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WIN

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World of Irish Nursing & Midwifery

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The journey begins

IN THIS journal you can read, and study, the INMO's submission to the Special Oireachtas Committee on the Future of Healthcare *(see centre pages)*. From this Organisation's perspective the decision by government to establish this committee and undertake this review over the next 10 years, with a particular focus on how to develop a single-tiered universal health system in this country, is most welcome and long overdue. This Organisation has argued, for many years, that the current two-tiered system, where ability to pay guarantees access to healthcare, is unfair and inequitable.

In this submission the INMO is calling for radical reform, which may take well over 15 years, so that we move to a single-tiered health service, with universal access for all, funded through a progressive equitable general taxation system. We are seeking that all essential services would be directly provided by the State through staff directly employed on public-only contracts. This fundamental objective will, at first glance, engender widespread support across the population. However, in seeking this massive shift in policy and attitude, we must remember that any single-tiered service must offer speedy access and quality assured services to every citizen, if it is to become a cornerstone of Irish society.

We all know that, currently, private healthcare, whether accessed directly or through private health insurance, offers swifter access to both diagnostic and, where necessary, procedures done on an elective basis. Any shift to a single-tiered service must therefore involve, for the transitional period, increased levels of funding so that existing services can be maintained while new models of care, necessary to ensure efficiency and effectiveness, are developed at local, regional and national level. This is necessary to secure, and maintain, public confidence.

We should not underestimate the challenge, at political, stakeholder and societal level, which will accompany the goal of introducing a single-tiered service over the next 15 years. However, to continue with the current inequitable two-tiered system, with its inherent unfairness, duplications and profit seeking elements, will completely fail to prepare us for the challenging demographics and ever increasing demands for healthcare, which will confront us in the years ahead.

The INMO looks forward to engaging with this Oireachtas Committee, and participating in the wider, public, debate which must now take place. We ask all members to join with us in seeking the establishment of this new universal public health service which will be good for the individual, communities and, ultimately, the economy.

Welcome to our new colleagues

During this month, more than 1,500 new undergraduate nurses and midwives will, in 13 colleges across the country, begin their four-year journey leading to registration as a nurse or midwife. On behalf of everyone in the INMO I want to take this opportunity to welcome these dynamic and energetic future professionals into the great professions of nursing and midwifery.

The INMO will be meeting all of the new undergraduates in our visits to the colleges in the coming weeks, to advise them of the services offered by the INMO. We will confirm that we want to be their partner, throughout their time, as an undergraduate student, and thereafter, as a registered nurse/midwife in this country.

I also want to take this opportunity to congratulate this year's graduates who are now completing their four-year journey (at last!) and to wish them well as they start their working career as a registered nurse/midwife. It is our earnest hope and wish, as we work to ensure they will be offered permanent posts in the Irish health service, that they take up these posts and give their knowledge, skills and competence to the health service here at home.

All professions constantly need to be energised by new graduates who refresh us all with their vitality. Congratulations to our new first years and our graduating fourth years – to all of you, I say the INMO will, always, be your supporter and partner.

Liam Doran
General Secretary, INMO

Irish **Nurses** and **Midwives** Organisation

Cumann Altraí agus Ban Cabhrach na hÉireann

Working Together

The INMO, as the largest professional union for nurses and midwives, represents circa 40,000 members in all disciplines and areas of the Irish health service.

The Organisation provides a full range of services including industrial relations, continuing education and professional development, together with the most comprehensive dedicated library with educational and research facilities in the country.

The Organisation now wishes to fill the following post:

Student/New Graduate Officer

The post will be filled, under a fixed term contract, for one year which may be renewed for one further year.

The post holder will be responsible for:

- Recruiting undergraduate nurses/midwives, developing/delivering services required by these members during their degree programme and in the period following initial registration as a nurse/midwife
- Social media: Seek to further develop the Organisation's activities on social media platforms, including strengthening our presence on Facebook and Twitter with a particular target audience of members under 35
- Organising: Assist, in collaboration with relevant staff, and under the direction of our Deputy General Secretary, with the Organisation's activities in the area of organising, particularly in large hospitals, for the purpose of growing membership through strong recruitment and retention strategies, developing Youth Forums and the INMO's Student Section.

A nursing/midwifery qualification is essential for this post as is recent experience of the undergraduate programmes. The post-holder must also have excellent communication, IT and organisational skills. The post, while based in our Head Office, will involve travel to third level campuses and placement sites around the country.

Salary Scale: Staff Nurse/Midwife Scale (as of December 2010).

The job description for this post is available from the General Secretary's Office or from our website **www.inmo.ie.**

Detailed curriculum vitae, together with current certificate of registration to Liam Doran, General Secretary, INMO, Whitworth Building, North Brunswick Street, Dublin 7, not later than **12.00 noon, on Thursday, 16th September 2016**, with envelope marked **"Student/New Graduate Officer Post"** or email liam.doran@inmo.ie.

Your priorities with the president

Martina Harkin-Kelly, INMO president

Hello and welcome

WELCOME back after the summer break. As your president, I have hit the ground running over the past few months. We have had meetings with Simon Harris, Minister for Health, and Helen McEntee, Minister of State for Mental Health and Older People, at which the Organisation clearly articulated:

- The need for consensus on our healthcare services – a clear plan for the future
- Immediate measures to address the nurse/midwife recruitment and retention crisis
- The ongoing saga of emergency department overcrowding and its impact hospital wide
- The support of evidence based dependency ratios that will take into account standards of care, manageable workloads and the health, safety and welfare of all nursing/midwifery staff across all service areas.

I am mindful that there is urgency out there among all nurses and midwives on the coalface to see results – culminating in accelerated pay restoration and a reduction in the working week. While Brexit has created uncertainty, surely uncertainty lies at the underbelly of all economies as nothing is certain unless conditions are right. The same goes for the work environments of nurses and midwives (staff and resources) – conditions must be right in the first instance to enable us to care for the sick and vulnerable. No pilot would fly an aircraft with even one extra passenger because it would put everyone at risk. However, I am aware that patients are put at risk on a daily basis due to overcrowding and short staffing. Therefore, there is no doubt that safety is compromised and care is left undone (CLUEs - Care Left Undone Events).

Mary Walsh, RIP

ON MAY 12 last, which was International Nurses Day, it was with great sadness that I learned of the death of Mary Walsh, a longstanding member of the Sligo Branch and the Executive Council. The attendance at Mary's funeral mass on May 14 and Memorial Service on July 7, organised by her theatre colleagues in Sligo University Hospital (SUH), was a fitting testament to the esteem with which Mary was held as a friend, work colleague and stalwart union member. Mary's union journey benefited from her vast professional experience. She was always there for anyone who required her support or assistance, informing, redirecting and checking back with them – for this the INMO is truly grateful. I will miss Mary as will all her colleagues who served with her on Executive Council. *Solas geal na bhFlaithis ar a hanam.*

Mary Walsh, RIP

Health Summit

ONE of my priorities is the holding of an Irish Health Summit. In the Irish healthcare system we have legacy issues of subscribing to care delivery processes that do not suit our society's demographics and as nurses and midwives we are in the best possible position to inform policy makers. At present, the Irish healthcare system is overwhelmed, the demographic shift to an ageing society, new types of epidemics such as obesity, mental ill-health, the rising costs of healthcare; and the worldwide economic crisis result in serious consequences on the health of the nation.

It is my vision that the Health Summit will seek to actively address these challenges by bringing together stakeholders from clinical care, research, education, patient groups, staff representative bodies and many other disciplines to jointly develop strategies to tackle these major healthcare issues. The outcome of the Summit should inform and influence decision-makers such as the Oireachtas Health Committee (10 year plan) for meeting future healthcare challenges. *(For more on this see centre page pull out.)*

I would welcome hearing your ideas, advice and thoughts on how to go about this.

Quote of the month

"Yesterday is not ours to recover, but tomorrow is ours to win or lose!"
– Lyndon B Johnson

Report from the Executive Council

SINCE the ADC in Killarney, the Executive Council has met on June 13/14 and July 4/5. My thanks to all branches who forwarded nominees for the two vacant seats on the Executive, which followed the resignation of Theresa Dixon from Naas and Kate Finnamore from Letterkenny. I would like to extend my gratitude to Theresa for her advice over the years and to reassure her that it was all taken on board. I would like to wish Kate well and I hope that she is settling in my home town of Letterkenny. Marie O'Brien from Ennis and Thomas Caulfield from Ballinasloe complete the new line-up.

The 21 strong new Executive is a dynamic group and is representative of all disciplines. As the chair, I am supported by Mary Leahy, first vice president, and Margaret Frahill, second vice president, and our combined backgrounds span education, community and acute services.

Sub-committees of the Executive Council have all been formed: finance and general purposes; industrial relations; nursing/midwifery education and practice; regulation and social policy; disciplinary; and editorial board. These sub-committees are fed into by the ongoing work of the management team.

Our next Executive Council Meeting is on September 12-13, 2016.

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

Fury at summer spike in trolley figures

THE INMO reacted furiously to a spike in trolley/ward watch numbers in the second week of July, which saw an increase of 38% compared to the same week in 2015. Analysis of the figures showed that the progress made up to the end of June was wiped out that week of July.

The INMO demanded an explanation and sought guarantees from management at the Workplace Relations Commission (WRC) that this increase would be halted. "The national ED agreement has worked and we will simply not allow the situation to slip back to a state of chaos where unacceptably low standards and overcrowding are accepted as normal", said Dave Hughes, INMO deputy general secretary.

The figures had reduced by 14% for the month of May and by 24% for June, however, the figures for July 7-15 showed 1,839 admitted patients were on trolleys compared with 1,336 for the same period last year.

Overall the month of July saw 6,751 admitted patients on trolleys – a 1% increase compared to 2015, but 95% worse this year than in 2006 when ED overcrowding was declared a national emergency by the Minister for Health. This increase came after two months of significant reductions in the number of patients without a proper bed.

The increased overcrowding took place as the number of vacant nursing posts in EDs continues to rise. Despite a Department of Health/HSE commitment in the national agreement, health employers have failed to fill all vacant nursing posts in EDs, which is now estimated to be over 150 (up from 135 earlier this year).

HSE figures confirm that there are still almost 3,500 less nursing/midwifery posts in the public health service now than in 2009. There were also 250 less staff nurse posts at the end of July this year compared to December 2015. The increased number of patients on trolleys is a direct result of the failure of the health service to increase bed capacity due to failure to recruit staff.

The ED Taskforce is scheduled to meet again on September 6 to plan for a winter initiative. The INMO has stressed the need for the taskforce to also consider immediate measures to alleviate the continuing crisis. With that in mind, joint chairs of the ED Taskforce, Tony O'Brien, HSE, and Liam Doran, INMO general secretary, met with Health Minister Simon Harris to discuss the current situation, including the continuing severe difficulties with recruiting and retaining nursing/midwifery staff.

Table 1. INMO trolley and ward watch analysis – July 2016

Hospital	July 2006	July 2007	July 2008	July 2009	July 2010	July 2011	July 2012	July 2013	July 2014	July 2015	July 2016
Beaumont Hospital	270	489	701	810	549	605	489	627	580	643	376
Connolly Hospital, Blanchardstown	189	219	283	179	408	321	313	540	295	442	203
Mater Misericordiae University Hospital	251	480	497	361	503	236	424	103	262	325	368
Naas General Hospital	152	18	84	424	201	285	136	146	169	310	145
St Colmcille's Hospital	70	65	81	258	162	175	227	101	n/a	n/a	n/a
St James's Hospital	26	38	199	259	66	158	168	85	216	188	117
St Vincent's University Hospital	418	611	537	521	509	497	502	111	167	161	173
Tallaght Hospital	307	314	359	305	657	419	127	290	266	432	442
Eastern	**1,683**	**2,234**	**2,741**	**3,117**	**3,055**	**2,696**	**2,386**	**2,003**	**1,955**	**2,501**	**1,824**
Bantry General Hospital	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	0	20	27
Cavan General Hospital	125	232	153	107	264	254	125	169	36	48	38
Cork University Hospital	407	211	247	509	470	388	187	358	228	307	375
Letterkenny General Hospital	215	25	30	38	27	27	21	79	382	175	147
Louth County Hospital	1	27	2	0	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Mayo General Hospital	136	58	111	110	149	9	74	0	96	73	137
Mercy University Hospital, Cork	89	145	138	159	143	138	173	135	164	81	156
Mid Western Regional Hospital, Ennis	66	56	20	55	14	2	5	4	n/a	19	10
Midland Regional Hospital, Mullingar	17	4	20	7	131	291	115	244	291	295	498
Midland Regional Hospital, Portlaoise	42	21	44	17	46	88	18	71	109	162	228
Midland Regional Hospital, Tullamore	3	1	3	13	13	111	84	201	208	176	333
Monaghan General Hospital	21	3	23	2	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	0
Our Lady of Lourdes Hospital, Drogheda	201	113	173	304	202	671	482	340	648	769	452
Our Lady's Hospital, Navan	17	48	29	41	53	13	40	57	38	33	49
Portiuncula Hospital	9	8	1	50	59	78	46	42	84	29	44
Roscommon County Hospital	11	7	12	28	50	27	n/a	n/a	n/a	n/a	n/a
Sligo Regional Hospital	44	31	38	107	113	106	93	45	129	172	111
South Tipperary General Hospital	31	32	134	20	32	30	234	284	118	58	304
St Luke's Hospital, Kilkenny	n/a	n/a	n/a	n/a	n/a	118	55	134	186	393	348
University Hospital Galway	76	145	317	269	282	343	213	295	446	654	447
University Hospital Kerry	85	43	18	17	32	25	73	25	71	98	144
University Hospital Limerick	92	18	123	176	371	238	300	260	475	495	649
University Hospital Waterford	n/a	n/a	125	66	113	78	168	218	86	94	353
Wexford General Hospital	89	73	194	228	391	286	52	160	38	62	77
Country total	**1,777**	**1,301**	**1,955**	**2,323**	**2,955**	**3,321**	**2,558**	**3,121**	**3,833**	**4,214**	**4,927**
NATIONAL TOTAL	**3,460**	**3,535**	**4,696**	**5,440**	**6,010**	**6,017**	**4,944**	**5,124**	**5,788**	**6,715**	**6,751**

Comparison with total figure only:

Increase between 2015 and 2016: 1%
Increase between 2014 and 2016: 17%
Increase between 2013 and 2016: 32%
Increase between 2012 and 2016: 37%
Increase between 2011 and 2016: 12%
Increase between 2010 and 2016: 12%
Increase between 2009 and 2016: 24%
Increase between 2008 and 2016: 44%
Increase between 2007 and 2016: 91%
Increase between 2006 and 2016: 95%

Staffing levels remain a critical issue

Actions agreed with HSE management to address recruitment crisis

STAFFING levels and the recruitment/retention of nurses and midwives remains an ongoing critical issue for members in all areas of the health service.

