please don't hesitate to get in touch." Email: michael.pidgeon@inmo.ie

Attack on midwifery school in Afghanistan

GUNMEN stormed a midwifery school in Jalalabad, Afghanistan in late July, killing three people working at the centre. All 61 student midwives and 12 children escaped the attack, which lasted almost seven hours. The students had locked themselves in a safe room, rescuing children from the on-site day care.

This was one of several attacks on educational and medical facilities in the country and is believed to be linked to opposition to women working outside the home. No group has claimed responsibility for the attack. The centre offers training courses to midwives, aiming to lower Afghanistan's high levels of maternal deaths and infant mortality. Over half of all births in Afghanistan take place without a trained midwife, and there are 396 deaths per 100,000 live births.

The INMO sends its solidarity to our colleagues working to protect patients in Afghanistan.

Tony Fitzpatrick reports on issues discussed at the

National Joint Council

The National Joint Council (NJC) is the primary forum for the management of industrial relations in the health service. The NJC meets every two months when the staff panel and senior managers within the HSE and Section 38 organisations address national matters and local issues that require national input.

The INMO plays a pivotal part on the NJC staff panel, which also includes SIPTU, FORSA, IMO, MLSA, Connect and Unite. The purpose of the staff panel is to use the collective might of all the unions involved to work as one on behalf of all our members within the health sector. As chair of the staff panel, I have issued correspondence to HSE management seeking to progress a number of matters raised in that forum. Matters discussed at the most recent meeting on July 24, 2018 are outlined below.

Leave as an option / overpayment

Management proposed as an option that staff can avail of leave in cases of overpayment, which would not affect their annual leave entitlement. A draft document has been circulated to the staff panel for its consideration and a joint response will be forwarded to the HSE shortly.

Attendance IT system

All staff panel unions object to the process of managing attendance IT system. Management is to meet separately with all unions to discuss this issue.

Fixed travel and subsistence

The staff panel sought clarity on the 8km away from base issue as, despite HSE instructions, there seems to be confusion in some areas around the country, where management is refusing to apply the rule. HSE management is to revert to the staff panel prior to the next NJC meeting with the updated version.

Joint declaration on lifelong learning

An independent chair Ray McGee facilitated a meeting of the working group set up to implement the Joint Declaration on lifelong learning/CPD in July 2018. As agreed, work by the group, made up of HSE and staff panel members, is due to conclude by early December 2018.

Compassionate leave

Following a number of WRC conciliation meetings, no agreement was reached on the application to the health service of the civil service circular issued in January 2017, which substantially increased the level of compassionate leave available to civil servants. This matter has now been referred to the Labour Court by the staff panel.

Section 39s SLA Re Chairman's note

Following discussion with the chair, this issue was to revert to the Health Sector Oversight Body which will follow up on same and no further action from the NJC is required.

Theatre on call

Management circulated terms of reference, however, issues raised by the staff panel remain outstanding. This issue has now been referred to the WRC and at the time of going to print, no date has been offered.

S38 on-call in ID

The issue of on-call in intellectual disability services is considered a national issue as it involves all grades, therefore this matter has been referred to the WRC.

CATH labs

Management is to meet with the INMO and SIPTU on issues of concern to cath labs at St James's Hospital GUH. Management is to revert with dates.

SATU nurses

A further meeting is to be arranged in August/September 2018 on matters of concern to nurses working in sexual assault treatment units (SATU).

South Tipperary staffing framework

The staff panel reiterated that this issue has been outstanding since May 2017, following the Labour Court Recommendation 21570 which outlined that the staff panel requested national engagement regarding this issue. HSE management responded that this was a work in progress and that a follow up meeting will be arranged and dates would be issued as a matter of urgency.

S38s application of injury allowance

The issue of the injury grant for Section 38 ID services remains outstanding. Each agency is to submit costings, including voluntary agencies. This is a broader issue for other unions if injury is a result of assault at work. The staff panel is to refer the matter back to the WRC for conciliation.

Stabilisation of financial systems

The HSE's stabilisation project aims to replace some financial systems, particularly in the west and mid-west regions. We, as part of the trade union staff panel, have flagged some issues with procurement in the project. All relevant unions will be contacted to discuss the project, and the HSE has committed to engaging with us on this in September 2018.

Non-application of overtime rates

The non-application of overtime rates as per PSA at St Michael's House and CHO 9 has been referred to the Health Sector Oversight Body for its consideration.

HR manual

The staff panel is not in agreement with the draft human resources investigation manual. It has requested a list of investigators, which has not yet been received. However, management did issue a communication on this matter. The matter was discussed at the Policy and Procedure subgroup.

PSA reduced hours

The staff panel requested a review to take place, to ascertain how many staff applied for reduced hours under the PSA and how many were granted this. They requested the figures be broken down by grade and by work location. This information was due to be received in early August.

Staff mobility/ transfer policy

The ID sector and voluntary agencies do not wish to be involved in the staff mobility/

latest National Joint Council forum

transfer panel process. The staff panel reminded IBEC of this at the last meeting of the NJC. At the recent NJC meeting, the staff panel had to remind IBEC that the intellectual disability sector and voluntary agencies do not wish to be involved in the public sector's staff mobility/transfer panel process. The HSE and the staff panel group will meet to discuss this policy.

Use of agency staff

The staff panel and the Department of Health noted that there was a continuous increase in the number of agency staff being used. They requested that the HSE looks at ways to stabilise the workforce. The staff panel requested information to assist it in understanding the figures offered on agency use. The staff panel suggested that an action plan was needed to tie in with the taskforce and conversion from agency contracts to permanent contracts, in order to stabilise the workforce.

Update on current staffing levels

The staff panel raised the issue of student nurse numbers being counted as one whole time equivalent (WTE) staff member. This is a change from the longstanding agreement and practice that students are counted as 0.5 WTE and this change is a misrepresentation of the numbers of nurses in the system. The staff panel requested that the counting of student nurses revert to the method agreed as before. Following the WRC process on this matter the HSE and the Department of Health agreed to revert to previously-agreed methodology.

Performance achievement

The HSE sought the staff panel to attend the WRC, dates to be circulated by the WRC.

New people strategy

The staff panel is to review the 2018 strategy and engagement with staff and unions is to commence shortly.

Temporary appointments

HSE management addressed the issue of temporary appointment posts (which affects in the region of 1,700 staff). It reported that an exercise in coding is underway to establish a full breakdown and segment out grade/group and categories. It said further time was needed to complete this work but it is envisaged this would be completed in early August. The unions raised the need for a new regulation process on temporary appointments and this was opposed by the HSE. Engagement on this was to take place in August, but had not yet happened at time of going to print.

QROPS scheme: recognised overseas pension scheme

The staff panel has communicated with HSE management on the issue of the QROPS, the recognised overseas pension scheme, and a meeting is to be arranged.

Recruitment – compliance with code of practice

The staff panel raised the issue of interviews, how posts were being advertised, the interview process, how interviews are conducted and the outcome. HSE management are to discuss same and revert to the staff panel.

Continuing care placement coordinators

Issues concerning continuing care placement coordinators in Cork/Kerry areas No 14(a), 16 and 17, combined with a time plus one-sixth issue in CHO area 4, need follow-up action. Attempts from the union side to resolve these issues locally were to no avail. The HSE is to follow up.

Grading of day centre managers

The HSE agreed to set up a meeting at a high level in Cork to try to resolve issues relating to the grading of day centre managers. The meeting dates are to be arranged.

Maternity leave for premature births

A circular on extended maternity leave for mothers of premature babies is awaited from the Department of Public Expenditure and Reform (DPER) and the Department of Health. This was expected to be circulated in early August 2018. Following discussion the staff side sought that the circular, when issued, would apply to mothers currently denied access due to the department's delay. The claim on behalf of these mothers is live and must be advanced.

Implementation of bed capacity report

The staff panel raised the issue regarding the increase in bed capacity, if this was the case staff numbers would have to reflect the same increase and therefore, union engagement is required.

Time and attendance system

It was agreed that St James's Hospital, IBEC and the Federation of Voluntary Bodies would meet and that a national level engagement with the unions would take place to discuss the framework/protocol and the principles going forward. IBEC is to forward dates for engagement.

– Tony Fitzpatrick, INMO director of industrial relations

Meeting on PHN /CRGN weekend working

THE INMO was due to meet with the HSE at the end of August 2018 in order to conclude an agreement on weekend working for public health nurses and community RGNs.

The INMO has argued that the current on-call arrangement for essential calls is not attractive to PHNs and CRGNs who may opt not to work weekends. In the absence of a seven-day service, there is an option for an enhanced arrangement at the weekend, similar to the Dublin Agreement.

The INMO has referred the matter to the WRC, however the HSE has indicated that it wishes to have one final direct meeting with the INMO prior to going to the WRC. This meeting was due to take place at the end of August and we will update members further thereafter.

– Tony Fitzpatrick, director of industrial relations

WRC agreement on move to Nazareth House new facility

MEMBERS working at Nazareth House, Mallow, Co Cork moved into a new state of the art facility recently, following an agreement reached at the Workplace Relations Commission.

This agreement included the commencement of pay restoration in line with the public service at Nazareth House, which is a Section 39 organisation.

In addition, an interim agreement was put in place regarding staffing levels. INMO members will reconvene under the auspices of the WRC in October 2018.

– Liam Conway, INMO IRO

Mater Private Group changes hands

THE Mater Private Hospital Group has now been taken over by Infra Via.

The INMO has gained assurances that the full impact of the Transfer of Undertaking Protection of Employee's legislation (TUPE) has applied and the terms and conditions for nurses employed there will remain unchanged.

Additionally, those employees who were with the company when it was previously sold received allocations of employee shares, the value of which can now be realised.

The INMO will continue to monitor the takeover and disbursement of the eligible employees' shares to ensure full transparency and protection for all INMO members employed in the group.

– Albert Murphy, INMO IRO

Tralee protest to highlight gross overcrowding in ED

INMO members protesting outside University Hospital Kerry to highlight the unsustainable overcrowding in the emergency department and the increasing number of admitted patients being cared for on trolleys in corridors

INMO members working in the emergency department (ED) of University Hospital Kerry held a successful lunchtime protest outside the hospital in early July for two hours.

Members of the public, many local TDs and members of the county council attended, showing their support for the ED nurses who were highlighting their grave concerns regarding the continuing overcrowding crisis in the ED at University Hospital Kerry, where an average of 16 to 18 admitted patients are left on trolleys in the corridors awaiting transfer to an appropriate hospital bed on the wards. The number of patients on trolleys continues to rise exponentially year on year.

Unlike other hospitals, University Hospital Kerry did not get any additional nurses to care for patients being accommodated on the ED corridor nor did the hospital receive approval to have an additional CNM2 for admitted patients allocated as did other EDs as a result of the 2015/2016 ED dispute.

INMO IRO Mary Power said: "INMO members are calling on the government and the HSE to ensure that additional nurses are allocated to care for admitted patients residing in the ED as well as providing funding for additional bed capacity within UHK to meet the continual growing demands on this hospital which has 300 inpatient beds and 45 additional day beds. Members continue to be concerned at the daily challenges they face, trying to provide optimum quality and safe patient care in an intolerable and inappropriate environment."

The INMO has lodged claims for appropriate staffing for admitted patients at this hospital at the national ED hearings in the WRC in June and July.