Consistent with the INMO's ongoing efforts on this issue, a meeting with senior HSE management took place in mid August. The issues discussed and the actions agreed are as follows.

Graduating nurses/midwives

The HSE reaffirmed its absolute commitment to offering permanent posts to all students graduating this year. It was acknowledged that difficulties have emerged at local level, and the HSE confirmed it is taking urgent steps to address this matter.

The INMO pointed out that a number of managements at local level (including Letterkenny, Sligo, Castlebar, Ballinasloe, Galway, Limerick, Tralee, Cork and South Tipperary) had only offered short term contracts in recent weeks. The Organisation also highlighted the reality that while the HSE was sending out conflicting messages, these young professionals are being offered and are accepting posts elsewhere.

The HSE stressed it was actively working to ensure a consistent approach on this matter, and that evidence of this would be seen shortly.

Members, particularly graduating members, are asked to keep the INMO advised of all offers of work made to them.

Filling of vacant posts (staff nurse/midwife/community RGNs/PHNs)

The INMO sought clarity and confirmation that directors of nursing/midwifery/public health nursing would be empowered to fill, without requiring sanction from any other senior manager or employment control group (at local hospital/group/CHO level), at a minimum, entry grade posts, ie. staff nurse/midwife/community RGN/PHN. Current restrictions and bureaucratic processes are constraining directors, who are always professionally accountable for their decisions, leading to avoidable staff shortages and increased clinical risk.

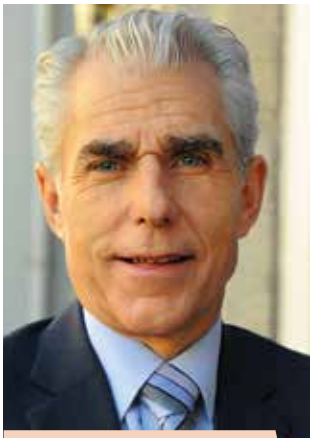
After discussion it was agreed that this approach had merit and potential, and the management side would further review it and revert quickly. The INMO is pursuing this matter to ensure early progress.

Recruitment confusion

The HSE confirmed that, arising from the recent allocation of an additional €500 million by government, there should be no delay in the filling of frontline posts. It was confirmed that all divisions had now received confirmation of their additional allocation from the €500m, and a note was circulated on this.

Against this background confirmation was sought on the implications for the filling of nursing/midwifery grades, at individual employment level following allocation of these funds. It was confirmed that all posts existing at the beginning of the year could now be filled in order to maintain existing levels of service. However, it was confirmed that additional funding for primary care was not allocated to fund frontline nursing posts.

The INMO sought the net effect of the funding from an employment improvement basis by hospital group/CHO, and the HSE has agreed to provide this. In the interim local INMO reps and members are asked to be vigilant with regard to the filling of frontline posts that fall vacant. Members are urged to contact the INMO immediately if they believe any frontline post is being left unfilled due to the inaction of local management.



Liam Doran, INMO general secretary: *The INMO is pursuing several matters to ensure the critical issue of the recruitment and retention of nurses and midwives remains at top of the HSE's agenda*

Overseas recruitment

Recognising the severe difficulties with the current recruitment of nurses/midwives, the INMO sought a review of the current incentives to address this. It was agreed that the *Bring Them Home Campaign* had failed in its objective and needed to be rebranded and relaunched.

It was further agreed that a small working group would be established to examine this matter further. The INMO confirmed that Liam Doran, as general secretary, would be the INMO nominee on this group. Names of the HSE nominees, and an early date and time for the first meeting, are awaited. The INMO suggested the Department of Health should also sit on this group.

The INMO will seek to engage with colleagues working in the UK and overseas in an effort to establish what additional incentives are needed to ensure a much better response to any international recruitment campaign over the coming months.

Overall manpower plan

The INMO sought immediate engagement on formulating an agreed manpower plan on nursing/midwifery recruitment. Such a plan must not only deal with immediate issues but also ensure that, for example, 2017 graduates would be offered permanent posts in January 2017. The HSE agreed to positively consider this proposal and to revert shortly.

Short staffing – protecting practice

The INMO placed on record that in the absence of significant improvements in staffing levels in all services, the Organisation will seek the curtailment of services. It was repeatedly stressed that members will not continue to work in an unsafe environment, for both patients and themselves, and that staffing levels must be improved immediately.

Management was reminded that INMO members were working to rule in Our Lady of Lourdes Hospital, Drogheda, and were balloting in other locations in protest at the critical shortage of nursing/midwifery staff. It was stressed that this is an absolute priority issue, as members across the service are being forced to work short, every day, with its negative impact on standards of care and safe practice.

Next steps

The group is to meet again to review overall progress in the Workplace Relations Commission on September 2, 2016 (ahead of the next WRC review of the national ED Agreement).

– Liam Doran,
INMO general secretary

INMO highlights HSE shortcomings in implementing ED agreement

THE fourth review of the Emergency Department National Agreement, accepted last February, was undertaken by the Workplace Relations Commission (WRC) in late July. The INMO continued to demand the 24/7 implementation of the agreement to ease ED overcrowding and workloads on nurses in these departments.

At the meeting the INMO identified a number of areas where health service management had failed to implement the agreement to date, with particular emphasis on staffing issues.

The INMO delegation was led by president Martina Harkin-Kelly, together with ED representatives and INMO officials, including general secretary Liam Doran. The management side delegation was led by Rosarii Mannion, HSE national director of human resources, together with officials from the HSE and the Department of Health.

Issues highlighted by the INMO at the review included:

- The number of admitted patients on trolleys in EDs or wards had increased by 12% in the first three weeks of July of this year compared to the same period in 2015
- Notwithstanding this, management continued to delay the filling of all vacant staff nurse posts in EDs
- A number of the posts established under the ED agreement to assist with patient flow remain unfilled, with management failing to act with urgency
- The failure of some local hospital managements to ensure, on a 24/7 basis, the nationally agreed Escalation Policy is put into operation as an ongoing priority.

In order to prioritise the implementation of all outstanding aspects of the agreement, it was agreed at the review that a three person group (one nominee each from the INMO, the Department of Health and the HSE) would be set up, immediately, to visit/review all hospitals to ensure all staffing issues are addressed and all barriers to the filling of vacant posts are removed. In addition, this three person group will ensure that all current fourth year undergraduate nurses are offered permanent posts on graduation, as one step in alleviating the continuing staffing crisis. The three person group has now been established with representatives from the National Acute Hospital Division, the assistant national director HR HSE, and INMO director of industrial relations Phil Ní Sheaghdha.

The INMO is demanding that all aspects of the agreement are implemented including:

- The appointment of seven CNM1s, where this has not taken place already
- The appointment of a CNM2 for admitted patients in a number of EDs
- The appointment of an assistant nursing director in all 26 EDs, specifically and solely responsible for patient flow
- The filling of all vacant posts as agreed in December 2015
- The presence of senior clinical decision makers over the extended day.

The WRC is to undertake its fifth review of the ED agreement on September 2, 2016.

INMO general secretary Liam Doran said: "It is quite apparent, from feedback from our members in EDs across the country, that they remain frustrated and angry at the continuing levels of overcrowding and the negative impact this is having on their ability to provide safe care. At the review, the INMO clearly advised, both the WRC and health service management, that the current situation cannot continue and industrial action was inevitable in the absence of significant progress on all staffing issues."

ED staffing expert group

THE ED Expert Group on Nurse Staffing, established as part of the ED Agreement, continues its work and is expected to issue its report shortly. This four person group (including Bernie Stenson, CNM2 in the ED at St Vincent's Hospital and Executive Council member representing the INMO) is charged with the task of:

- Examining international evidence on how best to determine ED staffing levels and to make recommendations on same
- Recommending immediate initiatives to address current staffing difficulties.

Safe staffing pilot phase now underway

THE *Taskforce on Nurse Staffing in Medical/Surgical Wards* has commenced piloting the recommendations contained in the interim report.

In this pilot phase, a number of wards in Beaumont Hospital, Our Lady of Lourdes Hospital, Drogheda and St Columcille's Hospital, Loughlinstown are implementing the interim recommendations on safe nurse staffing, to test their ability to improve patient outcomes and staff working environment.

These pilot studies will run until October/November, after which the results will be considered by the National Taskforce, with a final report being issued at the end of the year.

This taskforce was established as a direct result of the INMO Safe Staffing Campaign in 2014/2015.

The objective is that every medical/surgical ward in the country will ultimately have their staffing levels – complete with a skill mix of 80% registered nurse to 20% trained healthcare assistants (HCAs) – determined with reference to patient dependency and the professional judgement of a clinical nurse manager 2 (CNM2). On all medical/surgical wards, the CNM2 will be 100% supervisory and not hold a case load.

It is the view of the INMO, and indeed international experience, that the only way to establish and maintain safe staffing levels, leading to manageable workloads for staff, is to apply this kind of scientific approach; this is why the work of this Taskforce is so important.

On completion of this first phase on medical/surgical wards, the INMO will be demanding similar exercises in other areas including specialist/care of the elderly/community and intellectual disability.

– Liam Doran

Phil Ní Sheaghdha, INMO director of industrial relations,

ICTU calls for end of FEMPI legislation

FINANCIAL emergency legislation, entitled the Financial Emergency Measures in the Public Interest Act (FEMPI), was introduced by government during the fiscal crisis and this legislation remains on the statute.

Unions affiliated to the Irish Congress of Trade Unions, including the INMO, have sought the removal of this legislation as the government has argued and announced publicly that the crisis is over.

Government responded to this request on June 29, 2016 advising that the legislation has a retained necessity, due to the instability of the international economy, the still fragile nature of the domestic economy, the need to protect hard won competitiveness gains, the high level of debt and continued deficit, the obligation to comply with the stability and growth pact, and the need to balance competing demands within finite fiscal space.

Government see the Public Service Agreement, which is in place, as the commencement of the unwinding of this legislation, and restoration of some of the pay reductions and special public service taxations.

The INMO and other unions do not accept this position, as the economic situation in Ireland has stabilised and we have moved into the preventative phase of the stability and growth pact. Clearly, emergency legislation by definition, should only apply in an emergency situation and is not required in anticipation of instability. The negative effects this legislation has introduced to free collective bargaining is significant and is likely to lead to future industrial relations problems in the public service.

The public services committee (PSC) of ICTU has notified an intention to raise this as part of the published Public Service Pay Commission announced by government.

The points being made by the public services committee of ICTU are that serving public servants, who have suffered two, and in some cases three, pay cuts are understandably aggrieved and, often, demotivated.

Unless staff feel that they are being treated fairly, this will continue. The end of FEMPI legislation will help to restore motivation.

With an improving labour market, this will be essential in providing the assistance that will be necessary to facilitate recruitment and retention. The PSC believes that the proposed Commission has the potential to facilitate the speedy and orderly repeal of the FEMPI legislation and can also help to identify, and to assist, in addressing many of the issues regarding public service pay.

The Commission also needs to be cognisant of the public service's responsibility, as an employer, to pay fair levels of remuneration, according to the PSC.

Unpaid time

THE INMO is seeking to correct the discrepancies between attendance hours of nurses/midwives and paid contracted hours. It is reported that most shift patterns incur at least 40 minutes unpaid time. This is accrued during extended handover and unpaid unavailed of meal breaks.

The INMO sought an examination of and correction of this as part of the two most recent Public Service Agreements, and discussions have now commenced with the HSE. On-call rosters for theatre nurses are being examined as they too would now fall within the definition of working time, as per recent European case law definition, considering most on-call rosters require the nurses/midwives to reside on the hospital premises during the on–call period.

Conclusion of verification process

THE Lansdowne Road Agreement provided for discussions to commence on the transfer /sharing of four tasks from hospital doctors to nurses and midwives, and the restoration of the time and one-sixth premium pay in respect of hours worked between 6pm and 8pm, which had been abolished under the previous public sector pay agreement.

Discussions concluded in December 2015 with an agreement which provides for a process to enable an orderly transfer of the four identified tasks only when staffing levels are agreed and training has taken place.

The four tasks in question are: intravenous (IV) cannulation; phlebotomy that is currently carried out by NCHDs as distinct from general routine phlebotomy which is the responsibility of specifically trained and employed phlebotomy staff; intravenous drug administration (first dose); and nurse/midwife led delegated discharge of patients.

The time and one-sixth payment was sanctioned for restoration by government with effect from July 1, 2016, however, payment may be made retrospectively to January 1, 2016, subject to verification from the National Implementation and Verification Group that the tasks have transferred and associated benefits are being achieved as set out in the agreement.

The first verification report required as part of this agreement has now concluded and verified that payment is sanctioned for all acute hospital nurses and midwives. The process in care of the elderly and ID services is still being processed but the agreement is specific that retrospective payment to January 2016 is for all those who were paid this premium prior to its removal in July 2013.

A circular should now issue from the employer instructing payrolls to calculate the monies owing to those who have worked this shift pattern since January 2016.

The nursing medical interface verification process is due to conclude. This process involved site visits by the national verification team to each of the hospital groups, and reports from each hospital to the national verification team. The hospital site visits are all completed and the required written confirmation from the local implementation group of each hospital have now all been received.

The independent chairman of this process has convened the parties to finalise the process of verification.

reports on current ICTU, WRC and national IR issues

Call for action on falling numbers

Now more than 3,000 less nursing/midwifery posts than in 2007

THE current critical shortage of nurses and midwives in the health service has arisen from the unmanaged and ill-conceived reduction in nursing/midwifery posts between 2009 and 2014, which has resulted in the loss of more than 5,000 nursing/midwifery staff.

The impact of this policy is that services are now understaffed, posts have been left unfilled, maternity and other leave is not filled, and Ireland's graduate nurses and midwives have had to look for work abroad. In response to this dramatic reduction in nurse/midwife staffing levels, the INMO commenced its Safe Staffing Campaign in 2014 and as a direct result, the Minister for Health established a special taskforce on nurse staffing and skill mix.

Earlier this year, the taskforce published its interim report which focuses on the need to introduce agreed measures which will determine patient acuity and need, and to ensure the availability of a consistent, adequate and safe nursing workforce at all times. The framework is currently being piloted in three acute hospitals in general and specialist medical and surgical inpatient units *(see page 10)*.

It will be subject to external research to confirm improvements in environment for patients and staff.

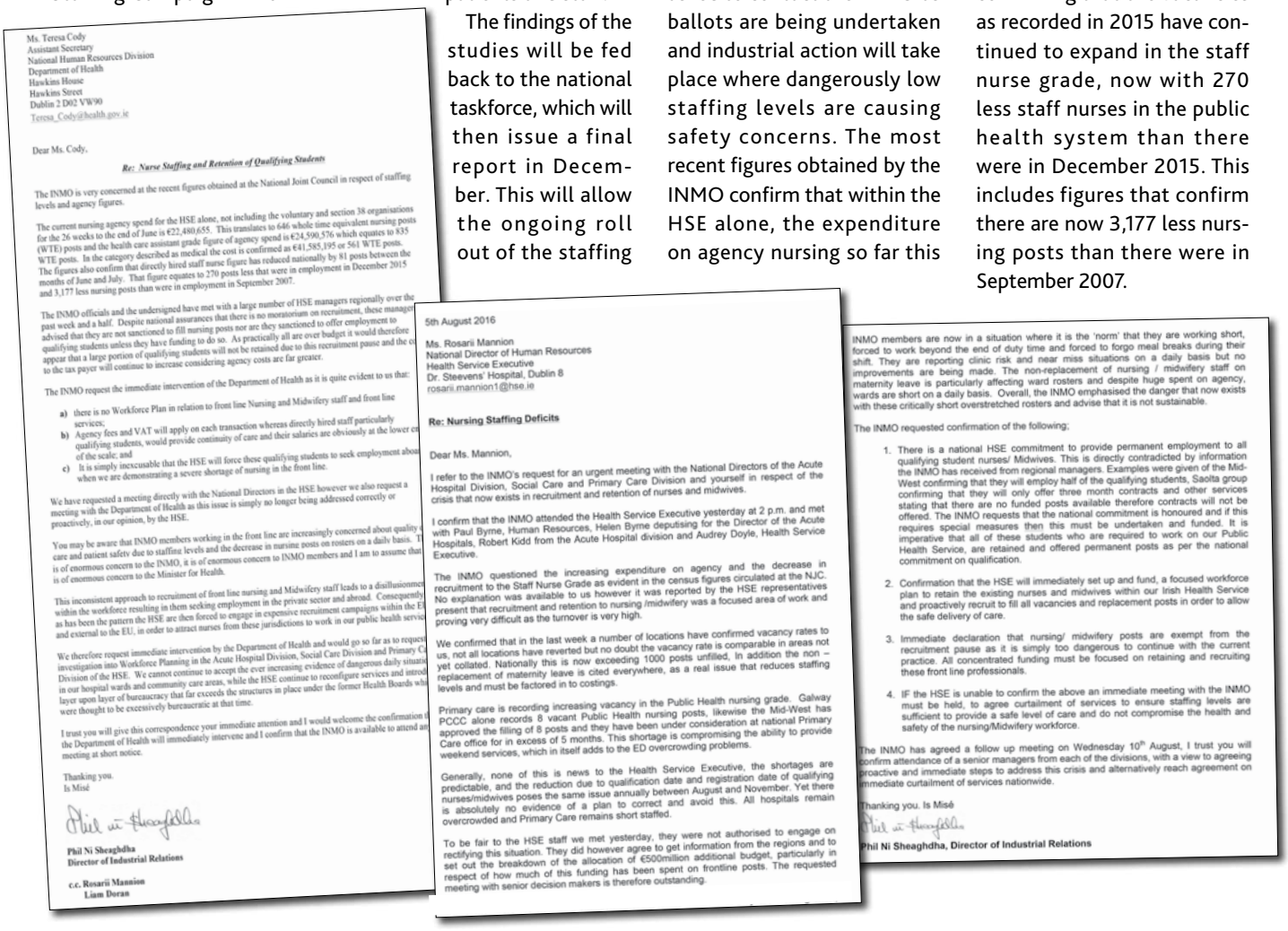
The findings of the studies will be fed back to the national taskforce, which will then issue a final report in December. This will allow the ongoing roll out of the staffing method to all medical/surgical wards to be included in the estimates for 2017.

While this is really necessary to establish the baseline for staffing, the levels are currently critically low in many hospitals and community care areas. The INMO has raised this continuously as the biggest crisis needing correction.

The INMO recently wrote to the Department of Health and the HSE on these issues (See *Figures* below), outlining its concern at the recent figures obtained at the National Joint Council in respect of staffing levels and agency figures. Members in locations where staffing is a problem are asked to contact the INMO as ballots are being undertaken and industrial action will take place where dangerously low staffing levels are causing safety concerns. The most recent figures obtained by the INMO confirm that within the HSE alone, the expenditure on agency nursing so far this year has reached €22,480,655, for healthcare assistants €24,590,576 and for medical staff €41,585,195. (Calculated for 26 weeks to end of June).

The INMO has met with a number of senior HSE managers who confirm that they are being refused sanction nationally to directly hire nurses due to budget constraints. This completely contradicts the HSE's stated position that there is no recruitment moratorium and that all qualifying nurses will be offered permanent posts.

This is further compounded by increasing vacancies unfilled in frontline staff nursing positions, with most recent figures confirming that the vacancies as recorded in 2015 have continued to expand in the staff nurse grade, now with 270 less staff nurses in the public health system than there were in December 2015. This includes figures that confirm there are now 3,177 less nursing posts than there were in September 2007.



Ms. Teresa Cody
Assistant Secretary
National Human Resources Division
Department of Health
Hawkins House
Hawkins Street
Dublin 2 D02 VW90
Teresa_Cody@health.gov.ie

Dear Ms. Cody,

Re: Nurse Staffing and Retention of Qualifying Students

The INMO is very concerned at the recent figures obtained at the National Joint Council in respect of staffing levels and agency figures.

The current nursing agency spend for the HSE alone, not including the voluntary and section 38 organisations for the 26 weeks to the end of June is €22,480,655. This translates to 646 whole time equivalent nursing posts (WTE) posts and the health care assistant grade figure of agency spend is €24,590,576 which equates to 835 WTE posts. In the category described as medical the cost is confirmed as €41,585,195 or 561 WTE posts. The figures also confirm that directly hired staff nurse figure has reduced nationally by 81 posts between the months of June and July. That figure equates to 270 posts less that were in employment in December 2015 and 3,177 less nursing posts than were in employment in September 2007.

The INMO officials and the undersigned have met with a large number of HSE managers regionally over the past week and a half. Despite national assurances that there is no moratorium on recruitment, these managers advised that they are not sanctioned to fill nursing posts nor are they sanctioned to offer employment to qualifying students unless they have funding to do so. As practically all are over budget it would therefore appear that a large portion of qualifying students will not be retained due to this recruitment pause and the cost to the tax payer will continue to increase considering agency costs are far greater.

The INMO request the immediate intervention of the Department of Health as it is quite evident to us that:

a) there is no Workforce Plan in relation to front line Nursing and Midwifery staff and front line services;
b) Agency fees and VAT will apply on each transaction whereas directly hired staff particularly qualifying students, would provide continuity of care and their salaries are obviously at the lower end of the scale; and
c) It is simply inexcusable that the HSE will force these qualifying students to seek employment abroad when we are demonstrating a severe shortage of nursing in the front line.

We have requested a meeting directly with the National Directors in the HSE however we also request a meeting with the Department of Health as this issue is simply no longer being addressed correctly or proactively, in our opinion, by the HSE.

You may be aware that INMO members working in the front line are increasingly concerned about quality of care and patient safety due to staffing levels and the decrease in nursing posts on rosters on a daily basis. This is of enormous concern to the INMO, it is of enormous concern to INMO members and I am to assume that it is of enormous concern to the Minister for Health.

This inconsistent approach to recruitment of front line nursing and Midwifery staff leads to a disillusionment within the workforce resulting in them seeking employment in the private sector and abroad. Consequently, as has been the pattern the HSE are then forced to engage in expensive recruitment campaigns within the EU and external to the EU, in order to attract nurses from these jurisdictions to work in our public health service.

We therefore request immediate intervention by the Department of Health and would go so far as to request investigation into Workforce Planning in the Acute Hospital Division, Social Care Division and Primary Care Division of the HSE. We cannot continue to accept the ever increasing evidence of dangerous daily situations in our hospital wards and community care areas, while the HSE continue to reconfigure services and introduce layer upon layer of bureaucracy that far exceeds the structures in place under the former Health Boards which were thought to be excessively bureaucratic at that time.

I trust you will give this correspondence your immediate attention and I would welcome the confirmation that the Department of Health will immediately intervene and I confirm that the INMO is available to attend any meeting at short notice.

Thanking you.
Is Misé

Phil Ni Sheaghdha
Director of Industrial Relations

c.c. Rosarii Mannion
Liam Doran

5th August 2016

Ms. Rosarii Mannion
National Director of Human Resources
Health Service Executive
Dr. Steevens' Hospital, Dublin 8
rosarii.mannion1@hse.ie

Re: Nursing Staffing Deficits

Dear Ms. Mannion,

I refer to the INMO's request for an urgent meeting with the National Directors of the Acute Hospital Division, Social Care and Primary Care Division and yourself in respect of the crisis that now exists in recruitment and retention of nurses and midwives.

I confirm that the INMO attended the Health Service Executive yesterday at 2 p.m. and met with Paul Byrne, Human Resources, Helen Byrne deputising for the Director of the Acute Hospitals, Robert Kidd from the Acute Hospital division and Audrey Doyle, Health Service Executive.

The INMO questioned the increasing expenditure on agency and the decrease in recruitment to the Staff Nurse Grade as evident in the census figures circulated at the NJC. No explanation was available to us however it was reported by the HSE representatives present that recruitment and retention to nursing /midwifery was a focused area of work and proving very difficult as the turnover is very high.

We confirmed that in the last week a number of locations have confirmed vacancy rates to us, not all locations have reverted but no doubt the vacancy rate is comparable in areas not yet collated. Nationally this is now exceeding 1000 posts unfilled, In addition the non – replacement of maternity leave is cited everywhere, as a real issue that reduces staffing levels and must be factored in to costings.

Primary care is recording increasing vacancy in the Public Health nursing grade. Galway PCCC alone records 8 vacant Public Health nursing posts, likewise the Mid-West has approved the filling of 8 posts and they have been under consideration at national Primary Care office for in excess of 5 months. This shortage is compromising the ability to provide weekend services, which in itself adds to the ED overcrowding problems.

Generally, none of this is news to the Health Service Executive, the shortages are predictable, and the reduction due to qualification date and registration date of qualifying nurses/midwives poses the same issue annually between August and November. Yet there is absolutely no evidence of a plan to correct and avoid this. All hospitals remain overcrowded and Primary Care remains short staffed.

To be fair to the HSE staff we met yesterday, they were not authorised to engage on rectifying this situation. They did however agree to get information from the regions and to set out the breakdown of the allocation of €500million additional budget, particularly in respect of how much of this funding has been spent on frontline posts. The requested meeting with senior decision makers is therefore outstanding.

INMO members are now in a situation where it is the 'norm' that they are working short, forced to work beyond the end of duty time and forced to forgo meal breaks during their shift. They are reporting clinic risk and near miss situations on a daily basis but no improvements are being made. The non-replacement of nursing / midwifery staff on maternity leave is particularly affecting ward rosters and despite huge spent on agency, wards are short on a daily basis. Overall, the INMO emphasised the danger that now exists with these critically short overstretched rosters and advise that it is not sustainable.

The INMO requested confirmation of the following;

1. There is a national HSE commitment to provide permanent employment to all qualifying student nurses/ Midwives. This is directly contradicted by information the INMO has received from regional managers. Examples were given of the Mid-West confirming that they will employ half of the qualifying students, Saolta group confirming that they will only offer three month contracts and other services stating that there are no funded posts available therefore contracts will not be offered. The INMO requests that the national commitment is honoured and if this requires special measures then this must be undertaken and funded. It is imperative that all of these students who are required to work on our Public Health Service, are retained and offered permanent posts as per the national commitment on qualification.
2. Confirmation that the HSE will immediately set up and fund, a focused workforce plan to retain the existing nurses and midwives within our Irish Health Service and proactively recruit to fill all vacancies and replacement posts in order to allow the safe delivery of care.
3. Immediate declaration that nursing/ midwifery posts are exempt from the recruitment pause as it is simply too dangerous to continue with the current practice. All concentrated funding must be focused on retaining and recruiting these front line professionals.
4. IF the HSE is unable to confirm the above an immediate meeting with the INMO must be held, to agree curtailment of services to ensure staffing levels are sufficient to provide a safe level of care and do not compromise the health and safety of the nursing/Midwifery workforce.

The INMO has agreed a follow up meeting on Wednesday 10th August, I trust you will confirm attendance of a senior managers from each of the divisions, with a view to agreeing proactive and immediate steps to address this crisis and alternatively reach agreement on immediate curtailment of services nationwide.

Thanking you. Is Misé

Phil Ni Sheaghdha, Director of Industrial Relations

Dave Hughes, INMO deputy general secretary, argues that constructive action is needed towards redistributing Ireland's economic growth

CSO under pressure on GDP increase

IN a spectacular case of 'shoot the messenger', Ireland's Central Statistics Office (CSO) was casually dismissed as having produced 'leprechaun economics' when it reported that Ireland's gross domestic product (GDP) increased by over 28% and is continuing to grow.

The figures produced by the CSO are consistent with those used for all other European economies and the international developed economies of the world. The GDP and GNP (gross national product) figures produced by the CSO were regularly used to justify the austerity imposed on Ireland throughout the period 2008 to 2015.

GDP and GNP are closely related measures. GDP measures the total output of the economy in a period, which is essentially the value of work done by employees, companies and self-employed people in the economy. This work generates incomes but not all of the incomes earned in the economy remain the property of residents.

Equally some residents may earn some income abroad. The total income remaining with Irish residents is GNP and it differs from GDP by the net amount of incomes sent to or received from abroad.

In Ireland's case for many years in the past the amount belonging to people abroad has exceeded the amount received from abroad, due mainly to the profits of foreign owned companies, and our GNP is therefore less than our GDP.

True to form, for 2015 and the first quarter of 2016, which showed the exceptional growth, Ireland's GDP was over 28% and its GNP was over 18%. These are extraordinarily high figures and would dwarf the performance of any other European economy with the very best of them achieving an 8% increase in GDP.

So did a leprechaun run riot through the Central Statistics Office in Cork and produce daft figures or do they reflect reality? If they reflect reality why is it that so many people feel no benefit from such extraordinary growth? Our national media were quick to jump on the bandwagon of economists, who generally speak for vested interests, and who quickly labelled the Irish results as 'leprechaun economics'. This became the standard phrase on current affairs and news reports of the Irish economy. We were treated to shallow explanations such as a large number of Boeing jets being re-registered in Ireland and pushing the growth rate up to that level. We were told it had no impact at all on the economy, yet the government, through the Minister for Finance Michael Noonan, confirmed that the Irish contribution to the EU will be increased by almost €300 million as a result of the growth figures. If it was a matter of leprechaun economics or unreal reporting, then we surely would not be prepared to pay such a high level of contribution to the EU and would be disputing the facts.

The truth is that the Irish economy did in fact grow by these extraordinary figures and some of it relates to internationally reported activity in financial services on Dublin's docklands, which in other countries, has been described as a tax haven for large multinational companies. It is alleged that brass plate companies operate in the IFSC who have a very small number of employees but are registered here for the purpose of flushing money through the system in a way that minimises their tax liability.