INMO express solidarity with Mandate workers at Lloyd's Pharmacy:
The INMO Executive Council passed a motion of support for members of Mandate trade union, who are currently in dispute with Lloyd's Pharmacy over trade union recognition and improvements in pay and conditions. The INMO and a number of other unions expressed their solidarity with the Mandate campaign by joining a protest outside Lloyd's head office in City West, Dublin in July (pictured above) – Albert Murphy, INMO IRO and Organiser

Section news round-up and details of upcoming events

All-Ireland Midwifery Conference

The poster competition for the All Ireland Midwifery Conference is now open and members are invited to submit a poster for this event. Guidelines and application forms are available to download from the INMO website, or by contacting the INMO directly. See *page 20* for full programme details.

OHN Section Conference

The OHN Section annual conference is taking place later this month in Limerick. The theme of the day is 'Occupational health – Creating a culture of health, safety and wellbeing in the workplace'. See *page 50* for full programme details or log onto **www.inmoprofessional.ie** to book your place.

Assistant Directors Section

The Assistant Directors Section is calling on all its members to ensure that the Section has their most up-to-date contact details. The section wishes to link with members who have recently taken up posts to engage with them through the national networking structure. Simply email: membership@inmo.ie to align to the section or update any of your details. The Section, in conjunction with the Directors Section, is set to hold an executive masterclass on Thursday, September 27. See *page 63* for full details.

ED Section

At a recent meeting of the ED Section, the decision was made to hold a masterclass for nurses and midwives working in the ED setting. The date will be Wednesday, February 6, 2019. The venue for the masterclass will be the INMO Richmond Education and Event Centre. Topics that will be covered will include: the coroner's court, SATU, staffing and skill mix, new innovations, and a session on burnout. Full details of this masterclass will be issued to all section members and will be advertised both in *WIN* and on the INMO website.

Orthopaedic Nurses Section

The Irish Orthopaedic Nurses Section (IONS) wishes Gerry Tuohy a happy and healthy retirement. Gerry's contribution to orthopaedic nursing has been enormous. While at Sligo University Hospital and later in the School of nursing, Gerry consistently advocated for orthopaedic nursing. During his time in the School of Nursing, while contributing to the student nurse training programme, he was responsible for delivering a postgraduate certificate programme in orthopaedic nursing to qualified nurses – one of only two programmes in Ireland at that time. While lecturing in the Centre of Nursing and Midwifery Education in Sligo, Gerry remained an active member of the Section, attending our biannual meetings and representing orthopaedic nursing and our group at national and international conferences. We look forward to his continuing association with us during his retirement – *Rosemary Masterson, ION Section*

INMO International Nurses Section

invite you to attend

a cultural evening for our nurse and midwife members, and their families

on **Saturday 15 September from 5pm – 9pm**

in The Richmond Education and Event Centre

Please RSVP to: Elizabeth Allauigan, National Chairperson of the section by email: **elizabethallauigan@yahoo.com** to confirm your attendance.

We look forward to welcoming you to this unique event.

Wheeled in, walking out

Nurse-led care shines through at the Mater Hospital's post-acute care service in Fairview, writes **Michael Pidgeon**

AS THE temperature cools to the high 20s, an elderly patient with dementia relaxes. It's been a long day. She puts her bare feet in the sand, soaks up the late afternoon sun, and listens to the sounds of the seaside. Other patients play with a beachball, chat by a sandcastle, and pose for 'head in the hole' photos with friends. Some simply sit outside beach huts, taking in the music.

Even though their hospital rooms in the Fairview Community Unit were only a few steps away, this felt like a day out. The seaside had come to visit them.

"The patients came back to me in the ward and they were so excited," says Allison Kennedy, a clinical nurse manager and INMO member. "They were totally submerged in the colour, the chat and the music. It was a beautiful day, everyone was in such good form.

"There were people from all over to talk to: Spain, Italy, Argentina. The patients would be asking volunteers where they were from and about their home countries. It was fantastic," she said.

Volunteers from Google had come to spend the day at the unit. In the morning, they worked with nursing staff to create a virtual seaside in the central garden space, and after lunch spent time painting, chatting and singing with patients.

This was part of a scheme with Business in the Community, which sees volunteers from various companies come to spend time with people in the unit. Other days have seen, for example, PwC staff come in for pottery and crafts, or to help decorate the unit with pictures of historical Dublin.

Local scouts built wooden features for the garden, and other volunteers have helped create a small village, with an imitation post office, post box and even a village pub.

Days like these are a regular feature in the Post-Acute Care Service at the Mater Community Unit in Fairview. The nurse-led team was founded in 2011, when more than 20% of the Mater's acute hospital beds were full simply because of delays in discharging patients.

The Mater reconfigured beds and designated a team to run this inpatient service. The staff focus on arranging an appropriate discharge plan and getting the patient back home, if and as soon as possible.

"In terms of patient flow, we could be considered the back door of the hospital," says Ciara Dowling, a CNM, who was instrumental in setting up the facility in 2011. "I've seen patients wheeled in here, who are walking out in a few weeks."

One of the main problems patients face is "PJ paralysis", which some get from a stay in hospital. Not only do patients lose muscle mass lying on a hospital bed – as much as 10% over 10 days – but they also lose confidence and think of themselves as being sick.

The nurses work to change that. "We encourage independence," says Allison. "Patients wear their own clothes, they dine together, and we get them up and out. Very much away from the hospital mentality, from that sick role."

Patients eat in a homely, decorated canteen, and if they need help to eat, staff sit and share the table, rather than standing over them.

Those who use walking frames have regular 'pimp my zimmer' sessions, where they decorate their frame with ribbons and badges related to their interests. One man has Dublin county colours all along the side of his frame, another has Liverpool stickers.

This kind of interaction is possible because nursing staff take the time to talk with families, work with public health

nurses, and get to know patients better.

"It's person centred. Many of our patients have lost their confidence, especially if they've had a fall. But we try to give people a bit of their humanity back," said Allison.

"And we work with families on that too. Sometimes they'd be afraid to even take them out for coffee, which is what you'd get in the acute hospital setting," she added.

Families are encouraged to take a patient home for a few hours or a single night, to see what obstacles there may be.

"We've one lady here," Ciara explained, "who was in acute hospital, and she was going to be discharged to a nursing home. She's been here three weeks, and I've just met with her daughter. She'll be going back home in a few days, and her daughter says her mobility is better than it was six months ago, before she went to hospital."

The system seems to work. Starting with 25 beds, they have now trebled in size. Of the patients sent to them who were to be discharged to a nursing home, 22.5% have seen improvements allowing them to return to their own homes.

The unit has even been nominated three times by members of the public for the Tesco Community Fund.

None of this would be possible without great staff. As a nurse-led unit, many have had to expand their roles and responsibilities. The unit doesn't have any formal, assigned rehabilitation health professional, so the results are primarily driven by nurses, care assistants and the rest of the team.

There are more than 35 staff nurses, six CNMs, over 30 care assistants, and one advanced nurse practitioner.

"We've got the whole team working together and staff retention is good," Ciara said.

Some nurses have come in on their days off with family to plant flowers in the garden, and others have fundraised with bag packing events at the supermarket. "Once people hear that you're a nurse, they always drop in some change," said Allison.

But this voluntary work is a reminder that the unit does not escape the problems of the Irish health service. As elsewhere, funding shortages cause problems. On the day that the seaside came to the unit, many nurses were under too much pressure to pop out and join in.

Some patients require some home care or access to a public health nurse, if they're to safely go back home. But when that funding is slow to be released, the patients are stuck in limbo.

There have been cases where people have been sent to nursing homes instead of being provided with more appropriate home care, simply because of how HSE budgets are allocated. Despite the financial constraints, the unit is constantly looking at ways to improve practice. The director of nursing has given them extra flexibility and the unit has hosted Dragon's Den-style events for staff to present new ideas. They've done away with the drugs trolley, instead giving each patient their own drugs cabinet. This, they say, not only improves independence for when patients go home, but cuts administration time by nearly 20 hours a week.

The unit uses a system of intentional rounds, where each patient is visited once every hour or two, which helps build up trust and ensures that nobody feels abandoned.

One-off days like the virtual seaside help build a real sense of fun and independence. But for the nurses of the Fairview Community Unit, it's about the values that underpin it.

According to Allison, it's "simple, old-style, proper nursing. It's simply about applying the core values of the job and putting the patient first."

Michael Pidgeon is the new INMO media relations officer

Allison Kennedy, CNM 2, INMO member

Allison is the CNM for the Yeats unit, one of the three post-acute units in Fairview. Trained in the Mater, Allison has been in the role for over three years. She has previously worked in tissue viability and vascular work and was a clinical placement co-ordinator for over six years. She is also a DCU dementia champion.
"This place is ideal for me," she says. "I'm very much a Mater nurse, and want to put traditional skills to use, putting the person front and centre."
Allison is pictured on the cover of this month's 'WIN', with Maya, Ciara's niece

Ciara Dowling, CNM 3, INMO member

Ciara set up the post-acute services at the Mater Community Unit in 2011, and has been there ever since. She has a HDip in cardiac nursing from UCD and has since added qualifications in cardiac care and a MSc in health service management from Trinity. "My mother was a nurse and tried to talk me out of it, but growing up with disability in my family, nursing seemed like a natural direction for me. I love nursing and especially working in the Mater Hospital. No day is ever the same."

Pictured at the Post-Acute Care Services Unit in Fairview on virtual seaside day were: (opposite page - main photo) a Google volunteer dances with a resident; (inset photo) Allison Kennedy, CNM2 with Maya; (below left) a Google volunteer having fun with a resident; (below centre) Google volunteers; (below right) nursing staff on duty during our visit; (below top) Allison Kennedy, CNM2

Photos by Lisa Moyles

This is the first part of a series on nurse-led community care. If you have a story you would like to share please get in touch by email to: michael.pidgeon@inmo.ie

Your future starts here

INMO student and new graduate officer, **Neal Donohue** welcomes new entrants to nursing and midwifery undergraduate programmes

CONGRATULATIONS on beginning what I hope will be a very rewarding career for you in nursing/midwifery. I have tremendous respect for all of you who are taking on this course when the challenges in the public health sector are notorious. While you are busy learning to care for, protect and promote the welfare of patients and service users, my position in the INMO exists to support you.

I strongly advise all students to avail of free INMO membership as you will often need specialist professional advice and representation. I look forward to meeting you all in the colleges and hospitals where I will explain the numerous resources and services available to you from the INMO.

The INMO is a professional trade union that specialises in supporting and promoting the nursing and midwifery professions. We have approximately 40,000 members which accounts for over 80% of nurses and midwives in Ireland. We pride ourselves on being the only trade union that is solely dedicated to the professions of nursing and midwifery.

For those who do not know what a union is, we are a group of people who have joined together with a common interest and purpose of promoting our profession and achieving the best possible standards for our members in the workplace and in society. I am available to answer any questions you may have. I will update you on our local, national and international activity. I will advise you on your rights and entitlements on anything you may experience in the academic environment in third level institutions, and on clinical placements in hospitals and care facilities.

In the true spirit of collectively supporting each other, members of the INMO Student Section and Youth forums have offered their advice and experiences to help you in beginning your career. We also have some testimonials from some of our experienced student and new graduate representatives.