The Irish government denies this and we were, once again, treated to popular jargon instead of indepth analysis when this was highlighted in Dáil Eireann and the Minister assured us that the 'double Irish' loophole was being closed. Of course the closing of that loophole allowed all those who already benefited from it to continue to benefit for a considerable period.

We would do well to remember the phrase 'lies, damned lies and statistics' (coined by American intellectual Mark Twain) whenever an economist is trotted out in the media to criticise an independent arm of the state whose data is used and accepted as factual in almost all economic and social activity.

Whether the increase in GDP and GNP will eventually flow down to the vast majority of Irish people is an entirely political matter, which relates to the distribution of wealth and the income generated within the country. Why would economists working for large corporations dismiss our CSO figures so promptly and with such vigour?

One could venture to suggest that they do so as part of a wider agenda, which is to keep wages down, increase the amount of state activity going into private hands and reduce the public service. All of these strategies are deeply embedded and relate to the concentration of wealth in fewer hands.

There are other significant signs of economic growth returning to Ireland: the number of large cranes in Dublin city centre and its outskirts have always been an indication of increased economic activity; on August 9, the Dublin Airport Authority announced that passenger numbers at the airport had increased by 13.4% in the first half of the year, making Dublin the leading performer among the top tier European airports (the average growth in European airports was 4.9% for the first half of the year). The growth at Dublin Airport follows last year's record-breaking performance when the airport welcomed 25 million passengers for the first time ever.

Sometimes the biggest deceptions are carried out in full view and not behind closed doors. When economists dismiss the CSO as leprechauns the rest of us need to take note and ask why. Returning again to Mark Twain who famously said: "if you don't read the newspapers you won't be informed, if you do read the newspapers you'll be misinformed."

As house prices rise, economic indicators improve and there is more money available, there is an increasing instinctive awareness within some sections of the workforce of the need to fight for increased wages. The media will be quick to come down heavy on such groups of workers but other workers, including INMO members, need to see such actions as being in the interests of all employees and constructive action towards redistributing the economic growth, which Ireland is achieving.

Work now underway at Richmond building

Refurbishment works on the Richmond building, to develop the INMO's Education and Event Centre, have now commenced and are expected to be completed in early January 2017, with a formal opening in the spring.

This work will see the Richmond building becoming a dynamic centre for all of the professional development activity carried out by the Organisation, as it prepares for mandatory competency assurance for all registered nurses and midwives over the next two to three years. In addition the refurbished building will allow the INMO offer the facility to other bodies, thus delivering a new funding stream for the Organisation.

INMO welcomes publication of two reports examining the NMBI

THE INMO welcomed the recent publication of two reports examining organisational and financial processes within the Nursing and Midwifery Board of Ireland (NMBI).

Identifying serious shortcomings in the past, both reports recommend significant changes to governance, internal procedures and structures generally, which must be implemented immediately.

The reports' findings also fully vindicate the INMO's campaign of opposition, which took place in the first half of 2015, against a proposed 50% increase in the annual registration fee levied by the NMBI.

Throughout this campaign the INMO constantly sought greater detail and clarity with regard to the Board's processes, which were never forthcoming.

The INMO also notes that, in recent weeks, significant changes have taken place, at leadership level within the Board, with the appointment of a new CEO and the election of a new president.

The INMO is committed to working with this new team in implementing the recommendations of these two reports.

"The public is best served by a strong regulatory Board which has the confidence of nurses and midwives by ensuring they are in a position to deliver high quality care through safe practice. This must be our collective goal over the next two years," said INMO general secretary Liam Doran.

Carparking chaos compounds staffing problems

NURSES and other shift workers are facing serious chaos as over 300 carparking spaces have been removed from the grounds of St James's Hospital and no alternative has been provided. The loss of spaces is directly related to the commencement of work for the new children's hospital, which was not expected to commence until October.

At a meeting of over 100 INMO members the actions of management were condemned. The meeting heard how nurses working 12 hour shifts need to be assured that a safe and secure car space will be available for them.

In the current climate of severe difficulties in retaining nurses, this move, which completely disregards the cost implications that will accrue and the inconvenience for shift workers, is unfair considering the already reduced salaries of these grades. The lack of adherence to the most basic good practice of consultation, is also felt by INMO members as a disregard for the public service agreement and a lack of appreciation for them as employees, considering the flexibility and productivity they have shown throughout the past number of difficult years.

As a result, nurses are seeking employment elsewhere. Many nurses are writing to the board of St James's, expressing utter dismay at the handling of the carparking arrangements for staff and are calling on board members to resign.

INMO IRO Clare Treacy said: "This is a total fiasco. How can this decision be considered acceptable? There was a lack of consultation with staff; a total disregard for safety of a predominately female workforce; and this is further compounded by the absence of an alternative plan to minimise disruption. We asked management to defer the decision for a short period of time, to allow for safe alternatives to be put in place, but no response has been received. INMO members are understandably angry and feel disrespected by their employer. Such action is likely to have serious consequences for the recruitment and retention of staff."

The INMO has referred the matter to the WRC for an urgent hearing.

Pictured at an INMO meeting to address the lack of consultation on carparking reduction at St James's Hospital as building works begin were (l-r): Celine Chapman, Emma Hayes, Clare Treacy (INMO IRO), Melissa Meally, Eilish Duignan, Gabby Dunne and Joanie Halpenny, all nursing staff at St James's Hospital'

Concern at leaks of ED downgrading

THE INMO has expressed serious concern at reports that up to nine hospitals are to have their emergency departments scaled back. Media reports, based on leaked information allegedly from the Trauma Steering Group established by Leo Varadkar when he was Minister for Health, have suggested that serious trauma cases involving car crash victims and patients with broken bones, would instead be sent to the nearest major hospital where there are more specialist doctors in place.

Dave Hughes, INMO deputy general secretary, said: "Nurses are fed up with piecemeal change which actually makes the situation worse rather than better. This is not the first time that the redirecting of EDs to separate major trauma centres has been proposed. In fact it has been attempted in the Mid-West with a scaling back of Nenagh and Ennis, in the West through the reduction in services provided at Roscommon, in Tipperary with the concentration of services in Clonmel Regional, in the North East in Our Lady of Lourdes Hospital and in South Dublin in St Vincent's Hospital. In all of these cases the so-called centres of excellence have been reduced to chaos when the major hospitals with few additional resources are expected to take the serious trauma, previously destined for other hospitals, on an already overcrowded and overworked department".

The INMO said that the rationalisation of hospital services, in the absence of a comprehensive multiannual plan which would develop primary care and alternatives to hospital admission, along with the development of real centres of excellence as an alternative way to deliver emergency care have neither been funded or developed.

The INMO has called for a 10-year all party agreed health plan, which can be bought into by all stakeholders and provide for the provision of a comprehensive vision for delivery of healthcare for our expanding population and developing nation *(see centre pages)*.

The INMO called on the government to make a clear statement that existing EDs are not threatened by this report.

St Ita's rosters

MANAGEMENT at St Ita's, Newcastlewest are seeking to review rosters based on the existing allocated staff roster. The INMO and SIPTU have objected to this on the basis that management are refusing to provide details of the existing allocation per ward.

Transfer of Ennis dementia unit

Discussions are ongoing within the HSE and INMO/SIPTU on the transfer of the specialist dementia service at the Holly Unit, St Joseph's, Ennis from care of older persons to mental health services.

While no agreement has yet been reached it is likely that all matters will be agreed in advance. Regardless of the agreement on transfer there is a particular emphasis needed on staff safety as there has been a significant number of increased staff assaults in 2016 so far.

– Mary Fogarty, INMO IRO

Progress slow at Limerick Maternity

INMO members at the University Maternity Hospital, Limerick are re-balloting to commence a work to rule arising from the slow implementation by the HSE of a WRC agreement reached last November on staffing levels and management of hospital activity.

The agreement covered the employment of additional midwives, porters, clerical admin and healthcare assistants, but, as of July 2016, no progress on the filling of any of these additional posts had been achieved.

Additionally, and critically for the management of hospital activity, an electronic booking system was to be in place with numerous start dates provided and none met.

Mary Fogarty, INMO IRO: "The INMO is closely monitoring situation at UMHL"

At a meeting since the commencement of the ballot the HSE accepted that at present there are 36 overall midwife/nurse vacancies.

Management advised that they expect to have an additional 25 staff midwives by October 2016, the majority of whom will be newly qualified, and that an additional six clerical admin personnel will be employed by the end of August. They said that the electronic booking system would commence shortly.

The INMO advised that implementation of all of the above, plus a second porter on night duty and the availability of additional HCAs, are essential if a dispute is to be avoided.

– Mary Fogarty, INMO IRO

Critical safety issues at UHL

CRITICAL safety issues reported to the HSE by nurses as a result of vacant/unfilled nursing posts at University Hospital Limerick, as well as patient wards operating above full capacity, have given rise to the commencement of a ballot of nurses on all medical and surgical wards.

Members have highlighted that urgent immediate action is required to address the gaps in rosters and to curtail activity until the nursing workforce is stabilised.

At the time of going to press the ballot had just commenced. While the hospital is currently undertaking a pilot on two wards (1D and 3D) to look at ward activity and rosters which will be key in future organisation of work, there are currently basic nurse deficits on the agreed rosters that can not be left if patient safety is paramount.

Once the result of the ballot is available the INMO will consult further with members to agree a way forward.

– Mary Fogarty, INMO IRO

OLOL members ballot on revised proposals to address staffing levels

INMO members in Our Lady of Lourdes Hospital, Drogheda were balloting on improved proposals to address their claim for safe staffing levels in medical and surgical wards, as we went to press.

The INMO took industrial action in the form of a work to rule seeking that the provision of care is matched to a safe nurse staffing level on the hospital wards. However, the hospital has been unable to recruit or retain sufficient nursing staff in order to appropriately staff these wards, thus compromising patient care.

Further proposals were put forward following the intervention of the Workplace Relations Commission (WRC). However, these proposals were overwhelmingly rejected by INMO members as being insufficient to address this crisis. The work to rule was reinstated on July 29, however two days of talks between members and management on August 17-18 resulted in an addendum agreement. This agreement, in addition to the WRC proposals of July 4, allowed the INMO to cease the work to rule pending a ballot of members, which was due to conclude by August 26. Management agreed to immediately implement all aspects of the agreement. The WRC has agreed to oversee the implementation and a hearing will take place in four weeks time.

INMO IRO Tony Fitzpatrick said: "The INMO secured significant additional measures which ensure that the shortage of nursing staff is recognised, escalated and proactively managed. Staffing shortages are now a trigger in the hospital's escalation policy that allows CNM2s to seek a pause in admissions or capacity curtailment in response to shortages. The proposals are extremely balanced and assist in the effective and efficient management of the hospital while protecting the wellbeing of patients. The INMO commends the members and their local rep for the professional way they managed the dispute locally."

Concern at sudden closure of Athlone care centre

THE INMO expressed concern at the sudden decision in July by HSE management to transfer vulnerable patients out of St Vincent's Care Centre, Athlone. Management cited health and safety reasons for this decision, indicating an unsafe electrical fire risk involved.

The INMO's priority is to ensure that a safe and high standard of care is given to all residents in St Vincent's. Accordingly, as such a risk was identified, the INMO supported the decision to move the patients to a safe environment. However, the Organisation remained concerned about the short notice given of this decision, noting that it put a great deal of stress on the residents for whom St Vincent's is their long term home. The provision of alternative care should have been planned and emergency contingency arrangements agreed.

The INMO stressed that it would have been appropriate for HSE management to contact the INMO in advance of this in order to arrange appropriate contingencies for all patients and staff. It is a matter of grave concern that this was not done. The INMO has demanded concrete evidence that such a dramatic disruption to the lives of residents and staff was absolutely necessary. The INMO is also seeking confirmation that the closure of the centre is only temporary and that St Vincent's will reopen in the shortest possible time.

– Anne Burke, INMO IRO

Three successful updates for members in northwest

THREE successful information sessions were held in northwest recently. Phil Ní Sheaghda, INMO director of industrial relations, held a well-attended session for public health nurse and community RGN members in Buncrana. Members were updated on topics such as sick leave policy and related issues.

Another information session in Donegal was held in Letterkenny University Hospital by Catherine Hopkins from the INMO information office, Dean Flanagan, student/new graduate officer, and Maura Hickey, INMO IRO for the region. They also conducted a hospital walkabout last month and members were given information on a range of topics and advised on their rights and entitlements.

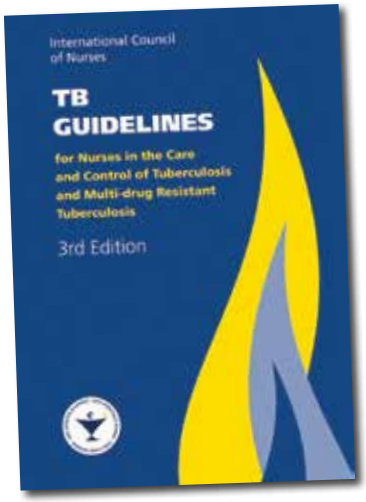
There was also a walkabout in Sligo University Hospital in July, at which INMO president Martina Harkin-Kelly accompanied Mr Flanagan and Ms Hickey. Members had queries answered on their rights and entitlements.

These two hospital walkabouts presented excellent opportunities for new graduates to meet the student officer and be updated on relevant matters.

– Maura Hickey, INMO IRO

At the INMO information sessions in the northwest recently were: (top) Phil Ní Sheaghdha addressing PHNs and CRGNs in Buncrana; (above) Dean Flanagan, Maura Hickey and Catherine Hopkins In Letterkenny; and (left) Marie Feeney with Dean Flanagan, in Sligo Regional Hospital

New global guidelines on TB for nurses



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

THE International Council of Nurses (ICN) recently published updated guidelines for nurses working in the care and control of tuberculosis (TB) and multi-drug resistant tuberculosis.

These guidelines are intended to help nurses in their important role of detecting TB cases, providing care and managing TB treatment. It sets out a nursing approach to planning and delivering patient care, aimed at improving access and quality of care throughout the treatment period.

TB is a major global health problem. It causes ill health in millions of people each year and ranks alongside the human immunodeficiency virus (HIV) as a leading cause of death worldwide. With six million new cases of TB reported to the World Health Organization (WHO) in 2014 and an estimated additional 37% not diagnosed or reported, it remains a significant health issue that requires ongoing attention.

According to the *WHO TB Report 2015*, TB mortality has fallen 47% since 1990, with nearly all of that improvement taking place since 2000, when the Millennium Development Goals (MDGs) were set. In all, effective diagnosis and treatment of TB saved an estimated 43 million lives between 2000 and 2014. The WHO 2015 report describes higher global totals for new TB cases than in previous years, but these reflect increased and improved national data rather than any increase in the spread of the disease. In 2014, TB killed 1.5 million people (1.1 million HIV negative and 0.4 million HIV positive). The toll comprised 890,000 men, 480,000 women and 140,000 children. According to WHO, to reduce this burden, detection and treatment gaps must be addressed, funding gaps closed and new tools developed.

For decades the ICN has been at the forefront contributing to the prevention, detection and treatment of many diseases. In relation to TB, the new guidelines are another example of the proactive role that the ICN invests in making a difference globally. It is recognised worldwide that nursing in many countries delivers the highest proportion of direct patient/client care. Therefore, nursing undoubtedly exerts considerable influence over whether, in reality, the change advocated by health policymakers can actually be achieved. According to Dr Frances Hughes, chief executive officer of the ICN: "Nurses are crucial in the prevention, detection and treatment of TB and multi-drug resistant TB (MDR-TB). They are the first, and often the only, healthcare professional to see a person with TB. These new TB guidelines are an important resource for nurses on the ground and will be used in ICN's TB/MDR-TB project to train experienced nurses to cascade information to nursing colleagues and other health workers, with the purpose of making improvements to patient care delivery. They will provide a complete understanding of TB and MDR-TB and strengthen nursing competence in tackling this growing epidemic."

For further information on the WHO End TB Strategy, a 20-year global agenda to combat tuberculosis and the key role of nurses in TB control, see *page 67*.

TB has reached epidemic proportions in many parts of the world. Nearly 1.5 million people die every year from a disease that is curable and preventable in most cases, even in very resource-poor settings. Everywhere in the world, nurses encounter patients with TB, those who have symptoms and those presumed to have the disease. Roughly three million nurses work or are registered in the 22 countries where 80% of TB cases are found. In most of these countries nurses are the primary healthcare provider, and often the only source of care, though they often work in deficient

systems, with poor access to adequate training, supplies and resources.

The ICN guidelines offer a review of TB and MDR-TB and provide an overview of organisational issues that can have an important impact on TB control programmes. The publication is a continuation in a series of ICN products on TB and is intended to be a comprehensive guide for the busy nurse.

Other ICN publications on TB address practice development with regard to TB care, TB-related stigma, infection prevention and control, and occupational issues. The guidelines in part are supported by a grant from United Way Worldwide made possible by the Lilly Foundation on behalf of the Lilly MDR-TB Partnership. The guidelines and other TB related publications and education tools are available on the ICN website at: **www.icn.ch**

Elizabeth Adams is INMO director of professional development

International nursing chiefs visit INMO headquarters

ICN chief executive officer

INMO president, Martina Harkin-Kelly met with Dr Frances Hughes, the ICN's new chief executive officer, on her recent visit to Ireland. A native of New Zealand, Dr Hughes has held the post of chief nurse and midwifery officer of Queensland, Australia since 2012. Prior to this, she was chief advisor (nursing) to New Zealand's Ministry of Health and, as consultant at the WHO and other NGOs, has worked in Australia, South Pacific, UK, Canada and Asia. She also held the position of commandant-colonel of the Royal New Zealand Army Nursing Corps and was the first professor of nursing at the University of Auckland.

Dr Hughes, who has a strong background as a health clinician, manager and educator, has received a number of distinguished awards over the years. She was most recently honoured with a lifetime achievement award from the Convenient Care Association and Pharmacy Times Continuing Education. The award honours nurse practitioners "who go above and beyond the call of duty to achieve excellence in patient care" over a lifetime. Dr Hughes received her award at the Second Annual Convenient Healthcare and Pharmacy Collaborative (CHPC) in Orlando, Florida in July 2016.

INMO president Martina Harkin-Kelly and Dr Frances Hughes discussed the strong relationship between the two organisations since 1925 and their commitment to work in collaboration and partnership to make a measurable difference for the future.

Pictured at the visit of Dr Frances Hughes, ICN chief executive officer, to INMO HQ were (l-r): Elizabeth Adams, INMO director of professional development; Dr Frances Hughes, Martina Harkin-Kelly, president INMO, and Liam Doran, general secretary INMO

Pictured left to right at the visit of Janet Davies, RCN chief executive officer and general secretary, to INMO HQ were (l-r): Elizabeth Adams, director of professional development, INMO; Janet Davies; and Liam Doran, general secretary INMO

Royal College of Nursing

Janet Davies, chief executive and general secretary of the Royal College of Nursing (RCN), met with Liam Doran, INMO general secretary, on a recent visit to Ireland. Prior to taking up the post of general secretary, Ms Davies was the RCN executive director for nine years, much of which was as deputy to the previous CEO. Her areas of work at the RCN cover professional nursing, policy, employment relations, international and learning and development. She has an exemplary clinical nursing career with experience in acute, mental health and community settings before moving into director of nursing roles. Prior to joining the RCN, Ms Davies was chief executive of Mersey Regional Ambulance Service NHS Trust, where she was credited with overseeing an extensive programme of change and development.

Leading the world's largest professional union of nursing staff on commencing this post, Ms Davies made a pledge to make it an "even louder voice for nursing than it already is". On her appointment she stated: "These are challenging times for nurses, midwives and healthcare assistants, and I will work to ensure that their talent and dedication is properly recognised and that their voice continues to be heard loudly and clearly in the debate about the future shape of healthcare in the UK".

Over the years the INMO and the RCN have developed a strong mutually beneficial partnership to share expertise and support nurses and midwives in both jurisdictions. The meeting of the two leaders, Liam Doran and Janet Davies, to discuss the strategic direction, many challenges and opportunities within the current political and economic environment, has ensured the strengthening of the positive mutual relationship between the two organisations.

Spotlight on Clinical Placement Coordinator Section

THE Clinical Placement Coordinator (CPC) Section of the INMO was reactivated on June 16, 2015.

Since that date, the section meetings have been very well attended with colleagues also availing of teleconferencing facilities. CPC Section meetings allow members to discuss pertinent healthcare issues within a collegial supportive environment. Issues discussed at section meetings have been both current and varied in nature, with great information being imparted, which is enhanced by personal and professional shared experiences of those in attendance. The group has also been afforded the opportunity to have highly informative sessions hosted by various speakers. Subject areas such as record keeping and documentation, student welfare and support have been covered as well as updates from our elected colleagues who are INMO representatives on the Executive Council and the Nursing and Midwifery Board of Ireland (NMBI).

The CPC Section proposed a motion at the ADC this year highlighting issues of increasing student placement numbers and the need for adequate resources to be put in place to deal with this increase. This motion was very well received and accepted at the ADC. The overwhelming support shown by the delegates for our motion not only demonstrated their support for this subject but also reinforced the section's belief that the role of the CPC is seen as vital. CPCs will continue to strive to afford all available supports and guidance to both students and the registered nurses and midwives who guide and assess their practice in today's dynamic and challenging healthcare system.

The INMO CPC Section is happy to invite any member currently employed in the role of CPC to join our group. Please forward your contact details to jean.carroll@inmo.ie if you would like to join the Section or contact the officers.

Section Officers

Chairperson

Shirley English

Education officer

Ann Marie Murray

Secretary

Liz Nolan

Affiliation Form for INMO Section Membership

Name:_____

INMO membership No:_____

Home Address:_____

_____

_____

Tel (work):_____

Tel (home/mobile):_____

Email:_____

Place of employment:_____

Job title:_____

Second section option (to obtain information only):

_____

Forward completed form to:

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

Tick ONE relevant Section you wish to affiliate with

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

New section established for INMO research nurses and midwives

A NEW Research Nurses/ Midwives Section was established, marking a landmark development in the history of research nursing in Ireland.

The initial broad objectives of the newly established section were discussed and points for discussion were agreed on.

Among key areas to discuss are the absence of national uniformity for research nurses in areas such as; domains of practice, progressive career pathways, grading structure, security and tenure of research nurses' positions and structured educational programmes to address the diversity and challenges within this distinctive professional role.

Section members pictured at the inaugural meeting of the Research Nurses/Midwives section which took place in June

A committee was formally elected, details of which will be available on **www.inmo.ie** in the coming weeks.

As an initial step, the committee would like to call on all INMO members who are research nurses and midwives to consider areas for further development within this specialised nursing and midwifery role.

There is a designated webpage for each section on **www.inmo.ie** and here, members will find all relevant information and contact details for the national section officers.

The committee looks forward to raising the profile of the research nurses and midwives in Ireland.

Retired Nurses and Midwives Section – update

MEMBERS from the Retired Nurses and Midwives Section visited the Pearse Museum, the former school run by Patrick Pearse, in St Enda's Park,Rathfarnham, Dublin in June.

A guide gave members a very informative and educational tour of the former school and the special exhibition on the Pearse family. It was a very interesting and historical tour. Admission into the museum is free and can be reached by the Dublin number 16 bus.

The next Retired Nurses and Midwives Section meeting will take place on Thursday, September 22, 2016 from 11am in INMO HQ. Please note this change of date.

Student health nurses gather for educational update on dermatology

MEMBERS from UCD Health Centre hosted colleagues from the INMO Third Level Student Health Nurses Section for an educational day focusing on dermatology.

The meeting, which took place in the parliament style Fitzgerald Chamber at UCD, saw dermatology nurse specialist, Carmel Blake from the Irish Skin Foundation, present an educational update to nurses on a wide array of skin conditions including acne, psoriasis and eczema.

Section members also received a comprehensive report from the annual delegate conference by Michelle Cresswell, who represented the section in Killarney in May.

The meeting was followed by a social event at the Radisson Blu St Helens, where members marked the retirement of their colleague Alice Meagher, Limerick IT. Jennie Scott from DIT also received well wishes as she moves into her new role.

Members of the Third-Level Student Health Nurses section pictured at a section meeting, which focused on dermatology and saw a presentation from dermatology nurse specialist Carmel Blake

The next meeting of the Third Level Student Health Nurses Section will take place at INMO HQ on Saturday, October 15, 2016. Please contact jean.carroll@inmo.ie for further details.

"We must never accept the abnormal as the norm"

Anne Burke talks about her priorities as new IRO based in the INMO Galway office. **Tara Horan** reports

NEWLY-appointed industrial relations officer Anne Burke urges INMO members not to get caught on the rollercoaster of accepting abnormal practices as the norm. Anne, who took up her post based in the Galway office in July, stressed that the moratorium on recruitment and pay cuts of recent years has unfortunately encouraged an acceptance of the 'abnormal' in relation to staffing levels in the Irish health service.

"There is a generation of newly qualified nurses, midwives and other healthcare professionals who may never really know what it is like to work in a normal, safely-staffed healthcare environment.

"The conditions in which nurses and midwives are working at present bear no resemblance to what I learned to be 'normal'. Normal means nurses and midwives in all healthcare settings can work with adequate staffing levels that provide safe and timely care to patients. Unfortunately, that hasn't been happening on the coalface for a very long time.

"I believe that the challenge for all members and grades within nursing and midwifery is to resist the pressures of being forced to accept substandard working conditions. Always seek out best practice even if it means putting your head above the parapet," she advised.

One of Anne's main priorities as an IRO covering the Western Region is to ensure that members both retain and improve all their terms and conditions of employment.

"Nurses and midwives need to start reclaiming what they have lost. I believe that the process starts with creating an awareness at both an individual and team level in the workplace," Anne said.

"Nurses and midwives have been so busy doing more with less that many have put their own place in the healthcare setting at the back of the queue. I believe that much of my role as an IRO is to support and empower nurses and midwives, as members of the INMO, to work together and advocate for themselves in a more vocal and tangible way in order to reclaim their rightful status in the workplace."

Safe practice workshops

Anne stressed the importance of safe practice workshops and continuous professional development, of the need for nurses and midwives to pause, reflect and say 'It's time to advocate for myself now'.

"Nurses face an extraordinary challenge in the current climate in trying to safeguard their practice. It will be one of my priorities to get that message across to members," said Anne, warning that there is nothing more important for nurses and midwives than to protect their registration.

Conflict resolution

Nipping conflict in the bud at the earliest possible stage is a mantra that has served Anne well since becoming an INMO workplace representative in Galway University Hospitals in 2002, a role for which she was released from her clinical post on a half-time basis for the past six years.

"As an INMO released rep I learned that nurses and midwives felt that their voices were not being heard," said Anne. "Exploring and guiding members in resolving grievances and conflict was and is an area that I enjoy so much. As a released rep in GUH between 2010 and 2016, I was well known to members and was able to get in and deal with issues at the lowest possible level, when appropriate. While we can't resolve every grievance at local level, I strongly believe that there needs to be more emphasis among employers and employees of timely, informal approaches to resolving conflict. So much can be achieved with early, meaningful dialogue in these situations," Anne said.

"One of my aims as an IRO will be to promote that very message to nurses and midwives. If there are issues of concern or conflict in our workplaces, we have to learn to recognise the tools that are available to us in order to resolve that conflict, such as the grievance procedure, and that we should be utilising these approaches

in resolving conflict rather than escalating straight away," said Anne. "Obviously, when the going gets tough, I believe that members can be very confident that the INMO will never be found wanting with regard to providing robust representation and I am very proud to be part of the team of IROs providing this excellent service".

Career

A native of Galway, Anne trained as an RGN in Regional Hospital Galway (now UHG), where she went on to train as a midwife and practised for just over a year. In July 2000, spurred on from her background in the Order of Malta Ambulance Corps, she took up a post in the very busy ED of UHG, where she worked until taking up her new IRO post. She completed a higher diploma in critical care nursing in 2002 and became a clinical nurse manager 2 in Galway ED in 2006. Anne has been a member of the INMO since the 1999 nursing/midwifery strike and became really active in the Organisation in 2002 with the national ED strike, which was launched to improve conditions in EDs.

"At that time we didn't have the chaos in EDs that we have now. If we didn't secure the structures that we got arising from the 2002 ED campaign such as 24/7 shift leaders and other key posts and resources, I wouldn't like to think what our EDs would be like today, particularly in light of the crisis that has unfolded in the past 10 years," she said.

Anne was chair of the Galway Branch of the INMO from 2008-2012 and was elected to the Executive Council in 2010, on which she served until June of this year.

She is an avid music fan and has been a member of choral associations and choir director of a children's choir for several years. She was a proud member of the Order of Malta Ambulance Corps for 25 years now. The Order of Malta in Ireland was established in Galway in 1937 and her late uncle was one of the founding members.

Coalface challenges

"Our community settings, the wards and EDs of our hospitals, and our intellectual disability services have all been decimated by staffing cuts since the moratorium on recruitment," said Anne. "With the latest agreement in January this year, EDs have been enabled to implement changes to ensure that more investment is made into their health and safety, education, staffing and operational management. That is a great achievement for the INMO. I have no doubt that the new posts such as CNM1s and assistant directors of nursing posts for patient flow will play a major role, once implemented, in making the working lives of so many ED nurses more bearable than is currently the case.