Student and new graduate 10 tips for the degree programme:

- Be organised. Use a diary, set reminders and never leave anything until last minute
- Be prepared for an emotional rollercoaster. There is support available from the college, hospital supports, and the INMO. Ask for help sooner rather than later
- Ask questions if you don't know something. Someone's life may depend on it
- To be happy in your life it is important to be happy in your career. Find balance between study/work/social life. Before you take care of someone else you must first take care of you. Try not to work too many hours or your grades will suffer
- Challenge everything. As a third-level student you will be expected to be able to critically analyse everything. Do not be afraid to question what you see. New and innovative practices come about because people are not afraid to ask the question why? Don't be afraid to appeal decisions. Whether you are applying for a grant or appealing academic decisions, there is a process of appeals that you may use. Don't let go of your dreams easily
- Know your rights and entitlements. Join the INMO and talk to the student/new graduate officer. You will have a better understanding of the system if you do
- Get good shoes. When you have been on your feet for hours, you will understand
- Social life: Get involved in college activities. While nursing and midwifery students have a lot of commitments, it is also important to have a social life and connect with your peers
- There will be placements that you don't like, and there will be times when you question whether or not you will carry on. Look for support. People are there to help you pass, not to watch you fail
- Be careful with social media. As a professional whatever you post may affect you in your professional life.

Information selected by Neal Donohue from submissions by students and new graduates: Tara McCormack, TCD; Aoife Collins, DCU; John Farrell, DCU; Jacqui Piggott, NUIG; Clarence Suliman, SVUH; Tara Moran, OLOL; Aishling Byrne, OLOL; Corinne Rushe. St. Angela's, Sligo; Niamh Donohoe, TCD; Celia Hynes UL; Lily Dineen, TCD; and Anthony Mullins, UL.

If you are interested in learning more about the INMO contact Neal Donohue student/new graduate officer. The INMO provide training for any student that wishes to be a representative. The student rep acts as an advocate and organiser for their peers and is a contact for the INMO. You will be supported and informed on everything relating to nursing and midwifery, you will gain leadership skills and enhance your CV. You will also have the opportunity to positively influence your profession.

Testimonials and advice from some of students and recent graduates follows.

As a student nurse you will face many challenges, especially when you are on placement. You will receive a very high level of education in college, but when you are on placement you will be working alongside people with different levels of education and skill mix. There is an increase in the number of social care staff being hired instead of nurses which brings a lot of challenges for the RNID.

The reason I went into ID nursing was to try to improve people's lives. I had worked in the area of disabilities for seven years prior to commencing the BNID course. Before starting I was of the opinion that I had sufficient experience to care for people with intellectual disabilities. As I progressed further into the four-year degree programme I realised that RNIDs are specialists in co-ordinating the care of people with intellectual disabilities and provide knowledge and expertise to educate and support people with ID and their families across all stages of their lifespan.

Even as a student you will be responsible for making sure you provide the most current and up-to-date practices, making sure the person with intellectual disability is the centre of that care. From the very first day you must understand that your education and training makes you the best advocate for any person with ID. You need to learn to use your voice to protect the most vulnerable people in our society.

– Aoife Collins RNID, Year 4

I have four years training done and I am one year qualified. Throughout your training you will see and hear a lot of negative things about nursing. It's all about becoming the nurse you want to be and not just what others want you to be. Pick your role models carefully. Nursing and midwifery are not glamorous jobs, you will not be living the high life. We know how to make the most out of what we have, because we've seen the highest of highs and the lowest of lows. We are strong individuals and at the end of the day our patients are our priority. We'll hold their hand when no one else is around, we listen to stories about the old days, the good and the bad days. We see people at their lowest, but we can get them to their best. We see new life being born and we see life end. It is the greatest privilege to know someone is comfortable enough to let you help them at their lowest and most vulnerable.

Nurses and midwives are the strongest people I know. Would I change anything? No. I have my role models, I know the nurse I want to be and I look at the good days rather than the bad. It is a great profession; you are needed everywhere, you can travel the world, the world is your oyster with this profession. The best advice I can give is remember the good days. Remember your first birth. Remember the banter with the old women and them trying to set you up with their grandsons. The men talking about the GAA on Sunday like they're in the pub. The glitter stuck to you after a shift of art with the children. The smiles, the thank yous and the looks that can say a thousand words of gratitude. Those are the things you remember, and if you can do that every other day will be that little bit easier. Best of luck to all the new nurses!

Tara Moran, qualified nurse

I am Anthony and I am currently starting my third year studying general nursing. I would like to congratulate you on your success on being accepted into your nursing or midwifery course. After my first year working on the wards, I used to think that it was the norm to be stressed when finishing a day of placement. Having spoken to multiple staff nurses I decided to do the INMO rep training. Initially, I felt no different but when I then went back on clinical placement I felt more confident going onto the wards knowing my rights and entitlements and knowing how students should be supported and treated. After identifying a few minor issues in one of the training hospitals myself and other INMO reps came to the conclusion that the correct student supports were not in place. We contacted the INMO and received a lot of support. The INMO met with hospital management on our behalf and after discussing and negotiating our case it was agreed that more CPC support would be put in place in line with NMBI guidelines. This was a very positive agreement that will improve support for all student nurses attending the hospital in the future and it will essentially improve the standards of care for the patients. It was great to be part of the solution to some of the problems in healthcare, rather than sitting back and doing nothing.

As part of my role as an INMO representative I was able to attend the 2018 INMO annual delegate conference in Cork representing the Western Youth Forum. I proposed the motion that there should be standardisation in nursing and midwifery education in Ireland, since there are significant variances in training from hospital to hospital. It was a great experience again to have a positive influence on my profession through the INMO.

After having these positive experiences with the INMO I decided to become more involved. I attended the Global Association of Student and Novice Nurses Conference which was held in Dublin in 2018 as an INMO delegate. I met students from all over the world and it was shocking to see and hear the different stories of how student nurses are being treated abroad. Of course, after all these stories we also had a few pints. As a rep you have an opportunity to positively influence your profession, but you also have the opportunity to socialise with like minded people from all over the world making new connections and friends.

My hopes for nursing and midwifery in Ireland in the future is that conditions improve for nurses and midwives. If this doesn't change many Irish healthcare professionals will move abroad where the pay and conditions are often much better. I advise all interested students to become an INMO rep and be part of a movement that is changing things for the better. My experience as a rep has helped me develop leadership skills and I plan to continue to support my colleagues to help create a better working environment and improve standards of care.

Anthony Mullins, third-year general nursing student

Brace yourself! No one said it was going to be easy but if you didn't hear this before, I am telling you now you are going to be tested to your limits; be put out of your comfort zone; be put under extreme levels of stress; and you will definitely shed some tears. But here is why... You know you are becoming a nurse or midwife to help those who are not just in need, but also vulnerable and that it makes you proud that you are the reason that a patient realises they have the strength to keep going. Social media is currently portraying such a negative image of working conditions but be proud that you are part of that workforce that hasn't given up.

You will be tested to your limits because nursing will teach you how to be an amazing multitasker. Remember that it is YOU who will be able to assess all that information and plan and implement the best way to deliver that care that will put that smile on your patients face. That smile is what will make you realise you're glad and proud to be a nurse! You will be out of your comfort zone because you will be the one who your patient or their family will disclose how hard an illness is to live but how your care made it easier for them to get through the day. You will be put under extreme levels of stress as you might feel overwhelmed by the inexhaustible things to do to perfect your tasks for the day BUT THEN you will remember how you have your colleagues who are there to support you and put a smile on your face. Always remember that you work as part of a team so you are never alone.

It is you who will assist in bringing life into this world as you hand a Mum's baby to her and experience the happiness in the room as their eyes meet for the first time.

I can't wait for you to experience the first time you throw on that student uniform and feel both scared and excited to put all that you've learned into practice. I equally can't wait for the day you have your graduation where you throw your cap in the air to celebrate the end of an unforgettable four years and embark on an adventure of a career!

This is only the beginning, you will NOT regret it!

Clarence Soliman, Dublin Youth Forum/INMO SVUH Branch

When children fail to thrive

In the latest clinical update in this continuing professional development series, **Angela McHenry, Stephanie Laidlaw** and **Gerry Morrow** examine faltering growth in children

FALTERING growth, also known as failure to thrive or under-nutrition, is a term used to describe a lower weight, or rate of weight gain, than expected for age and sex in childhood. Faltering growth indicates that the child is not receiving adequate nutrition for optimal growth and development. This is a common condition, present in approximately 5-10% of children seen in primary care. The term 'faltering growth' is used in preference to 'failure to thrive' as the latter may be seen as more negative and potentially critical to parents/caregivers.[1,2]

Growth in children in Ireland is monitored on growth charts based on the World Health Organization (WHO) growth standards based on longitudinal studies of healthy breastfed infants. Lines highlighted on the growth charts are called centiles – short for percentile. These mark the weight or height below which a specific percentage of children matched by age and gender will fall, for example, 25% of children are below the 25th centile. Children's weight, length/height and head circumference, depending on age, are plotted over time to visually represent growth – if a child gains weight more slowly than expected for age and sex, their plotted measurement moves to a lower centile on the chart (crosses centiles).

Where appropriate, specific growth charts should be used for very preterm infants, children with significant health problems and children with Down's syndrome.[1,2]

Faltering growth can encompass a wide spectrum of reasons for divergence from expected growth and can occur at any stage from birth to adolescence. Newborn infants often lose weight in the first few days of life, this is usually a physiological process associated with body fluid adjustment. However, weight loss of more than 10% of birth weight, or an infant not returning to their birth weight by three weeks of age may indicate difficulties with the establishment of feeding or be suggestive of an underlying cause.[1,2]

Faltering growth is often due to a combination of biological, psychological and environmental factors and often a specific, underlying cause cannot be identified. Factors which may contribute to faltering growth can be split into the following categories; inadequate nutrient intake, inadequate absorption of nutrients and excessive energy expenditure.[2,3]

Inadequate nutrient intake can be caused by a lack of availability of healthy food, which can indicate child maltreatment. Feeding difficulties such as problems with breastfeeding or formula preparation, reduced ability to suck or swallow, such as cleft lip/palate, or poor appetite can all lead to inadequate nutrient intake. Lack of knowledge of age appropriate healthy food, feeding skills and poor parental interaction can all contribute as can eating disorders in older children.[2 3]

Inadequate absorption of nutrients can be caused by persistent vomiting, for example, due to gastro-oesophageal reflux, food sensitivities or an underlying metabolic disease. Conditions such as coeliac disease, inflammatory bowel disease and chronic diarrhoea can all lead to inadequate nutrient absorption which can lead to faltering growth.[2,3]

Excessive energy expenditure due to underlying disease:

- Cardiac conditions such as congenital heart disease
- Respiratory disorder such as cystic fibrosis
- Metabolic and endocrine disorder such as hyperthyroidism or diabetes mellitus
- Renal disease such as renal tubular acidosis immunodeficiency
- Genetic conditions such as Down's syndrome
- Malignancy.[2,3]

Potential complications of faltering growth include impaired cognitive, immune, cardiac and gastrointestinal function and impairment of long-term growth. If faltering growth is due to an underlying condition the prognosis will depend on the specific condition and its treatment. Early identification and treatment of all cases of faltering growth may improve prognosis and prevent long-term complications.[3]

Diagnosis

During the first few days of life, faltering growth should be suspected if weight loss is more than 10% of birth weight, or weight does not return to birth weight by three weeks of age.

After the first few days, up to the age of two years, suspect faltering growth if :

- Weight falls across one or more weight centile spaces and birthweight was below the ninth centile
- Weight falls across two or more weight centile spaces and birthweight was between the ninth and 91st centiles
- Weight falls across three or more centile spaces and birthweight was above the 91st centile
- Current weight is below the second centile for age, regardless of birthweight.[1]

In children over the age of two years faltering growth is indicated by body mass index (BMI) and length or height measurements. If BMI is below the second centile this could be due to undernutrition or a small build. A BMI below the 0.4th centile is indicative of probable undernutrition. If a child's length or height is more than two centile spaces below the mid-parental

range, undernutrition or a primary growth disorder should be suspected.[1]

When assessing a child with suspected faltering growth a detailed history should be taken. The history should begin with the specific concerns of the parents/carers or other healthcare professionals. Feeding or eating patterns should be investigated in detail, including information relating to 'what' is eaten, 'how much' and 'how often' – a three-day feeding diary may be helpful. The amount of liquid consumed should also be estimated. This is particularly important with toddlers as excess liquid consumption can lead to fullness before meals.[1,2,3]

Ask about any associated symptoms such as fever, pain, coughing, shortness of breath, difficulty in swallowing (dysphagia), vomiting or diarrhoea may indicate acute or chronic illness.