However, in relation to the wider healthcare setting Anne believes recruitment initiatives will have to be driven harder by employers in order to retain nurses and midwives in all areas, not just in EDs. "I believe that it was never as important as it is right now for nurses and midwives to demand safe staffing levels and keep the issue on every agenda at every single level and forum in the system. I really look forward to working with INMO members in all the different care settings to make their working lives and environments better. Nurses and midwives deserve to have normality restored to their places of work," Anne said.

Anne Burke is based in the INMO Galway office, Westside Business Centre, 74 Old Seamus Quirke Road, Galway; Tel: 091 581818; email: anne.burke@inmo.ie

It's time to schedule a training course

INMO organiser **Albert Murphy** focuses on training courses and workplace events available to members

THE recent proposals for emergency departments from the Workplace Relations Commission placed a major emphasis on health and safety in the workplace. It is therefore vital that all INMO reps in EDs across the country undergo health and safety training.

The next health and safety training course for ED reps will be held in INMO HQ on September 19, 2016. The first of these courses was held in May. All ED reps who have not yet taken this course are urged to attend. Health and safety reps are legally entitled to paid release to attend such training.

New reps/refresher training

The INMO has organised rep training courses for all new reps or for those who would like a refresher course. The course covers how to meet members' expectations through the grievance procedure and how to advocate on behalf of members in your workplace. It also contains case studies where representatives will be given an opportunity to demonstrate their new skills.

Advanced nurse rep training course

An advanced nurse reps training course will take place in INMO HQ on November 10-11, 2016. This course is available for those who have completed the basic rep training course or who have been a rep for a number of years.

To reserve your place on any of these courses, contact Martina Dunne at Tel: 01 664 0624 or email: martina.dunne@inmo.ie. Numbers are limited and therefore early application is advisable.

INMO general secretary Liam Doran updating members at a recent training course in INMO HQ

Keep in contact

As part of the INMO campaign to build a stronger union, nurse representatives are advised that contact detail forms are available from INMO HQ. These forms are used to capture members' details and are a useful way of ensuring that the membership in your own area is kept up to date. Copies are also available from your local IRO.

INMO workplace events

The INMO has developed the following presentations/events which can be held at workplaces at a time to suit members, such as lunchtime:

- *Fitness to practise presentation* – This is a short course on the important changes that have taken place regarding fitness to practise hearings, which are now held in public
- *Statement writing* – Getting statements right is vital. This course will show you the dos and don'ts of statement writing
- *Sick pay scheme* – This course will explain the new rules that apply to the public service sick pay scheme.

If you are interested in organising an event in your workplace please contact your local industrial relations officer or Albert Murphy at Tel: 01 664 0600 or email: albert.murphy@inmo.ie

Albert Murphy is INMO industrial relations officer/organiser; Email: albert.murphy@inmo.ie

Q and A Bulletin Board

With INMO director of industrial relations Phil Ní Sheaghdha

Query from member

I have a query in relation to pregnancy-related sick leave. I am currently out on sick leave as a result of my pregnancy. I have been out for a number of weeks so far and have been hospitalised for two consecutive days. What is my entitlement to sick leave?

Reply

Because you were hospitalised for two days or more you would be covered under critical illness protocol (CIP). This allows sick leave to be paid at six months full pay and six months half pay. The employer will take into account any previous sick leave. When submitting medical certificates to the employer the consultant or GP must write on the certificate that the sick leave is pregnancy-related.

Query from member

I understood the sick leave changes were to be reviewed by government. Can you advise if this review has taken place? And if so what was the outcome?

Reply

You are correct, when the changes to sick leave were introduced for all public servants including nurses and midwives in 2014, the government committed to reviewing these changes after the first year. The review was initially delayed as there had been legal challenges to the changes. The review has now commenced. The unions are represented by the public service committee of ICTU, on which I am the INMO representative. The government is represented by the Department of Public Expenditure and Reform and the following guidelines for the review have been set.

This is not a greenfield review of sick leave and other associated leaves – the overarching scheme framework will remain. As a result certain issues are not in scope for the purposes of the review including:

- Occupational injury
- Sick leave limits
- Dual look back.

The main issues of concern for ICTU public service unions are:

- Critical illness protocol, the delays associated with its application, the fact that very serious illness is not always covered. (government advised that across the public service in 2014, over 2,000 applications for CIP were submitted. In total 84% were successful, 75% of these were granted on medical grounds and 25% were granted under management discretion. This includes the outcome of appeals. A total of 19% of those that were refused appealed, and half of these were successful)
- Temporary rehabilitation pay when it applies and the delays in its application currently
- Pregnancy-related illness
- Sick leave records continuing in circumstances where compensation for earnings are repaid to the employer.

The next meeting is to be scheduled in September and I will update members thereafter. In the meantime the INMO and other unions in the health service are meeting with the HSE to deal with occupational health injuries and how they are addressed, and also the grant allowed to employees covered by the injury at work grant.

A column by Maureen Flynn

Quality & Safety

Quality and safety walk-rounds

THIS month's column introduces new resources for quality and safety walk-rounds, which aim to create a culture where quality and safety is everyone's primary goal.

Quality and safety walk-rounds bring senior management team members together with frontline staff and service users to have quality and safety conversations. They are proven quality improvement interventions that allow healthcare organisations to move towards reflective, rather than inspection, focused programmes.

Central to the success of walk-rounds is a collaborative, open approach. It is about creating an environment where change and improvement can thrive, about leading differently and in a way that fosters innovation. At the heart of the process is deference to the expertise and experience of frontline staff. As a more formalised framework, patient safety walk-rounds were initially introduced by Frankel in 2003[1] and have since been developed by the Institute of Healthcare Improvement in 2004,[2] governments[3] and hospitals[4,5] as a tool to engage senior managers and frontline staff in a meaningful discussion of patient safety concerns with agreed actions.[3]

Championing walk-rounds

The HSE published a toolkit for introducing quality and safety walk-rounds in Ireland in 2013. This has been used by many services across the country.

On June 8, 2016, the HSE Quality Improvement Division, in conjunction with Beaumont Hospital, launched *Quality and Safety Walk-rounds: a co-designed Approach – Toolkit and Case Study Report*. Following this case study, the guidance document and resources have been updated and are being shared for wider use. The document sets out the steps taken over 18 months by a team at Beaumont which formalised a quality and safety walk-rounds programme and shared its findings.

Using the Model for Improvement[6] and a phased implementation approach, a total of 12 quality and safety walk-rounds took place in clinical and clinical support sites across Beaumont Hospital. The walk-rounds were led by a member of the leadership team, which was made up of senior managers and clinicians from across the hospital.

In preparation, all members of the team completed a modularised, accredited leadership development programme co-designed by Beaumont Hospital and the National Quality Improvement Programme (HSE QID/RCPI) to support and enable the initiative. The walk-rounds, which are ongoing, create a forum for senior managers to hear first-hand about frontline challenges to delivering safer, better care, but also it revealed the innovative practices and good news stories that all too often never make it to the boardroom or across the organisation.

Benefits of walk-rounds

The benefits of the quality and safety walk-rounds initiative at Beaumont Hospital include increasing visibility of the senior management team and enhancing their experience and understanding of quality and safety issues at the frontline.

The initiative created the opportunity to enhance staff engagement and staff acknowledgement and empowered staff for solving local quality and safety issues with the support of other key stakeholders across the hospital, eg. facilities management and senior management. Improved clinician/management relations were also noted and the walk-round gave an alternative approach to patient involvement.

Opportunity to get involved?

At your next ward, department or unit meeting you might consider quality and safety walk-rounds. Discuss this quality improvement with your manager and suggest inviting the senior management team to your area to showcase your achievements for quality and safe person-centred care and seek support for your further suggestions for improvement.

Further information

To hear more about this case study, go to **youtu.be/dHlH-2Zf-GTs**, where you can watch a conversation between Liam Duffy, project sponsor and CEO of Beaumont Hospital, and Dr Philip Crowley, national director, HSE Quality Improvement Division. You can also access resources aimed at helping organisations to start this important quality improvement initiative on the HSE Quality Improvement Division website at: **www.qualityimprovement.ie**

Who to contact?

If your organisation would like to talk about starting quality and safety walk-rounds in your service please contact Siobhan Reynolds, Quality Improvement Division, HSE, at email: siobhan.reynolds2@hse.ie

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

Acknowledgements
Special thanks to Karen Greene, Petrina Donnelly, Kate Costello, Barbara Keogh Dunne and the many staff of Beaumont Hospital and the Quality Improvement Division Governance for Quality team for the commitment and support they have given to sharing their learning. We much appreciate Dr Peter Lachman's leadership and expertise throughout the process

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Recruitment crisis looms large

The immediate need to recruit and retain nurses and midwives, and overcrowding in July hit the headlines this month. **Ann Keating** reports

THE *Irish Times* (July 28) wrote about recruitment and retention of nurses and midwives under a headline – **Financial incentives to nurses will be studied closely by other groups**. It reported: "There are now approximately 630 vacancies for nurses and midwives in public hospitals across the country. As part of a move to tackle this problem, the government is to offer permanent jobs to all 1,500 nursing graduates this year. However, it remains to be seen whether such job offers will be sufficient to attract young nurses and midwives in large numbers, at a time when they are increasingly in demand both in Ireland and abroad.

"In essence, the State is competing both with the private hospital sector in Ireland and with hospitals in the UK, Canada and Australia for nursing personnel... According to the INMO, the problem for hospitals is being compounded as more experienced nurses are also opting to leave for posts offering better pay and conditions. A recruitment campaign, including a package of incentives aimed at recruiting up to 500 Irish nurses and midwives in the UK, which was launched a year ago, has not succeeded.

"According to the INMO, only 90 staff were taken on and about half of these quickly left again. Nurses' pay is strictly governed by the various public service agreements introduced over recent years. Pay has been reduced twice – in some cases three times since 2009 – while working hours have been increased by an hour and a half a week... The government is to establish a new commission to look at the whole issue of public service pay generally and to make recommendations to it next year. However, any major pay award to nurses – or to doctors, where there is also a skills shortage in key areas – will be watched jealously by other public service groups. One of the tests for the government's planned Public Service Pay Commission will be how it addresses the growing problems in recruiting and retaining staff in key areas, without undermining the entire public service pay edifice built up over recent years."

Agency spend

The *Evening Echo* (August 6) ran a headline **Expenditure on agency nurses tops €22m**. Phil Ní Sheaghdha, INMO director of industrial relations, said: "The lack of a workforce plan has never been as evident as it is currently. The idea that some of the 1,500 graduating nurses, will potentially be forced, due to this HSE policy, to seek employment abroad again, despite the HSE spending excessively on agency nurses, is simply inexcusable."

July trolley watch analysis

Republic's trolley waits double over a decade was a headline in the *Irish News* (August 10). "Twice as many patients are languishing on the Republic's hospital trolleys since a decade ago – when the crisis was declared a national emergency. Latest figures show 6,751 patients in emergency departments were forced to wait on trolleys for a proper bed last month. It is the highest figure on record for July and almost double the 3,460 on trolleys a decade ago in 2006." Liam Doran, INMO general secretary, said: "More staff and beds are needed to deal with the crisis. That's the core issue, not more layers of management overseeing what other layers of management should be doing." He said: "Official figures also confirm almost 3,500 less nurses in the public health system compared to seven years ago."

The story was also covered in the *Irish Examiner* (August 10) – **Minister in need of new ideas to tackle old problems**. "The INMO has consistently said emergency department overcrowding and waiting lists difficulties cannot, and will not, be solved without additional nursing staff and an increase in bed capacity," said Liam Doran, INMO general secretary, "in what will surely become his epitaph".

Our Lady of Lourdes Hospital, Drogheda

The *Drogheda Independent* (August 3) gave space to news that **INMO members at Lourdes Hospital resume work to rule action.** IRO Noel Treanor said: "The decision to recommence the work to rule was not taken lightly by members. It is imperative that HSE management recognise the need to close beds in order to ensure the optimum level of services are provided, pending the recruitment of sufficient numbers of nurses with experience to address the current service demands."

University Maternity Hospital, Limerick

INMO votes for industrial action ballot was a headline in the *Limerick Leader County Edition* (July 23). "Midwives at the University Maternity Hospital, Limerick have voted "unanimously" in favour of balloting for industrial action over staffing concerns... The trade union has been calling for an additional 30 staff at the Ennis Road Hospital since January 2015, INMO spokesperson Mary Fogarty said this week.

"The UL Hospitals Group stated that it has taken on 14 staff, and is currently in the process of recruiting the remaining 16 staff. However, Ms Fogarty said that while 14 people have been recruited 'a large number of people have left'. She said that she was recently notified by management that there were 20 temporary vacancies at UMHL, which include people on sick leave and maternity leave. There has been no real net increase in staff numbers."

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

4 PAGE PULL-OUT & KEEP

INMO submission to the
Oireachtas Committee on the Future of Healthcare

The Pathway to an Equitable, Fair and Quality Assured Health Service

EXECUTIVE SUMMARY

Introduction

The Irish Nurses and Midwives Organisation (INMO) warmly welcomes the decision, of the Oireachtas, to initiate this debate on the future of healthcare in Ireland. We believe, as the pursuit of safe quality care and patient focused practice is the hallmark of this Organisation, that the establishment of this committee offers the potential for consensus for a single-tiered, universally accessible, public health service where access is determined solely by need and not by ability to pay.

1. Fundamentals for a single-tiered health service

Recognising the current two-tiered structure, with its perverse incentives, we believe that a timeframe, of at least 15 years, will be required to develop a uniform, single-tiered public health service. This process of transformation will require political and societal consensus, ensuring consistent public health policy, supported by adequate funding.

2. Current realities

The economic downturn of the last eight years has negatively impacted on the ability of frontline staff, in particular nurses and midwives, to deliver the highest quality care based on international best practice. This negative impact has arisen from a misguided political perception that investment in healthcare services is a waste. Whilst we acknowledge that funding has increased, in the last two years, with total expenditure now €14.3 billion this remains 20% less than in 2007 despite greater service demands.

3. Changes to models of care

As the priority must be integrated care this transition will involve significant changes to our acute, primary and social care service models. In particular it must be recognised that the required shift, away from acute to primary care, will involve a period where both pathways are maintained as no existing service can be ended until an alternative, quality assured and accessible service is available to the local community.

The transition must involve a detailed review of our acute bed and operational capacity within our **acute services.** This review must deliver additional beds to address severe overcrowding in a number of hospitals. We must also ensure acute hospitals are fully operational on a 7/7 basis with team working, fully utilising the skills of all staff, a fundamental requirement.

We are also calling for radical reform of, and expansion to, our **primary care services**. This will involve all health professionals, providing primary care services in teams, being directly employed. Existing contracts, for both GPs and Consultants, can be retained, but not renewed, while all GPs/Consultants must be afforded the opportunity to move from existing contracts to a direct public contract. In addition to this our primary care services, if they are to provide access on an extended seven-day basis, will require significant numbers of additional health professionals, particularly in the public health/community nursing areas, and this must be planned for as part of an overall workforce plan.

In recent years, in the absence of any public debate, the provision of **long term care** has been privatised and de-professionalised in the absence of adequate, sustained, investment in our public long term care facilities. In a single-tiered system this policy must be reversed and the State must be in a position of providing long term care, when it is required, to all our citizens with world class physical infrastructure. The current practice of investing only to improve existing buildings, to meet HIQA standards, actually results in a decrease in public capacity for older care.

The provision of **disability services** will also require significant reconfiguration and radical reform during this transition period. The current reliance upon external agencies, some of them within the public service while others are in the private sector, to provide these services has, in the past, served this country well. However, the reality is this type of provision can lead to inequality of access and, in more recent times, a loss of public confidence with regard to the proper utilisation of all monies granted or donated. We must shift towards a directly provided model and again this can be achieved over a medium timeframe. This must be accompanied by legislation which guarantees access to all services, as a human right, for the disabled person.

While most **mental health services** are currently directly provided, by the State within the public health system, they have been, for many years, subject to huge underfunding, loss of staff and inconsistent in their availability in different regions of the country. The transitional process must see increased investment which must not only touch upon capital infrastructure but, critically, on educating and retaining sufficient numbers of health professionals to provide a comprehensive, community based service over the seven-day cycle.

4. Health workforce

A cornerstone of this transformation must be the development of a health workforce plan which clearly identifies the human resources for health required to staff this expanded, comprehensive, public service. We cannot rely upon overseas recruitment (apart from the ethical dilemmas it creates) to staff our health service. We must, as a first goal, seek to educate and retain people in this country. This will require the new health service, which will be the largest employer in the State, to be a world class employer offering excellent pay and other terms and conditions of employment. In return for this the service can expect dedicated, committed and quality assured care from all staff.

5. Funding

Politically the process of change to delivering a single-tiered world class public health service will require fundamental reform of the current funding model. This element must be underpinned by a willingness to commit the required adequate amount of funding at a minimum of 10% of GDP with 12% to 14% over the transitional period. This, in turn, will address current and future workforce needs, ensure investment in necessary capital infrastructure and, thereafter, maintain health spending at the required level to ensure a world class service for all. In that regard funding, through a progressive taxation system, is the most equitable. This will require cross party political consensus which, to date, has been absent with regard to shaping our nation's health services.

Conclusion

Against this background the journey, beginning with the work of this Oireachtas Committee, must see a transformation, as to how we deliver healthcare and how the political system views the public health service as a social good benefiting – the individual, communities and the economy. Complacency must be guarded against with public health policy being the subject of regular reviews spread over the transformational timeframe. We must address, in a timely and meaningful manner, all obstacles thus preventing dilution of a commitment to a single-tiered system, essential for social cohesion, the health and wellbeing of the population, and, ultimately, a growing economy.

FUNDAMENTALS FOR A SINGLE-TIERED HEALTH SERVICE

1.1 The Irish Nurses and Midwives Organisation (INMO) warmly welcomes the establishment, by the Oireachtas, of this special Committee to consider the future of healthcare in Ireland based on the central tenant of equity, fairness and quality.

1.2 The INMO believes this must be the first step in a radical, comprehensive, transformational and sustained process of change leading to a seamless universal single-tiered health service with access based solely on health need rather than ability to pay is a fundamental social good. This service must provide all essential health services required at all stages of the life cycle.

1.3 The achievement of this objective will require short, medium and long term actions, spread over 15 years plus, but will deliver significant improvements for individuals, families and the economy.

1.4 Shaping, forming and sustaining this single-tiered, universally accessible, public health service (including ownership and delivery), will require political consensus stretching far beyond the normal electoral cycle. It will require this, and future, governments, and oppositions, to accept that the transformational change required cannot be interfered with for political reasons. This will be important particularly during the transitional period when additional investment, both current and capital, will be required and when existing incentives, targeted at private healthcare, will have to be phased out.

1.5 All government policies must be shaped to promote the maintenance of good health for the whole population. This must include taxation policies which encourage healthy lifestyles while heavily taxing all products which lead to illness and obesity, ie. alcohol, cigarettes, sugar drinks and snack foods.

1.6 Annual expenditure, on a single-tiered service, must, at a minimum, be maintained at 10% of GDP (12% to 14% during the transitional period). Separate funding, over a five to seven year period, is necessary for capital investment to improve existing health infrastructure and develop new community based health facilities.

1.7 Over the last 12 years, many policy and organisational reform programmes have been attempted. These have not delivered qualitative and quantitative improvements but have fragmented services and diminished integrated care. The transition, to a single-tiered system, must see simplified, transparent and lean, organisational structures with funding and accountability devolved to frontline managers who can respond to changing need, demographics and demand.

1.8 Ireland's future, single-tiered, health service, must also provide a dynamic, proactive and rewarding career for all its staff. In reality this new service will be the largest employer in the State and must be an employer of choice with excellent HR practices. It must also be recognised that, in this global economy, health professionals are mobile and, in particular, Irish health professionals, are recognised and highly regarded across the world. The working environment, career and reward structures, must be competitive and must ensure that we attract, and retain, the best and brightest health professionals and support staff in the interests of quality care and best possible patient/client outcomes.

1.9 Recommendations:

1.9.1 *It is recommended that this Committee propose that as public policy, endorsed and supported by all political parties, this country move to a single-tiered, universally accessible, directly funded public health service where access to care is solely determined by need and not ability to pay.*

1.9.2 *It is recommended that it be accepted that this transformational change will take a minimum of 15 years and will require sustained political consensus with regard to the levels of capital and current funding required.*

1.9.3 *It is recommended that this public policy be the subject of regular reviews, spread over 15 years, to address all issues that arise thus preventing any dilution of a commitment to a single-tiered system, essential for social cohesion, the health and wellbeing of the population and, ultimately, a growing economy.*

2. CURRENT REALITIES

2.1 Over the last eight years, the Irish health service has been subject to radical contraction, in an unmanaged and unplanned way, which has left it unable to meet the demands being placed upon it.

2.2 In the same period, particularly between 2009 and 2014, funding for the health service was reduced, in real terms, by over €4 billion resulting in the premature contraction/curtailment of services without viable alternatives. This has negatively impacted upon the ability of frontline staff to deliver the highest quality of care underpinned by internationally proven best, evidenced based, practice and has had a negative effect on the health of the population through delayed access to services.

2.3 This has all taken place, not just because of a financial emergency or deep recession, but also because successive governments have never accepted that a quality assured health service is a social good essential for a dynamic economy. They have all too readily accepted the argument that the Irish health service is wasteful and a black hole in terms of taxpayer's money. This is an unfair, and incorrect, assessment as, despite all of the pressures upon it, standards of care, once accessed, are very good because of the commitment and professionalism of staff.

2.4 This contraction, in terms of budgets and staffing, has, at a minimum, resulted in the following:

- A loss of 2,000 public beds (acute and long term);
- The privatisation, in large part, of all services for older people in this country;
- Severe contraction, in an unmanaged way, of mental health services, with large gaps in service provision, across the country;
- Silent, but very harmful, cuts in disability services; and
- Very severe contraction, despite many public utterances by successive Ministers, in community based health services particularly in such areas as public health and community nursing, home care/home help, and community based services provided by allied health professionals.

2.5 It is acknowledged that, in the last two years, some increase in budget allocation has taken place. However, we would bring to the Committee's attention that, even after additional funding for the health service, this year the total expenditure is €14.3 billion when, in 2007, it was almost €17 billion.

2.6 The past seven years has also seen an unmanaged contraction, in terms of staff, and the following must, again, be noted:

- A loss of over 5,000 nursing/midwifery posts, amounting to a reduction of 13.5% of total employment;
- A loss of 3,500 general support and care staff;
- An increase in the number of medical personnel by over 1,500;
- A small increase (800) in the number of allied health professionals; and
- A reduction, of 1,200, in the number of clerical/administrative/managerial staff.

2.7 This unmanaged contraction, which was without purpose or direction other than budget saving, has left the service grossly understaffed, particularly in the frontline, where patients/clients receive care. This represents an immediate crisis for our health service. In addition, this contraction has resulted in the forced emigration of thousands of young health professionals. A major challenge will be to attract back these health professionals while we educate additional numbers of health professionals and ensure they remain upon qualification.

2.8 To provide a comprehensive 7/7, quality assured, service will require the replacement of these lost staff together with additional staff recognising the shift to extended day service availability.

3. CHANGES TO MODELS OF CARE

3.1 Integrating care

3.1.1 The key objective, within this reform programme, must be to develop, deliver and maintain highly integrated care pathways for every user of the service. This requires, as stated previously, a simplified organisational structure which clearly indicates responsibility for service delivery. This can only be done by devolving responsibility, for the provision of **all** care, to the frontline.

3.1.2 Acute hospitals must operate, on a 7/7, basis with ever present lines of communication to Primary and Social Care services. The service user must be assured they will have access to the appropriate health professional, over this seven day cycle, with both the quality, and quantity, of healthcare available remaining consistently high. We must abandon the increasing tendency to silo service models and offer the patient/client a fully integrated quality assured service.

3.2 Acute services

3.2.1 A core requirement will be a significant expansion in our acute bed numbers in a number of hospitals across the country.

- The current OECD figures confirm that Ireland, at 2.8 beds per 1,000 of the population, has a major under supply of acute beds (averaging at 4.8 beds per 1,000 of the population) and this must be addressed.
- These additional beds must be the required mix of day and seven day beds to reflect the changing nature of service delivery and the increasing shift to procedures done on a day basis.

3.2.2 It will also be necessary to greatly expand access to diagnostic and treatment services, over the seven-day cycle, in all major acute hospitals which will require investment in both staff and equipment.

3.2.3 Any transformational programme must involve, as a central requirement, that all new consultant staff work under a **public only** contract providing services, on an extended day basis, over the seven-day cycle.

- This will require significant additional numbers of Consultants, particularly in the core specialisms of Medicine, Surgery, Paediatrics, Obstetrics and Emergency Medicine.
- It will also facilitate a reduction in the system's reliance upon, and number of, doctors in training, (Non-Consultant Hospital Doctors – NCHDs).
- It must also recognise a transitional period during which existing contract holders, at Consultant level, will continue, if they wish, on their existing contracts or, alternatively, migrate to the new **public only** contract.

3.2.4 Staffing levels, in all acute services, must be evidence based, and maintained under the direction/control of the frontline clinical manager. This work has commenced, in the nursing/midwifery area, and should be extended across the

service as part of the change programme. This will ensure consistency of staffing and patient safety.

3.3 Maternity services

3.3.1 As part of this major reform we must also fully implement the recently published Maternity Strategy with its emphasis upon choice and quality of care for the pregnant woman.

3.3.2 This must include, and will require planning for, the nationwide availability of community based, accessible, midwifery led services. These should be linked to the greatly expanded primary care services referred to below.

3.3.3 A cornerstone of this very welcome strategy is the need to greatly increase the number of midwives, working in the public system, to ensure that the ratio of midwife to births stands at 1 to 29.5 which is recognised as being an optimal staffing level for quality assured care.

3.4 Primary care

3.4.1 The cornerstone of any single-tiered universally accessible health service will be the development of a primary care health service which works, at a minimum, on a seven over seven basis, with access being available on a 24/7 basis in major urban areas.

3.4.2 All staff, providing primary/community care services, should be directly employed on a public only contract. They must work on a team basis with the individual having the right to directly access the relevant health professional. Health professionals should also be in a position to cross refer, any patient, to another health professional in a different discipline, as required, to ensure the patients' needs are met. It is also imperative, in the interests of patient safety, that frontline health professionals have a reporting relationship to their senior colleagues.

3.4.3 This critical part of the transformation process will require a radical alteration to the current contract relating to General Practitioners (GPs). All future contracts should involve direct employment, extended day rostering and full integration into the primary care team with all other health professionals.

- Existing contract arrangements must be allowed to continue. All new contracts must reflect the reality of a single-tiered service with universal access delivered by directly employed staff.
- Where existing contracts are altered all staff in that practice should, together with that GP or group of GPs, be subsumed into the public health service.
- In a situation where the GP, (or group of GPs), do not wish to alter their existing contract other practice staff should still, in the interests of integrating care, be offered the opportunity to transfer to the public health sector.

3.4.4 Primary care centres must be built, complete with significant diagnostic and treatment services available within them, and it is recognised this will require sustained capital investment.

All primary care centres must provide at a minimum:

- Direct access to the full range of allied health professionals;
- A full range of basic diagnostic and treatment services; and
- Health promotion/screening services to promote the maintenance of good health and not just treat ill health.

3.4.5 The transformation programme should, ultimately, see the balance of funding move away from hospital (secondary) care to primary care services. This is not to suggest cost reductions but to allow the provision of a wider range of services, at a lower cost, per intervention. The shift to primary care should also assist in the promotion of healthier lifestyles, aided by targeted taxation measures, to reduce the incidence of ill health in the community over time.

3.4.6 Arguably the greatest challenge facing any future health service is the combination of demographic change, management of chronic diseases, and the growing incidences of obesity and the health challenges which arise. These can only be managed, treated and minimised by the existence of a primary care service which is not only accessible but reaches out to the population.

3.5 Care of older persons

3.5.1 To deliver a single-tiered universal health system the State must reverse its existing policy, of silently privatising care of the older person services, and commit to public provision of all services, for the older person, into the future. This must include a costed planned capital building programme for new facilities.

3.5.2 In addition nursing practice has progressed and expanded to include nurse prescribing and administration of medications under protocol. This development must be to the forefront of developing more efficient, patient centred, care in the community (home/care centres). This would replace the current practice of the elderly citizen being transferred to the acute hospital to access the most basic levels of intervention because this service is currently not available, or catered for, in our existing care of the elderly facilities/services. *'The system'* must catch up to the development in nursing practice and move immediately to develop extensive nursing led services in care of the elderly facilities.

3.5.3 This will require the phased elimination of current subventions to private nursing homes. It must also see significant capital investment, in new long term care facilities, recognising the ageing population, increasing life expectancy and the resulting increased morbidity which will require long term care in the coming decades.

3.5.4 Seeking profit/financial gain has no place in a single-tiered public health service. The State must accept responsibility for the delivery of high quality care, whether it be in the home, day/community based facilities or long term care facilities, for our senior citizens as part of this transformation of our health care system.

3.6 Disability services

3.6.1 The key objective, with regard to Disability services, is to ensure the individual always has access to appropriate qualified professionals who seek to ensure the person reaches their full potential while fully integrating into his/her community. Additionally, the human rights of persons with disabilities must be enshrined in legislation to ensure equity of access and parity of esteem with their fellow citizens.