Any complications during pregnancy or birth should be noted, such as intrauterine growth restriction and prematurity. Take note of any past medical history including congenital abnormalities, developmental delay, any chronic conditions and any allergies or intolerances. A psychosocial and family medical history should also be taken, including questions relating to social circumstances, family stress and the presence of any familial disorders.[1,2,3]

Management of weight loss in the first few days after birth

In all cases it is important to liaise with other healthcare professionals involved in care – such as midwife/public health nurse – to ensure that all concerns are identified; specific parental/carer concerns should also be identified and discussed.

If weight loss is than 10% of birth weight in the early days of life and assessment is normal reassure the parent/carer that it is common for infants to lose some weight during the first few days and this usually stops after around day three or four, with most infants returning to their birth weight by three weeks of age. Ensure the parent/carer has adequate feeding support from an appropriately trained professional (usually the midwife/public health nurse) and arrange follow up to monitor growth at regular intervals.[1,2]

If weight loss is more than 10% of birth weight in the early days of life or if the infant has not returned to their birth weight by three weeks of age refer to/discuss with paediatrics, with the urgency dependent on the clinical situation.

All infants with the following should be referred:

- Symptoms or signs suggestive of an acute or chronic underlying condition
- Rapid weight loss or severe under-nutrition
- Safeguarding concerns
- Slow linear growth or unexplained short stature
- Those who have not responded to management in primary care.[1]

Ensure all parents/carers have adequate feeding support from an appropriately trained healthcare professional, such as a midwife/public health nurse. Consider a direct observation of feeding by a person with appropriate training and expertise. Be aware that supplementary feeding with infant formula in a breastfed infant may help with weight gain, but can result in cessation of breastfeeding.

If breastmilk is supplemented with formula, the mother should be supported to continue breastfeeding, advised to express breast milk to promote supply and advised to give available breast milk before infant formula.[1,2]

Arrange follow up at appropriate intervals – no more than once daily if less than one month old – weight should be measured and recorded at each visit. If an infant with faltering growth develops new clinical symptoms or signs after the initial assessment, develops marked weight loss or fails to respond to feeding support, a referral to paediatrics should be reconsidered.[1,2]

Management of weight loss after the early days of life

Ensure all concerns from parents/carers and other involved healthcare professionals are identified. The concept of faltering growth should be explained to parents/carers and concerns should be discussed.[1]

Discuss with or refer to paediatrics if :

- There are safeguarding concerns
- Symptoms or signs indicate an acute or chronic underlying disorder
- There is rapid weight loss or severe under-nutrition
- The child has slow linear growth or unexplained short stature.[1,2]

If referral is deemed unnecessary consider if any factors are contributing to faltering growth, such as mealtime arrangements, types of foods offered (eg. are they age appropriate) or parent/carer-child interactions (eg. response to the child's mealtime cues). In milk-fed infants, consider whether feeding support might be helpful.[1,2,3]

Discuss the following, as appropriate to the child, with the child's parents/carers and ensure they receive ongoing support from an appropriately qualified healthcare professional, such as a public health nurse or paediatric dietician: the importance of encouraging relaxed and enjoyable feeding and mealtimes, making sure they are neither too brief nor too long (20-30 minutes); eating together as a family (or with other children) and establishing regular eating schedules, eg. three meals and two-three snacks in a day; encouraging young children to feed themselves and allowing young children to be 'messy' with their food; serving nutrient-rich, healthy food, appropriate to the child's developmental stage in terms of quantity, type and food texture; setting reasonable boundaries for mealtime behaviour while avoiding punitive approaches and coercive feeding; avoidance of too many energy-dense drinks, including milk as these can reduce a child's appetite for other food.[1,2,3]

In all children with faltering growth, arrange follow up to monitor growth with re-assessment frequency dependent on the specific clinical situation, measure and record the weight at appropriate intervals, considering factors such as age and level of concern, but usually no more often than :

- Monthly from one year of age
- Fortnightly between six to 12 months
- Weekly between one to six months
- Daily if less than one month old.

Be aware that recovery in weight gain usually begins within four to eight weeks of a successful intervention and may take several months.[1]

If a child with faltering growth develops new clinical features after the initial assessment, or if measures in primary care fail, reconsider whether discussion with/referral to paediatrics is needed.[1]

Angela McHenry is clinical author at Clarity Informatics, Stephanie Laidlaw is information specialist at Clarity Informatics and Dr Gerry Morrow is editor and medical director at Clarity Informatics. Clarity Informatics is contracted by the National Institute for Health and Care Excellence (NICE) to provide clinical content for the Clinical Knowledge Summaries service available through the Clarity Informatics Prodigy website at:
https://prodigy-knowledge.clarity.co.uk/

References
1. NICE (2017) Faltering growth: recognition and management of faltering growth in children. National Institute for Health and Care Excellence
2. BMJ (2018) Failure to thrive. British Medical Journal
3. Larson-Nath C, Biank VF. (2016) Clinical review of failure to thrive in pediatric patients. Pediatr Ann. 45 (2) e46-e49

Full reference list available from Prodigy at:
https://prodigy-knowledge.clarity.co.uk/

CPD Quiz

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

1. When should you suspect faltering growth after the first few days of life?

A) The child's length or height centile is less than two centile spaces below the mid-parental centile
B) The child's BMI is below the second centile
C) Weight falls across one centile space and birthweight was above the 91st centile
D) Weight falls across one centile space and birthweight was below the ninth centile

2.Inadequate nutrient intake can be due to?

A) Lack of available healthy food
B) Developmental delays
C) Malabsorption due to coeliac disease
D) Child given food which is not age appropriate

3. During the first few days of life, when should you be concerned about weight loss?

A) Infant does not gain any weight within the first week of life
B) Infant loses more than 10% of birth weight within the first few days of life
C) Infant does not return to birth weight by three weeks of age
D) Infant has returned to birthweight after two weeks of age

4.When managing faltering growth after the first few days of life which of the following are considered good advice?

A) Eating together as a family in a relaxed atmosphere
B) Setting the child target amounts to eat and punishing the child if these are not met
C) Supplementing the diet with energy-dense drinks such as milk
D) Allowing young children to be 'messy' with food

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

Clarity informatics

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

Answers: Question 1 = b, d, Question 2 = a, b, d, Question 3 = b, c, Question 4 = a, d

Quality & Safety

A column by Maureen Flynn

National Office of Clinical Audit

THIS month we continue our series on the work of the National Office of Clinical Audit (NOCA). NOCA established the Irish National Intensive Care Unit (ICU) Audit in 2013 to measure the quality of care in ICUs by benchmarking outcomes to internationally recognised standards.

The objectives of the audit include:

- Use audit to drive improvements in quality of care
- Measure activity to inform configuration of Critical Care services
- Provide data to support HIPE and Activity Based Funding (ABF)
- Audit Health Care Associated Infection (HCAI)
- Capture data on potential organ donors and organ donation to support Organ Donation and Transplant Ireland (ODTI) to minimise missed opportunities.

Information for ICU audit dataset

The National ICU dataset is comprised of the Intensive Care National Audit and Research Centre (ICNARC) dataset as well as an extended national dataset. The audit collects data from across the patient journey on areas such as:

- Pre-ICU admission
- Past medical history
- Diagnosis
- Interventions in ICU
- Infection in ICU
- Organ donation
- ICU and hospital discharge data.

Partnership

NOCA works in partnership with ICNARC in the UK for data validation and benchmarking. ICU audit data management is aligned to HIQA information standards and the forthcoming data quality guidance (HIQA in press) and the General Data Protection Regulation (GDPR) 2016/679. These processes include data collection, data storage/security, data entry, validation, extraction, dissemination and reporting.

ICU audit nurses from hospitals around the country pictured at a NOCA ICNARC workshop earlier this year

ICU Audit nurse's role

The ICU Audit nurse works as part of the hospital's ICU multidisciplinary team and participates in the local governance for ICU Audit. Nurses are critical to the success and sustainability of National ICU Audit in a hospital. The ICU audit nurse is essential for implementation, assisting the national team to link with existing local ICT systems. Ongoing responsibilities include data management, communication and dissemination of ICU Audit output. NOCA provides ongoing training, education and support to ICU Audit nurses nationally. NOCA also provide centralised workshop training bi-annually supported by ICNARC (Picture of workshop March 2018).

Get involved

At your next unit or team meeting you might like talk about the ICU audit findings for your service. ICU Audit is currently collecting data in 15 public hospitals, which encompasses 18 individual units, with the first unit going live in January 2015. Currently, University Hospital Limerick, Beaumont Hospital, Mater Misericordiae University Hospital, Our Lady of Lourdes Hospital Drogheda, St James's Hospital, Tallaght University Hospital, University Hospital Galway, University Hospital Waterford, St Vincent's University Hospital, Regional Hospital Mullingar, Wexford General Hospital, St Luke's Hospital Kilkenny, Connolly and Naas Hospitals and Midland Regional Hospital Tullamore are collecting live data. Cork University Hospital is in implementation, with the remaining six hospitals going live by mid-2019.

There is a planned further phase of implementation in public hospitals. There is engagement and interest from the private hospitals in participating in National ICU Audit. An interim National ICU Audit Report on 2017 data is planned to be published in early 2019.

Further information

More information is available on the website **www.noca.ie** or from Mary Baggot, National ICU audit co-ordinator at email: marybaggot@noca.ie

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

Acknowledgements
Thank you to Mary Baggot and the NOCA team for assistance in preparing this Column. Dr Rory Dwyer, ICU audit clinical lead, along with the ICU Audit governance committee, wishes to extend thanks and gratitude to ICU clinical leads and ICU audit nurses collecting and entering data.

Q and A Bulletin Board

With INMO director of industrial relations Tony Fitzpatrick

Query from member

I am a staff nurse on the LSI of €45,248 and got a promotion to CNM2. What point of the scale will I move to?

Reply

The principal Starting Pay on Promotion Rules, which are laid down in Department of Health Circular 10/71, apply in this instance. In a situation where the difference between a nurse or midwife's existing pay and the first point of the higher scale is greater than the value of an increment on the new scale, the nurse/midwife would move from their existing scale to the first point of the new scale. As the staff nurse's existing pay is €45,248 and the first point of the clinical nurse manager (CNM) 2 scale is €48,570, the difference is €3,322 which is more than the value of an increment on the CNM2 scale, the value being €805. The staff nurse will move to the first point of the CNM2 scale.

Query from member

I had planned to start my maternity leave at 37 weeks, two weeks before my due date, as per the Maternity Act requirement, but my baby came early at 34 weeks. How does the new change to the Social Welfare Act with regards to premature births affect me?

Reply

If your baby arrives early at 34 weeks and you had planned to start your maternity leave at 37 weeks, you will be eligible to extend your maternity leave by that three weeks. You will start your 26 weeks maternity leave at 34 weeks and as you are working within the public service, you will receive maternity pay for a period of 26 weeks.

On expiry of this 26-week period, you can then claim maternity benefit for the additional three weeks. Your initial maternity leave period will now extend to 29 weeks. Following this extended period of maternity leave, you can then commence any approved additional maternity leave. A circular on this matter is due from Department of Health in August and a further update will follow in due course.

Suspension of registration

Edward Mathews continues his series on the fitness to practise process, this month discussing suspension of registration pending a complaint being processed

IN THIS article, we continue our consideration of the Fitness to Practise (FTP) processes for nurses and midwives. This month we will focus on what happens when there is application to suspend the registration of a nurse or midwife prior to the complaint being processed in the normal way.

When a complaint is made to the NMBI, in the vast majority of cases it proceeds directly to the Preliminary Proceedings Committee. However, in a small number of cases the NMBI director of regulation, or the PPC itself, may form the view that the complaint is so serious that, in order to protect the public, it may be necessary to seek the immediate suspension of the registrant's registration pending resolution of the complaint through the normal FTP process. Indeed, the Board may form this view in relation to a nurse or midwife even if a complaint has not been made. Such a circumstance might occur where a registrant was convicted of a serious crime that has been reported in the media, but was not the subject of a complaint to the Board.

In these circumstances the complaint is initially dealt with pursuant to section 58 of the Nurses and Midwives Act 2011, which allows the Board apply to the High Court seeking suspension of registration pending resolution of the complaint through the normal PPC/FTP procedures. If the Board makes such an application it does so in a manner known as an *ex parte* application, which means that only the Board is heard and the registrant is not represented at the hearing.

In general, such hearings are held in private. The Court may grant or refuse the application, or may give such other directions as it thinks appropriate to the Board. The Board is then obliged to inform the registrant of the outcome. If the application is granted then the registrant's registration is suspended and, as such, they may not practice any element of nursing or midwifery pending resolution of the complaint in the normal way.

Where the director of regulation or the PPC determines that protection of the public safety may require immediate suspension of registration they inform the CEO of the NMBI, who then arranges a meeting of the full board of the NMBI to consider whether or not to make an application to the High Court. At this stage the registrant is informed of the nature of the complaint, is provided with all available documentation and is invited to attend the full board meeting with their representative. Here they can address the Board in relation to whether or not it should make the application to the High Court.

This is clearly a draconian measure that has the potential to have the most drastic effect on the life of a nurse or midwife, and as such it is a process to be approached only in cases where there is a perceived danger to the public. In addition prior to deciding whether to make an application to the Court, the Board is obliged by law to give careful consideration to a range of circumstances as was established by the Supreme Court in *O'Ceallaigh-v-An Bord Altranais* when considering the analogous provision in the Nurses Act 1985.

When the Board deliberates at this stage, it is not required to decide whether or not the allegations against the registrant are true, thus it does not investigate the matter and is required to make a decision based on the written information in the complaint and supporting the complaint, and based on any written or oral submissions made by or on behalf of the registrant at the meeting.

In order to proceed with a section 58 application the nature and circumstances of the allegations must be of such a magnitude that it would put the Board in a position of believing that such an application was required, and it was required by virtue of the necessity of protecting the public, which is a key function of the NMBI. The deliberations must also take into account the draconian effect that any application would have on the registrant, including the significant reputational damage which follows the granting of such an application and this must be weighed against the level of concern the Board may have for the protection of the public.

In looking at the nature of the allegations before the NMBI, it must consider whether, if they were true, they would impact significantly on the public interest. This analysis is also informed by the principle that allegations should be viewed in context. Specifically, case law mandates that the Board considers whether if the allegations were true they would represent a threat to public safety. When considering if there is a risk to public safety, the Board must consider if the allegations before them amount to a singular allegation of misconduct or allege a pattern of misbehaviour. It must then consider the nature of the danger it believes the alleged incident poses to public safety.

Level of urgency

Another point for the Board to consider is the level or urgency that the alleged allegations present. The Supreme Court has established that there must be a situation of urgency, arising from the seriousness of the allegations, before this draconian device is deployed. To determine whether such a situation of urgency exists the Board must consider the nature of the complaint, the apparent strength of the case against the registrant and whether if an adverse finding through the FTP process arising from that complaint, ie. if the allegations were found to be true, then the appropriate sanction would be to strike the registrant off the register permanently or for a defined period of time.

Drawing these elements together we see that section 58 allows the board to apply to the High Court for the suspension of registration prior to the complaint being addressed in the normal way. This is a draconian measure only to be used where there is a concern that suspension is necessary to protect the public. The full Board meets to consider whether this should occur and offers an opportunity for the registrant and their representative to be heard.

When making the decision the Board need to consider the following:

- The reputational and other damage such an outcome causes to a nurse or midwife, weighing this against the potential danger to the public
- They are not required to determine whether the allegations are true
- They should consider whether if they were true they would represent a threat to the public interest in the form of a threat to public safety, and in this regard also consider whether they are faced with allegations of singular misbehaviour, or a pattern of misbehaviour
- The situation must be sufficiently urgent, and urgency should be determined with reference to the nature of the allegations, the strength of the evidence, and the appropriate sanction should be a strike off if they were found to be correct.

It is essential that nurses and midwives are appropriately represented at the full board meeting. It is by no means the case that the Board always decides to make a section 58 application and there are instances where the representations made on behalf of the nurse or midwife, which will often give the Board an alternative view, have led to an application not being made and the registrant continuing in practice.

In addition, depending on the nature of the allegations, it may be possible for the registrant to give undertakings not to practice in certain areas or not to undertake certain types of practice. In some cases this assuages the Board's public safety concerns and an application is not made to the High Court.

Furthermore in some instances it may be advisable for the registrant to give an undertaking not to practise nursing or midwifery at all and offer this to the Board as an alternative to them seeking an order from the High Court suspending their registration. The Board is free to accept this, or not but in certain types of cases such an undertaking may assist a nurse or midwife when the Board is ultimately considering the sanction to impose against them after the FTP process has concluded.

If an application is made to the Court, or if an undertaking not to practice nursing or midwifery is accepted, then the registrant may no longer practice in any aspect. The case then moves along the normal path pursuant to section 55 of the Act and the PPC will firstly determine whether there is a face value case for you to answer. If it determines that there is, or if they do not and the Board nevertheless directs in inquiry, then the matter proceeds to an FTP hearing.

A section 58 application to suspend presents intense worry for a registrant, and clearly the effect is nothing less than devastating. That said, with INMO assistance it may be possible, depending on the facts of the case, to avoid an application being made to the High Court and it is imperative that you contact the Organisation the moment you receive any such correspondence.

Edward Mathews is INMO director of regulation and social policy

Nurse-led service cuts wait times for eye surgery

Diana Malata had a lead role in the implementation of a nurse-led corneal crosslinking service that has benefited both the patients and the Royal Victoria Eye and Ear Hospital where she works

THE waiting list of patients for a specialist appointment in public hospital services has increased over the past decade. In Ireland, hospital waiting lists continued to rise despite tens of millions of euro pumped into the health system to reduce delays.[1]

According to the National Council for the Blind of Ireland (NCBI), currently the longest waiting list for outpatient appointments and surgery is in ophthalmology.[2] The latest figures show that in February 2017, almost 34,000 people were waiting for outpatient ophthalmology appointments and 3,898 of these had already been waiting for at least 18 months.[2]

According to NCBI chief executive Chris White: "It is clear that ophthalmology waiting lists are out of control and this is even more shocking when you consider that as much as 75% of sight loss is avoidable."[2] This means that people are dealing with vision loss that may have been prevented if they were diagnosed early and had timely access to treatment. Such evidence would strengthen the need to develop more nurse-led ophthalmic services that will help reduce the growing waiting list in the health service.

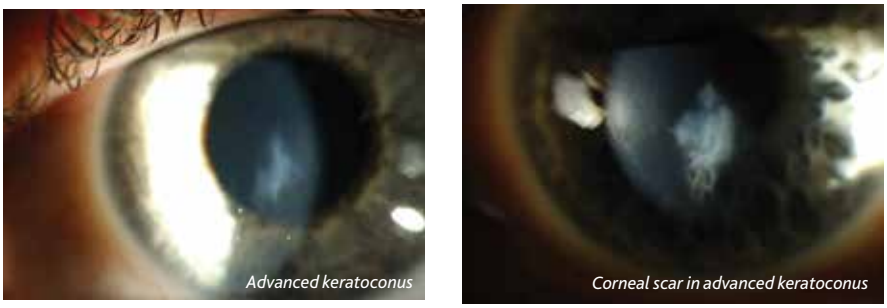
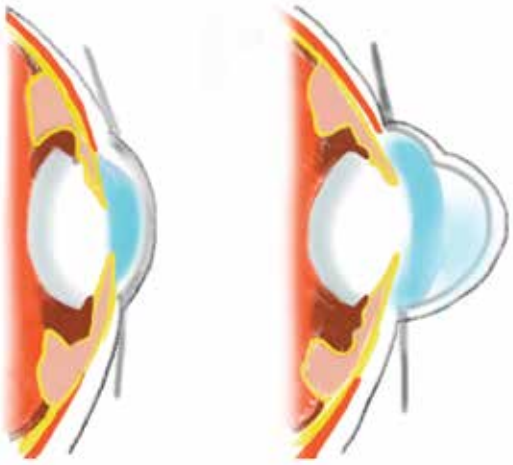


Figure 1: Illustration of a healthy eye and eye with keratoconus



Nurse-led corneal crosslinking service

Corneal crosslinking (CXL) is a treatment for keratoconus, a non-inflammatory eye condition in which the normally round dome-shaped cornea progressively thins causing a cone-like bulge to develop.[3]

In keratoconus, eye rubbing, genetic predisposition and poorly fitted contact lenses cause eye bulging which results in astigmatism, blurry vision and increased sensitivity to light.[4] It typically begins in the teens or 20s (age group: 10-44), and if not diagnosed early could result in significant visual dysfunction, reduced quality of life and permanent changes in lifestyle.[5]

Before CXL, there were no interventions available to arrest or slow disease progression and corneal transplantation was required in up to 25% of keratoconic eyes.[6] As soon as keratoconus is detected, at as young as 10 years of age, CXL is recommended to prevent vision loss.[5]

Early detection of keratoconus using topography screening has become the norm, resulting in many countries almost eliminating the need for corneal transplantation due to advanced keratoconus.[5] Therefore, early diagnosis is essential and timely access to CXL treatment is necessary to stop the progression of keratoconus and to achieve better visual outcomes.

The Royal Victoria Eye and Ear Hospital (RVEEH) through the years has pioneered nurse-led services in ophthalmology. In January 2016, with the collaboration of ophthalmologists and ophthalmic nurses in RVEEH who were open to innovation in ophthalmic services, the first nurse-led CXL service in Ireland started in RVEEH.

Five CXL procedures were observed before starting the training programme. Some 20 CXL procedures were done under supervision on February 23, 2016.

The nurse-led CXL service has its own

cohort of patients whereby the nurse assesses, obtains consent, performs the surgical procedure and prescribes medication.

Objectives

The main objective of this study was to explore the impact of the nurse-led CXL service on patient care. The study investigated patients' acceptability and satisfaction with the nurse-led ophthalmic service, its impact on reducing patient waiting time for treatment and patient stay in the hospital, its safety and cost-effectiveness.

Methodology

A retrospective chart review was performed in January 2017 to assess the result of the nurse-led CXL service. Medical charts of patients who were treated in the nurse-led CXL service from January 2016 to December 2016 were reviewed. A sample of 128 eyes from 100 patients was chosen for this study. Data on post-operative outcome, patient waiting time for CXL and patient stay in the hospital during CXL treatment were collected and analysed.

To compare the waiting time before the nurse-led CXL service, 20% of the 119 eyes treated with CXL from January 2014 to December 2014 were randomly selected. Information on patient waiting times for treatment and patient stay in the hospital was collected and analysed.

A patient satisfaction survey was carried out among patients who were treated in the nurse-led CXL service. The survey was conducted by telephone. This is to assess patients' acceptability and satisfaction with the nurse-led CXL service. The Likert-type scale was used for seven statements to assess satisfaction with the nurse-led service and one question was used to determine patient preference in terms of practitioner.

A medical student from the Royal College of Surgeons in Ireland (RCSI) surveyed the patients to avoid bias. The aim of the study was explained to the respondents and informed consent was obtained verbally. Patients' responses were entered into a database spreadsheet and analysed.

Findings

Patient satisfaction

Some 95 patients participated in the telephone patient satisfaction survey. Results showed that 72% of patients were very satisfied with the nurse-led CXL service, 23% were satisfied, 2% uncertain, and 3% were not satisfied – although in all of these cases the dissatisfaction arose from delays in receiving follow-up appointments rather than the procedure itself (*see Figure 1*).

During the telephone survey, the patients were also asked if they prefer a nurse or a doctor to perform the surgical procedure for them, this is to determine patient preference in terms of practitioner. Most prefer a skilled practitioner, be it a nurse or a doctor. The result showed that 78% of patients did not mind if a nurse or a doctor did the procedure, while 9% preferred the nurse and 13% would have preferred if a doctor did the procedure.

Table 1: Waiting time before and after nurse-led CXL service

Waiting time for CXL treatment	Doctor-led CXL Jan 2014-Dec 2014	Nurse-led CXL Jan 2016 -Dec 2016
Mean	125 days	53 days
Range	86 -212 days	7-194 days

Table 2: Patient stay in the hospital before and after nurse-led CXL service

Patient stay in hospital	Doctor-led CXL Jan 2014 – Dec 2014	Nurse-led CXL Jan 2016 – Dec 2016
Mean	Three hours 14 minutes	One hour 29 minutes
Range	One hour 50 minutes to three hours 55 minutes	55 minutes to two hours

Table 3: Cost of corneal transplant vs CXL

Corneal transplant	CXL performed by consultant	Nurse-led CXL service
€8,000 per eye	€1,700 per eye	€80 (government levy)
CXL is not covered by most health insurance. Only Laya and Irish Life cover CXL but they take time to approve the procedure		

Figure 2: Results of the patient satisfaction survey

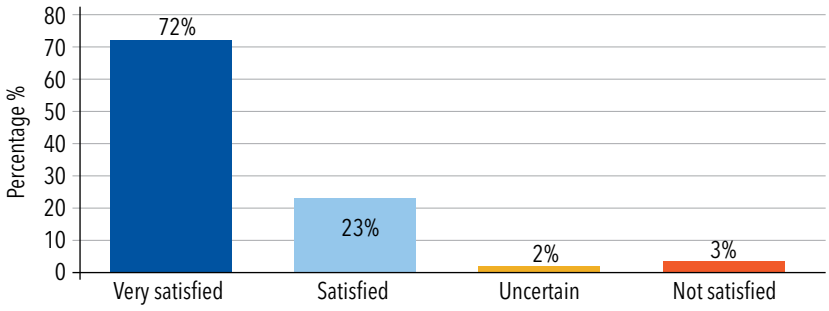
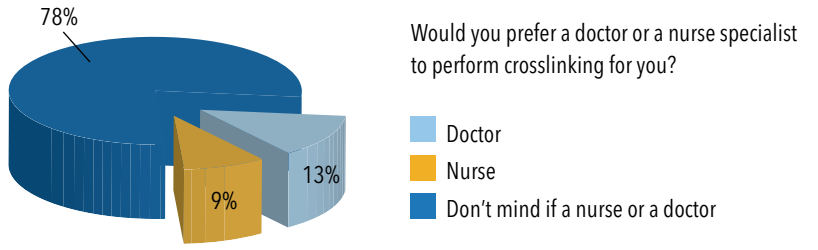


Figure 3: Preference for doctor or nurse-led surgery



Overall, the nurse-led CXL service was well accepted by patients *(see Figure 2)*.

Quality assurance

Quality assurance mechanisms are essential to ensure safe practice and to detect any suboptimal management in nurse-led ophthalmic services.[7] In this study, safety was monitored by recording the post-operative complications of nurse-delivered CXL over a 12-month period.

Some 144 eyes were treated in the nurse-led CXL service from January 2016 to December 2016. Twenty eyes were treated under the supervision of the consultant surgeon or corneal fellow/registrar and 124 eyes were treated by the corneal nurse specialist without direct observed supervision with no adverse events. Three (2.1%) eyes developed corneal infiltrates post operatively which responded well to treatment. Two eyes developed corneal haze which gradually improved after a month (*see Figure 3*).

Results showed no patient had serious post-operative complications from the nurse-delivered CXL. Most patients had healed corneal epithelium one week post CXL treatment.

Patient waiting times

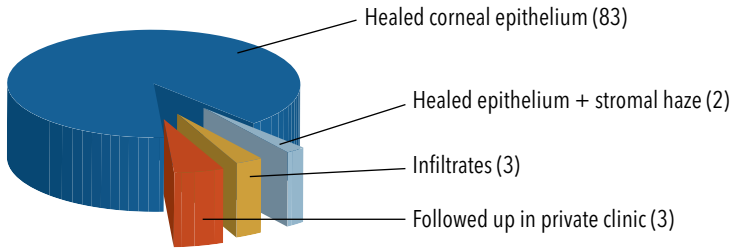
The goal of early treatment of keratoconus is to provide maximal vision function and to avoid the need for corneal transplantation.[5] It is essential that patient should be treated with CXL as soon as they are diagnosed. The study showed that the introduction of nurse-led CXL service has reduced patient's waiting time for CXL treatment (*see Table 1*).

Pre-operation waiting time can for most patients become a very emotional time, the longer they wait the more anxious they become. A study by Bleustein et al[8] confirms the strong relationship between waiting times and patient satisfaction.

While it has always been the goal of healthcare systems to provide quality care as efficiently as possible their study further emphasised the need to minimise waiting time to improve patient satisfaction. Minimising waiting time in hospital promotes better patient experience thus improving patient satisfaction. This is one of the goals of the nurse-led CXL service, to minimise patient stay in hospital.

The study showed that patient stay in the hospital from admission to discharge was reduced with the introduction of the nurse-led CXL service. Patients used to wait more than three hours for a doctor to be available to perform CXL treatment. This is because junior doctors are busy admitting patients in the ward or doing surgical procedures in theatre. With the nurse-led CXL service the mean patient stay in the hospital fell to 1.29 hours (*see Table 2*).

Figure 4: Safety of nurse-led CXL service



Cost-effectiveness

One of the main advantages of the nurse-led services is its cost-effectiveness compared to the medical-led services. The key determinant of cost-effectiveness is the practitioner's salary,[8] but cost of consumables also has an impact in the treatment of keratoconus patients. If keratoconus is not diagnosed and treated early, the condition continues to progress causing high corneal curvature, high astigmatism, low visual acuity, presence of corneal scarring and poor contact lens tolerance, in which case the patient will require cornaseal transplantation.[9] Corneal transplantation is traditionally viewed as being successful in restoring vision. However it consumes considerable resources in terms of surgical cost, surgical time and follow-up, and requires constant access to donor tissue.[10]

In Ireland, corneal transplant costs €8,000 per eye, excluding the consultant fee and anaesthetist's fee. There's also the risk of graft failure, graft rejection and repeat of corneal transplant. CXL has less risk than corneal transplant and is cheaper – costing €1,700 per eye in private hospitals in Ireland. However for the nurse-delivered CXL, the patient will only pay a hospital levy of €80 per eye. This service is contributing more savings to the health service (*see Table 3*).

Conclusion

To my knowledge, this study is the first report on the outcomes of nurse-led CXL service. The results showed that Ireland's first nurse-led CXL service at RVEEH is as safe and effective as CXL performed by ophthalmologists. The service is acceptable to patients as reflected in the patient survey, which revealed overwhelming patient satisfaction levels. The study also showed that the nurse-led CXL service has reduced patient waiting time for treatment as well as patients' stay in the hospital.

With early diagnosis of keratoconus and timely access to CXL treatment, the need for corneal transplantation can be eliminated resulting in significant cost savings to the health service and better quality of life to patients.

Diana Malata is a clinical research nurse at the Royal Victoria Eye and Ear Hospital in Dublin. Her work on setting up this service formed a research project that was the winner of the CJ Coleman 2018 INMO Research Award

Acknowledgements: Illustration by Ed Reynolds. Photos by Stephen Comiskey and Hugh Nolan. Patient survey by Othman Alrashidi

References

1. Cullen P and Duncan P. (2015) Inpatient, day case waiting list soar 11,710 percent, The Irish Times, October 9, 2015
2. Gordon D. (2017) Ophthalmology waiting lists 'out of control', Irishhealth.com, http://www.irishhealth.com/article.html?id=25730, March 14, 2017
3. Godefrooji DA, de Wit AG, Uiterwaal CS, Imhof SM, Wis RPL. (2016) Age-specific Incidence and Prevalence of Keratoconus: A Nationwide Registration Study, American Journal of Ophthalmology, Volume 175, 169-172
4. Trattker W. (2016) Corneal Cross-linking (CXL): For Keratoconus Treatment And LASIK-Related Corneal Ectasia. [Internet]: San Diego: allaboutvision.com; undated [updated 2016 Nov, cited 2017 Feb 15]
5. Tullo W. (2013) When do you diagnose keratoconus? Optometry Times, May 22, 2013
6. Pearson AR, Soneji B, Sarvananthan N, Sandford-Smith JH, (2000) Does ethnic origin influence the incidence or severity of keratoconus?, Eye (London), Aug;14 (Pt 4):625-8
7. Kirkwood JB, Pesuvidovs K, Latimer P and Coster D. (2006) The efficacy of a nurse-led preoperative cataract assessment and postoperative care clinic, Medical Journal of Australia, 184;6; 278-281
8. Bleustein C, Rothschild DB, Valen A, Valatis E, Schweitzer L, Jones R. (2014) Wait times, patient satisfaction scores, and the perception of care, American Journal of Managed Care, May;20(5):393-400
9. Kirkwood JB, Pesuedovs K, Loh R and Coster DJ. (2005) Implementation and evaluation of an ophthalmic nurse practitioner emergency eye clinic, Clinical and Experimental Ophthalmology, 33; 539-597
10. Sray WA, Cohen EJ, Rapuano CJ, Laibson PR. Factors associated with the need for penetrating keratoplasty in keratoconus, Cornea, 2002; 21(8):784-6
11. Salmon HA, Chalk D, Stein K, Frost NA. Cost effectiveness of collagen crosslinking for progressive keratoconus in the UK NHS. Eye (London). 2015;29:1504–1511

It's not a book about Brigitte

HAVE you read '*Lincoln in the Bardo*' by George Saunders?

Mister Freeze in Batman in the 1960s? Neh neh neh neh neh neh neh neh…

No, that was George Sanders.

Oh…what's a Bardo? Anything to do with Brigid?

Brigitte, not Brigid. And there's a 't' at the end of her surname.

Oh, so it is about her. And Abe Lincoln. Eh, isn't that a bit of a rude title?

No, no, no! Let's start again. It's set in America, during the Civil War.

I still haven't found out what a bardo is.

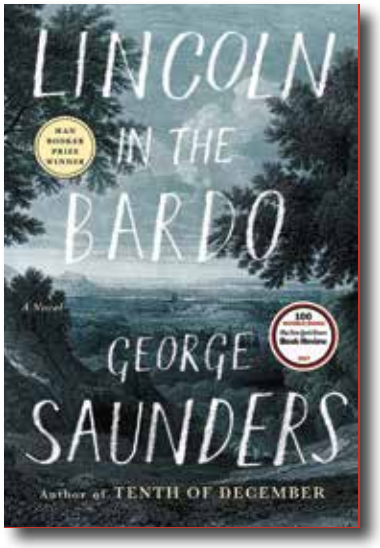
It's em… the state of the soul between death and rebirth. I think. Lincoln's son died during the war, aged 11.

So this must be a gripping and touching work of great literary, historical and social interest.

You'd think. It starts off sensibly enough, with a long bit. Continuous prose. Decent sized paragraphs. Setting the scene. Exposition, characterisation etc.

Ah. Compare and contrast, discuss with examples from text. Question 1 carries 50 marks. Didn't get the points you required? Don't despair…

Yes, yes, yes. Tried and trusted. Well



within one's literary comfort zone.

And then what happened?

Imagine my surprise…

I'm imagining it.

When I came across this: "Exotic flowers from the presidential greenhouse were in vases every few yards – Kundhardt and Kundhardt. *op cit*." And "Wild shrieks rang out. - Sloane. *op cit*."

Op cit? Wait a minute, isn't that like viz? Those yokes in the history books you always meant to read in college. Anyway what's your…

Point, what's my point? What's the book's point more like. There's hundreds of pages of short statements attributed to people with names like Roger Bevins the Third, It's not a novel, it's a series of historical tweets.

It's avant garde. Some people like that.

Such as the reviewer who wrote: "Oh joy! Run out into the street this instant, rend your garments in twain, hop, skip and jump to the village green, climb a maypole and declaim loudly. For this book is a structurally daring box of scrummy chocolates, forsooth!"

I read a book last week that had a big deep hole gouged in it half way through so people could see what happened on the last page. Which was handy 'cos I was getting a bit bored with it.

But this Lincoln in the Bardo yoke won the Booker prize!

I was always more of a Mills and Boon man meself…

– Niall Hunter

Lincoln in the Bardo. By George Saunders. Published by Bloomsbury. RRP £12.99

CROSSWORD Competition

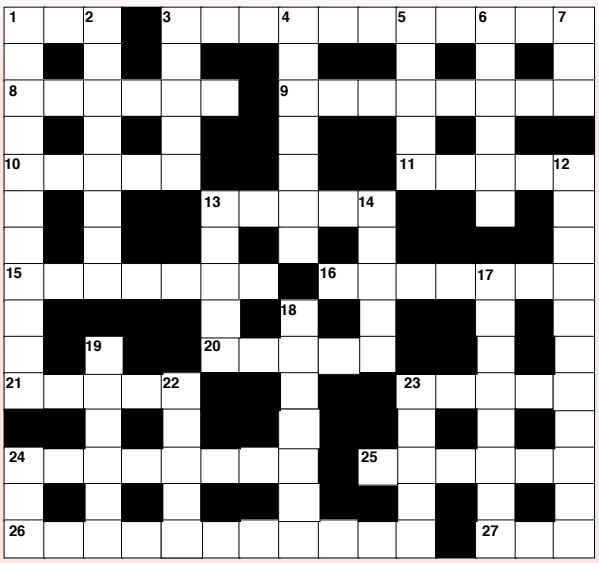
WIN a €30 gift voucher

Across

1 Taxi (3)
3 You can keep your hand in by playing with this! (5,6)
8 Save from danger (6)
9 The process of getting back to good health (8)
10 The charging of excessive interest on a loan (5)
11 Sum (5)
13 Invoices Messrs Clinton and Gates (5)
15 Struggled, scuffled (7)
16 Biblical girl's name (7)
20 Booth (5)
21 Toys that have their ups and downs! (2-3)
23 Entire (5)
24 The draining tube might literally act there (8)
25 Imitated (6)
26 Knocking down, destroying completely (11)
27 Spoil, impair (3)

Down

1 & 19d Lusty ceramic story about the heart, arteries and veins (11,6)
2 Cookies (8)
3 Garishly coloured (5)
4 Smallpox (7)
5 Historic German submarine (1-4)
6 Attractive, good-looking (6)
7 Your old word is found finally in Enniscorthy (3)
12 Money properly issued, not counterfeit (5,6)
13 Fracture (5)
14 Meat made of Southern hardwood (5)
17 This chemical element may let out a micro hum (8)
18 King or queen (7)
19 See 1 down
22 Explosive found on the beach? (5)
23 Incorrect (5)
24 Bounder (3)



Jul/Aug crossword solution

Across: 1 Antibiotic, 6 Odin, 10 Hippo, 11 Nocturnal, 12 Red deer, 15 Party, 17 Expo, 18 Okra, 19 Rambo, 21 Pageant, 23 Patch, 24 Brat, 25 Yelp, 26 Tales, 28 Theorem, 33 Twitchers, 34 Atoll, 35 Ride, 36 Clay pigeon

Down: 1 Ache, 2 Top secret, 3 Blood donor, 4 Ounce, 5 Inca, 8 Nil by mouth, 9 Support, 13 Elba, 14 Receipt, 16 Competitor, 20 Morse code, 21 Physics, 22 Nike, 27 Laird, 29 Hasty, 30 Omani, 31 Deal, 32 Plan

The winner of the July/August crossword is: Clodagh Cronin Cavan

You can now email your entry to us at nursing@medmedia.ie by taking a photo of the completed crossword with your details included.
Closing date: Friday, September 21, 2018
If preferred you can post your entry to: Crossword Competition, WIN, MedMedia Publications, 17 Adelaide Street, Dun Laoghaire, Co Dublin, A96E096

Name:
Address:

When it pays to switch

Ivan Ahern discusses the various benefits of switching health insurance policy

2018 has seen a lower average premium increase on health insurance policies than in previous years. Some insurers have even decreased premiums across many of their plans. That being said, all insurers have released new corporate plans to the market which may offer better value than your current cover. With more than 330 plans on the market across the three health insurers, comparing cover remains a challenge for consumers.

Whether you are buying your first policy or renewing your cover, the good news is that there are a number of ways to find the policy that best meets your needs while cutting the cost of your premium. We've put together some questions you can ask yourself to help you find ways to save money on your health insurance:

- Is private hospital room cover important to you? You could make significant savings if you change from private to semi-private room cover in private hospitals (a semi-private room includes a maximum of five beds)
- Is a 'Network Plan' something you would consider? These are plans that offer a limited selection of public or private hospitals
- Are all family members on the same health insurance plan? You may be able to save money by putting your children (including young adults aged 18-25) on a separate, lower cost plan that provides similar cover
- Do you pay for your policy in instalments or in one lump sum payment? Paying in instalments may be costing you more money in the long run. Calculate how much you may be saving by doing a comparison between paying upfront and your monthly cost
- Is cover for everyday practitioners (GP, physiotherapist, dentist etc.) something you need? Some plans allow you to claim back for these visits. A good rule of thumb is if you have less than three or four visits per year it doesn't make sense financially to pay extra premium to cover such visits. However, if you have several of these visits per year paying €50-75 extra on your annual premium could allow you to claim back €100s during your policy year. Do the maths before opting for a plan with (or without) these benefits.

New health insurance benefits		
Online GP	Free multi-trip travel insurance	Health screen contributions
Fertility benefits	Gym membership contribution	Telephone counselling services
Submit claims online	International second opinion service	Dietitian/nutritionist visits
Wellness benefits	Wearable tracker (Fitbit) Contribution	24 / 7 Nurse line

Savings

Potential health insurance savings can be made by switching to comparable plans with your existing provider or with an alternative provider. However, you need to be mindful when making savings on your health insurance. Downgrading health insurance to make savings can result in higher excesses, the removal of certain hospitals and restricted access to high tech hospitals etc.

It is also important to remember that if you downgrade cover and return to a higher level of cover at a later stage, then a two-year upgrade rule for existing illnesses could apply. This is where it is important to get advice from a qualified health insurance expert who can talk you through the impact of any changes you are making to your cover. On average those that used our comparison service to review cover saved €488[1] on their renewal.

The health insurance industry has evolved and many plans now provide cover for a variety of new benefits at no extra cost on your plan *(see Table)*.

Switching

Many people consider switching health insurance providers, but some are fearful of the consequences of doing so because of myths and misunderstandings. Reviewing your cover on an annual basis should be seen as an opportunity to make sure that you are on the best cover that meets both your budget and your needs.

It's important to remember that if you do switch insurers that:

- You will not have to re-serve waiting periods
- You will not have a break in your cover
- Any lifetime community rating loading will not be affected by switching
- It is not time consuming.

If you do decide to switch provider, you may be able to avail of new offers across plans such as child offers, young adult discounts, free multi-trip travel insurance etc.

Cornmarket's Health Insurance Comparison Service can add real value by reviewing the options from all the providers on your behalf and providing a documented comparison of your existing plan against its recommendation. This service compares all health plans on the market to help you choose the plan that suits you. Contact Cornmarket at Tel: 01 4086212.

Ivan Ahern is a director at Cornmarket Group Financial Services

1. Average saving based on 2,626 members who reviewed their cover between January 1 and September 30, 2017 Source, Cornmarket 2017.

Retirement of Breedagh Hughes

Stalwart of RCM Northern Ireland steps down after 21 years

DURING the summer, representatives of the INMO management team, the Midwives Section and the Professional Development Centre joined with the Royal College of Midwives (RCM) to celebrate the retirement of their Northern Ireland director, Breedagh Hughes.

Breedagh, in her 21 years with the RCM, promoted women's rights and midwifery care for mothers and children throughout Northern Ireland. She was a force to be reckoned with and in the most difficult of times travelled the length and breadth of the six counties promoting services and advancing midwifery practice, for the benefit of all.

Breedagh is both a dedicated advocate and a skilful diplomat showing the ability to deal with all of the political parties in Northern Ireland successfully but never backing off from a fight, where the rights of midwives or mothers had been compromised by cutbacks or lack of service.

Breedagh, in her years as director of RCM Northern Ireland, developed a strong relationship with the INMO and was a key force in establishing the annual all-Ireland midwifery conference. Most recently, Breedagh oversaw the partnership arrangement between the INMO and the RCM where our midwives in the Republic of Ireland will have full access to the major resources of the RCM in terms of education and training and mutual recognition when working in the other territory occurs.

The contribution of Breedagh Hughes to the RCM and to the development of health services in Northern Ireland is legendary. Her influence in bringing together the INMO and the RCM for the promotion of midwives and the services delivered is a testament to her excellence both as a trade unionist and as a midwife.

Breedagh is no stranger to Dublin, as she spent most of her summer holidays in her youth with her aunt in North Dublin. She promises to be a regular visitor during her retirement but first she is off to Spain to experience some rest, relaxation and good weather.

Breedagh Hughes and Anne Marie O'Neill, RCM administrator, pictured on the occasion of Breedagh's retirement from the RCM

Everyone at the INMO wishes Breedagh a very long and happy retirement.

New ANP role appointment in Sligo

Rosaleen White is Ireland's first ANP in pre-operative assessment

IRELAND'S first advanced nurse practitioner position in pre-operative assessment has just been appointed at Sligo University Hospital. Rosaleen White took up the position at the hospital in July 2018. The new role will support patients and families on their surgical journey while supporting the delivery of a patient-centred, evidence-based service.

Maximum pre-assessment of elective surgical patients increases day-of-surgery admission rates while reducing day-of-surgery cancellations, risk of infection and average length of stay. This has been shown to improve outcomes for patients after surgery.

SUH's pre-admission unit is an out-patient service to assess elective surgery patients within six months of the planned procedure. The clinic provides a multidisciplinary assessment for patients within the general surgical, urology, ear, nose and throat, gynaecological, obstetric and orthopaedic specialties. Once the need for surgery has been identified, the pre-admission unit is the initial point of contact for patients as they begin their surgical journey.

Rosaleen has extensive surgical and orthopaedic experience and has worked as a CNM2 in the pre-admission unit for almost ten years. A registered nurse prescriber, she trained at Connolly Memorial Hospital, Dublin and holds a BA and MSc in nursing studies from Trinity. She also completed postgraduate diplomas in orthopaedic nursing in St. Angela's in Sligo and in advanced nursing practice in NUIG. Her new role was supported by nurses, medical staff and hospital management.

Speaking about her appointment, Rosaleen said: "I'm delighted to start in the new role. Good pre-admission work not only improves outcomes but helps make patients feel supported through, what can be, a worrying time."

Rosaleen White, Ireland's first advanced nurse practitioner in pre-operative care

The INMO wish the very best to Rosaleen and all at SUH in this new venture.

Evidence shows that nurses save lives and improve outcomes

THE International Council of Nurses (ICN) has released a new position statement on evidence-based safe nurse staffing which calls for increased investment in safe, effective and needs-based nurse staffing levels in order to improve patient outcomes and create positive practice environments.

"There is clear evidence of the importance of safe nurse staffing in relation to patient safety in all healthcare sectors. Inadequate or insufficient nurse staffing levels increase the risk of care being compromised, adverse events for patients, inferior clinical outcomes, in-patient death in hospitals and poorer patient experience of care. The ICN recognises that safe staffing is a key priority and major issue of concern for many of our members and the nurses they represent," said Howard Catton, ICN director of nursing and health policy.

Research shows an increase of one registered nurse (RN) per 10 beds is associated with an 11-28% reduction in death 30 days following a stroke and with an 8-12% reduction one year following the stroke. Evidence further demonstrates that hospitals with higher proportions of baccalaureate prepared RNs have better patient outcomes and lower mortality rates.

In addition, inadequate staffing levels can lead to lower job satisfaction, increased levels of stress, staff burnout, a higher inclination to leave and increased staff turnover. This also has resource implications which a number of studies have shown are very significant.

The substitution of healthcare support workers for RNs and the development of new non-RN roles have been implemented in some countries as a possible solution to address a shortage of RNs and to reduce the wage bill. However, research shows that substituting RNs for less qualified cadres of workers may worsen patient outcomes and may not be cost-effective.

"Patient safety and the health of the nursing workforce are two sides of the same coin," said Catton. "Many nursing associations are concerned that staffing decisions are being driven by financial considerations rather than improved patient outcomes and practice environments. In order to deliver quality, patient-centred care, there is a real need for positive practice environments with an adequate number of staff, manageable workloads, managerial support, high quality leadership and the ability of nurses to work at their full scope of practice."

The position statement sets out both principles and key elements of approaches to ensuring safe staffing which is intended to help and support all those involved in determining staffing levels and ensure there is clear nursing leadership on this vital issue. It calls for:

- Establishment and implementation of safe nurse staffing systems based on real-time patient information
- Sufficient healthcare funding to deliver needs-based safe nurse staffing
- Effective staffing systems based on both patient safety and the health and wellbeing of staff
- Public awareness of the impact that safe nurse staffing has on patients, families and communities
- An end to the creation of substitute roles for registered nurses
- Promotion of nurse staffing research that includes economic analysis.

Workers struggling to secure rental homes

Threshold aims to assist those with accommodation difficulties

EVERY day Threshold's frontline services deal with the serious failings of the private rental sector. There is an ever-increasing number of people who are 'flat broke', unable to afford to rent or save for a deposit and who are ineligible for public housing, even if this was available. Across the country rents are significantly higher than a decade ago. Rents have risen from their lowest point by 70% on average – 87% in Dublin, 68% in the other cities and 53% elsewhere.

The severe lack of supply in rental accommodation is also pushing the cost of renting beyond the means of many, particularly key workers in the emergency services and in nursing. Conversations about getting on the property ladder are shifting as the reality for many people is that their struggle to find a home – to buy or to rent – feels more like being on an impossible treadmill.

Thomas, a public sector worker based in Cork told Threshold of his difficulties in finding somewhere to live: "Even if we could find a house, we cannot afford the rents being asked. We cannot get medical cards, GP visit cards or FIS. We cannot get state support of any type as we both work. We are exempt from nothing and liable for everything".

Securing a place to call home is a bit like a game of snakes and ladders but the rules of the game are constantly changing. No longer are rental deposits equivalent to a month's rent, landlords are seeking two and three months' rent in advance and there is no guarantee that your deposit will be returned. With rents averaging at €1,261 per month (according to a recent **Daft.ie** report) tenants are being asked to pay between €2,522 and €3,783 as a deposit. This exceeds the monthly take home pay of a staff nurse. Throughout the years Threshold has been campaigning for the introduction of a rental deposit scheme that would ensure that a tenant's deposit is safeguarded during their tenancy and that their deposit is returned to them at the end of their tenancy unless the landlord has clear grounds for seeking the deposit due to, say, damage to the property.

Threshold assists many individuals and families who have lost their homes when a landlord has served a 'notice to quit' based on a number of different grounds. These grounds include: the sale of the property, or because the landlord requires the property for their own use or that of a family member, or substantial renovation. Some landlords are terminating tenancies for spurious reasons to attempt to sidestep the rental cap regulations in rent pressure zones.

Last year Threshold dealt with over 5,000 queries in relation to tenancy terminations. Receiving a notice to quit can come as quite a shock, as one of our clients, Jean, who had been renting in Galway, pointed out: "We were given our six weeks' notice on Friday last and will be out by the end of August just in time for kids going back to school and my youngest is starting school for the first time. As of yet we have no idea where we will be living".

Dramatic rent increases and a lack of supply are closely associated with a rising trend in overcrowding. From our experience of working with people renting, bunk beds are now more common across rental accommodation in cities such as Dublin, with people doubling, tripling, and quadrupling up in rooms because of the lack of affordability and supply. In some situations, shift workers share a bed, using it at different times of the day.

It is more important than ever that people who are renting their homes are aware of their rights and receive the support they need to remain in their homes. Through both boom and bust over the past 40 years, Threshold has been to the fore in campaigning for better standards in rented accommodation and greater legal protections for people and families who are renting.

Threshold's free tenancy protection service provides crucial advice and support to people renting. We work to ensure that individuals and families can remain in their homes by advocating with landlords and letting agents and challenging invalid notices to quit and rent increases.

Here to help

Threshold is here to help, with regional advice centres in Dublin, Cork and Galway. For free, independent and confidential advice on your rights, you can Tel: 1800 454 454 or visit: **www.threshold.ie**

COPD risk for children exposed to secondhand smoke

CHILDREN who are exposed to secondhand smoke for long periods may face an increased risk of dying from lung disease later in life, a new study suggests.

Chronic obstructive pulmonary disease (COPD) is Ireland's fourth biggest killer and currently affects an estimated 380,000 people here.

While it was already known that secondhand (passive) smoke has an adverse effect on the lungs of both adults and children, until now, it was unclear whether childhood exposure to secondhand smoke was linked with mortality in adulthood.

US researchers decided to investigate this further. They looked at almost 71,000 non-smoking men and women aged between 50 and 74, over a 22-year period.

The study found that the mortality rate from COPD of those who had lived with a daily smoker throughout childhood, was 31% higher when compared with those who had lived with non-smokers.

While the researchers only looked at deaths, they believe that the findings suggest that living with a smoker during childhood could also increase the risk of non-fatal COPD.

The study also found that those who were exposed to secondhand smoke as adults (10 or more hours per week), had a 9% increased risk of dying from all causes, a 23% increased risk of dying from stroke, a 27% increased risk of dying from heart disease and a 42% increased risk of dying from COPD.

These findings were published in the *American Journal of Preventive Medicine*.

September

Wednesday 12
OHN Section Annual Conference Limerick Strand Hotel. Log onto www.inmoprofessional.ie for further details

Wednesday 12
RNID Section meeting from 10am on Care Management and Care Planning followed by national section meeting. To book please log onto www.inmoprofessional.ie or call 01-6640641/18

Thursday 13
Workforce Planning Symposium – The Richmond Education and Event Centre – go to **inmoprofessional.ie** to book your place

Thursday 13
Irish Nurses and Midwives male/female golf society annual outing - Ballinrobe golf club Co Mayo Cost €50 for coffee on arrival golf/dinner. To book Tel: 0949541118 or send your name, club and fee to Peggy Butler c/o Ballinrobe Golf Club. Cheques payable to Irish Golf Society (nonrefundable)

Saturday 15 September
International Nurses Section cultural evening from 5-9pm in the Richmond Education & Event Centre. Contact elizabethallauigan@yahoo.com, chairperson, to book your place

Tuesday 18
Retired Nurses and Midwives Section meeting, including a talk on the Fair Deal Scheme by journalist Sinead Ryan, INMO HQ

Saturday 22
Community RGN Section meeting. INMO HQ. 11am-1pm. Contact jean.carroll@inmo.ie for further details

Saturday 22
School Nurses Section meeting, Midland Park Hotel (formally Heritage Hotel Portlaoise). 10.30am. Contact: jean.carroll@inmo.ie for further details

Saturday 22
Clinical Nurse/Midwife Managers Section workshop. INMO HQ. Contact: marian.godley@inmo.ie for further details

Monday 24
National Children's Nurses Section meeting. INMO HQ. 11am. Contact jean.carroll@inmo.ie for further details

Thursday 27
Directors and Assistant Directors Section Executive Masterclass, Richmond Education & Event Centre. Followed by national section meetings. To book go to **inmoprofessional.ie** or Tel: 01-6640642

October

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

Saturday 6
PHN Section meeting, INMO HQ. 11am-1pm. Please note change of date. Contact jean.carroll@inmo.ie for further details.

Saturday 6
Reunion of past Meath Hospital Nurses Clayton Hotel, Burlington Road, Dublin. 5pm. Cost €50 per person. Contact Mary Kelly, Tel: 087 9393801

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

Saturday 13
Midwifery Section meeting, 2pm, Limerick. Contact jean.carroll@inmo.ie for further details

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

Thursday 18
SALO Group INMO HQ. 12-2.30pm. Contact jean.carroll@inmo.ie for further details.

Tuesday 23
Care of the Older Person Section education session on diabetes, and section meeting. INMO Cork office. Bookings via **inmoprofessional.ie** or Tel: 01-6640641

Tuesday 23
Third Level Student Health Nurses Section meeting. INMO HQ. Contact jean.carroll@inmo.ie for further details.

November

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

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

Saturday 24
The Non-Communicable Disease Epidemic – the role of Practice and Community Nurses. Please note this date in your diary. For additional information visit **inmoprofessional.ie**

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

INMO Membership Fees 2018

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

FOHNEU 2019

7th FOHNEU International Congress – April 24-26, 2019

The Federation of Occupational Health Nurses within the European Union (FOHNEU) is pleased to announce the 7th FOHNEU International Congress where the focus will be 'WORKFORCE HEALTH = NATIONAL WEALTH'.

We welcome abstracts for presentation from occupational health nurses and others on business, management, leadership, consulting, and financial aspects in all practice areas of occupational health nursing (final date for abstract submissions, September 30, 2018).

The 7th FOHNEU International Congress will take place in Budapest, Hungary on April 24-26, 2019. More information on the Congress can be found on the conference website **http://www.fohneu2019.hu/**