3.6.2 In considering this aspect of our health care service it must be recognised that the provision of disability services has, over many decades, been devolved, by the State, to various voluntary organisations and not for profit community based groups. It should be recognised that, for the most part, the services have been of the highest quality and the State owes a great debt of gratitude to these providers.

3.6.3 However it has to be also recognised that the delivery of disability services, through these disparate groups, has led to gaps in service provision and variations of standards which cannot be ignored. Equally, particularly in recent years, there have been difficulties, with regard to funding and other financial matters, which cannot be ignored and have damaged public confidence.

3.6.4 Against this background, and in order to again ensure equality of access and the highest, consistent, standards of service, the transition to a single-tiered service, must involve the State, through direct provision, in providing disability services. This model should address the holistic health issues, throughout the life cycle, bearing in mind the need for the State to provide services as the role of families and carers may diminish with increasing life expectancy. The Registered Nurse in Intellectual Disability (RNID) is the only holistically trained professional capable of supporting these services into the future.

3.6.5 A particular challenge, over the next 15/20 years, in the area of disability, will be balancing the ongoing shift from institutional care to community based living facilities. This requires greater levels of infrastructural investment, where it is appropriate, while also involving the provision of intensive supports, in residential facilities where necessary, to optimise the lives, opportunities, potential and well-being of the person with a disability.

3.7 Mental health

3.7.1 It is self-evident that the State has failed to provide a comprehensive range of services, regardless of means or location, to our fellow citizens encountering mental health difficulties over many years. There are examples of world class services in this country. However, we must also acknowledge examples, over many years, of neglect, failure and, at times, segregation, of those with a mental health illness which cannot continue.

3.7.2 The transition, to a single-tiered health service, must see very significant investment, linked to the primary care centres referred to earlier. This will allow the individual access services, on a 24/7 basis, fully utilising the full range of specialist professionals who should be located in both the primary care centres and emergency departments of large hospitals in urban areas.

3.7.3 Most mental health services are already delivered through the existing public health service. However, this has been subject to severe cutbacks, in recent years, and confusion over the provision of new services and staff. The transformation programme must see this service receiving the attention it warrants so that it can be accessed, at all times, by those who need support.

3.8 Recommendations:

3.8.1 *It is recommended the reform/transitional programme deliver a fully integrated service, within a flat management structure, with responsibility, with autonomy, devolved to clinical frontline managers who can access all services for the patient/client.*

3.8.2 *It is recommended that, as part of this transition, the recently published Maternity Strategy, is implemented as a matter of priority thus providing choice to the pregnant woman.*

3.8.3 *It is recommended that the new service involves all health professionals fully utilising their skills and competencies. This must entail direct access for all patients/clients, to any health professional, and the ability for health professionals to cross refer depending upon the needs of the patient/client.*

3.8.4 *It is recommended that the existing service model, providing disability services, be dismantled, over this 15 year period, and replaced with directly delivered services with a key focus upon fully utilising health professionals and providing, under legislation, guaranteed access to appropriate services.*

3.8.5 *It is recommended that an expanded range of mental health services are provided, on a seven-day basis through primary care centres fully utilising the skills of all health professionals.*

4. HEALTH WORKFORCE

4.1 An immediate challenge, facing any transformation programme, will be the development of a health workforce plan which identifies the human resources for health necessary to provide this expanded service. This plan should recognise the public good, in terms of overall health and wellbeing, arising from a properly staffed service and include timelines for full implementation.

4.2 It is a reality that, currently, our staffing levels, skills mix, roles and function are based on historical factors. They are not related to the demands currently on the system, patient/client acuity and dependency and the turnover of staff, particularly professional staff, within our health service.

4.3 In that context a cornerstone, of any programme, must be an assessment of future need, based upon the form and type of service to be delivered and how we will, recognising the worldwide shortage of health professionals (in particular nurses and midwives), educate and retain sufficient numbers of our own to meet service requirements. Recognising the global labour market we cannot rely upon unethical overseas recruitment to staff our services into the future. This will require significant work, informed by available international evidence and best practice, of intra professional working including a review of roles and functions. This must seek to ensure the full utilisation of skills, with manageable workloads recognising the acuity/dependency of patient/clients. Ongoing employer supported education and professional development is a must for a modern developing health service. This ensures the commitment to innovation and development of new methods of care delivery which, in turn, retains staff as they have a greater input into best practice and development of services.

4.4 In the formulation of this multi-faceted plan, and in the context of our single-tiered service being a dynamic world class employer, we must also target health professionals who have left this country in recent years. The reality is that, particularly in nursing/midwifery, we have an ageing workforce with increasing numbers of retirements taking place over the next 10 years. This must be recognised, in this workforce plan, as we maximise the number of undergraduate places, in all disciplines, as well as targeting overseas recruitment to attract back those who have left in recent years. All of these professionals will be necessary to establish, and maintain, optimum staffing levels which, in turn, are proven to enhance outcomes for patients/clients.

4.5 The key, to this workforce plan, is that the Irish public health service will become an employer of choice, with excellent terms and conditions of employment. This will attract, and retain, the numbers of dynamic, committed, health staff necessary to deliver a world class health service.

4.6 Recommendations:

4.6.1 *It is recommended that the new health service, as the largest employer in the State, must be, recognising the worldwide demand for Irish health professionals, an employer of choice offering excellent pay and other terms and conditions.*

4.6.2 *It is recommended that the move to a single-tiered service, providing a full range of services on a seven-day basis, must include a comprehensive workforce plan which will ensure the following:*

- *Ireland educates, and retains, the required number of health professionals to staff the expanded public health service;*
- *Staffing levels, within the service, are determined by an evidenced based approach, informed by international best practice, which will involve assessment of patient acuity and dependency and acceptance of the professional judgement of the health professionals involved; and*
- *That all direct care in the reformed health service is provided by the most appropriate person in the most appropriate place closest to the patient's/client's own home where possible.*

4.6.3 *It is recommended that all new contracts, for Consultants and General Practitioners, specify public only employment with existing contract holders being offered the choice of moving to the new contract or remaining on their existing contract which would not be renewed when it expires or the individual retires.*

5. FUNDING

5.1 In 2013 OECD figures state the government allocated 7.2%, of Ireland's GDP, to public health spending. These figures confirm public expenditure, on health in Ireland, has decreased since 2009 and now represents 67.4% of total health expenditure in this country. The figures also confirm the degree of contraction in health expenditure over the period 2009-2014, was unparalleled when compared to any other OECD country.

5.2 This level of public expenditure is significantly below the OECD average, of approximately 9.2%, and further exacerbates the years of underfunding, of our public health service, covering the last 25 years.

5.3 In parallel with this direct, publicly allocated, level of funding, the same OECD figures confirm that individuals, either through private insurance or direct out of pocket expenditure, account for 32.6% of the total level of expenditure, in 2013, in this country. Indeed, in tandem with the reduction in public expenditure, on health, since 2009, private expenditure, whether from private insurance or direct cost to the individual, has increased.

5.4 It should also be noted that while this data reflects that out of pocket individual spending, on health insurance, remained relatively constant, in the years 2005-2007, this spending has risen, in proportion and volume, compared with private insurance expenditure in the years 2008-2013 and has remained consistently above the 2005-2007 levels. In other words those who could afford to, increased their out of pocket expenditure, on health, which begs the question what negative consequences arose for those who could not afford any additional expense.

5.5 When taken together this overall level of expenditure on health, either through government expenditure, private health insurance or direct out of pocket payments, confirm that our total expenditure, at this time, is approximate to 10% of GDP. However the manner of this expenditure, which clearly reinforces the two-tiered structure, only serves to guarantee faster access to diagnostics and treatment for those who can either afford private insurance or direct out of pocket costs. This is inherently unfair and inequitable.

5.6 Recently NERI have produced a forecast of Irish healthcare expenditure from 2014-2015 in view of the demographic changes expected to occur and their implication for, and pressure on, health spending. As the study evidences, Ireland will likely face a confluence of factors that will significantly impact health costs including an increasingly ageing population, a decrease in fertility, migration and changes in life-span and morbidity. Indeed:

- *While Ireland currently has one of the youngest populations in the EU, the population over the age of 65 is projected to nearly treble over the next three decades from about 606,000 in 2015 to between 1.7 and 1.8 million individuals in 2046. This implies increased expenditures due to the higher costs associated with these cohorts as well as changes in the overall allocation of resources within the public system. (Kelly 2014).*

5.7 Having reviewed the current practice in Ireland for the financing and provision of healthcare services, as well as forecasts for cost implications of inaction and modelling of proposed reform measures, we propose the following:

- As stated we propose the abolition of the current two-tiered system of healthcare provision in favour of universal access to services, free at point of delivery, with access based on need;
- Establish a single-tiered health service funded from general taxation – acknowledging that various models of general or specific taxation may be deployed to achieve this objective;
- Determine a quantum of funding that is necessary and sufficient to meet the healthcare demands of the Irish population into the future, and to do so based on a cross party, cross sectoral, process which embraces the concepts of equity of access, based on need, and develops a changed service which truly meets the needs of the population;
- Create a health service which adequately meets the healthcare needs of the nation;
- Emphasise sustainability, cost management and equity in the funding and provision of healthcare; and
- Adopt best practices and models of care which produce the best health outcomes.

5.8 The move to this funding model must also include:

- The phased abolition of all tax reliefs pertaining to private health insurance;
- The ending of any contracting for services to provide direct care; and
- The phased ending of subventions to private nursing homes.

It is recognised this reform will take an extended period due to a range of factors including contracts/bed stock/development of new facilities.

5.9 This approach to funding, both during the period of transition and thereafter, must secure and maintain the support of both the political system and the taxpayer. The shift to funding, through general taxation, and the phased abolition of tax reliefs and subventions, for healthcare, must be undertaken in a very open and transparent manner if it is to enjoy cross community support. This must see public perception change from health insurance gives you fast/better access to one where it is understood a progressive taxation system, within which everyone pays their fair share, leads to the provision of a world class accessible health service **for all.**

5.10 Recommendations:

5.10.1 *It is recommended that this public health service is funded through a progressive general taxation system which will seek to ensure that every citizen's contribution is based upon their ability to pay.*

5.10.2 *It is recommended that, once established, the public health service be funded to a minimum of 10% of GDP recognising that, during the transitional stage, the funding levels necessary will be 12% to 14% of GDP.*

5.10.3 *In tandem with this move to a single-tiered service, funded through general taxation, it is recommended that all tax reliefs, for health insurance policies and direct subventions, to private nursing homes, be phased out and ultimately eliminated.*

5.10.4 *It is recommended that all public policy be geared to encourage healthy living and active lifestyles. This should include, as a first step, increased taxation on sugary drinks and snack food which encourage obesity.*

Type 2 diabetes mellitus

In the latest clinical update in this continuing professional development series, **Ikwuoma Udeaja, Charlotte Bowe** and **Gerry Morrow** examine type 2 diabetes mellitus

DIABETES is a lifelong chronic condition, affecting approximately 225,840 people in Ireland.[1] It is defined as a group of metabolic disorders which are either caused by inadequate insulin production (type 1), or insulin resistance (type 2) or a combination of both of these factors. The defining characteristic of the insulin deficiency or resistance is a raised blood glucose level which can have serious detrimental effects on the person's health.

The term diabetes mellitus comes from the Latin 'diabetes', meaning to pass through, and 'mellitus' meaning honeyed or sweet.

Type 2 diabetes

Type 2 diabetes, previously known as 'non-insulin dependent' or 'adult-onset' diabetes due to its occurrence mainly in people over the age of 40, has been diagnosed with increased frequency since 2004.[3]

It is the most common form of diabetes mellitus, accounting for nearly 90% of all adult cases[2] and has a rising prevalence in children.[3] It is estimated that by 2030, almost 280,000 people will have type 2 diabetes. This will mean that 7.5% of the population of Ireland will have the condition.[1]

Type 2 diabetes is caused by a combination of insulin resistance and relative insulin deficiency. This results in poor glucose absorption, leading to persistent increased blood glucose levels (hyperglycaemia). Common risk factors associated with developing type 2 diabetes include obesity, lack of physical activity, a family history of diabetes and having high blood pressure or high levels of cholesterol.

If not successfully managed, it can lead to long-term complications such as reduced quality of life, reduced life expectancy, psychological problems, and microvascular and macrovascular complications.[2] Type 2 diabetes can be managed using a stepwise approach with a combination of diet and lifestyle changes, oral antidiabetic drugs and insulin.

In comparison, type 1 diabetes is classified as an absolute insulin deficiency, where the body does not produce enough insulin due to the insulin producing cells within the pancreas being destroyed. As a result of this, if the person were not to use insulin replacement therapy, they would die within days or weeks.

Risk factors for type 2 diabetes

Risk factors for type 2 diabetes can be a combination of genetic and environmental factors. Environmental factors are largely influenced by lifestyle such as obesity and inactivity, these account for 80-85% of the overall risk of developing type 2 diabetes. Overeating and inactive lifestyles can exacerbate insulin resistance and poor dietary habits, such as low fibre and food with a high glycaemic index (cakes, pastries etc.) may increase the risk of obesity, which in turn increases the risk of type 2 diabetes.

Genetic factors, such as ethnicity and a family history of type 2 or gestational diabetes also increases the person's risk. People with a family history of type 2 diabetes are two to six times more likely to develop the condition than people without, and if a child is born to a mother with gestational diabetes they have a six-fold increased risk of developing the condition.

People of Asian or African descent are two to four times more likely to develop the condition than Caucasians. Other risk factors include certain drug treatments such as statins or corticosteroids, and other pre-existing conditions such as polycystic ovarian syndrome and metabolic syndrome.

Diagnosing type 2 diabetes

Early diagnosis is seen as the best starting point for living well with diabetes; early detection speeds the treatment of cardiovascular risk factors, particularly improving the management of lipids and blood pressure.[4] Diabetes is diagnosed mainly on clinical grounds; it should be suspected in the presence of key diagnostic factors including: the presence of common risk factors such as family history and obesity, and persistent hyperglycaemia. Other characteristic symptoms such as fatigue, blurred vision, thirst and weight loss are usually not severe or may be absent. Diabetes is usually diagnosed by a blood level of HbA1c of 48mmol/mol (6.5%) or more,[5] however the diagnosis should never be based on a single abnormal HbA1c or fasting blood glucose level; at least one additional abnormal result is required for a firm diagnosis.

Due to the increased prevalence of type 2 diabetes in children, it is important to suspect diabetes in a child if they present with the following symptoms: persistent hyperglycaemia, strong family history of type 2 diabetes, obesity, or are of African or Asian family origin. Children with type 2 diabetes typically have no additional features of type 1 diabetes. These features of type 1 diabetes are rapid onset of symptoms, weight loss or signs or symptoms suggesting the diabetic emergency of ketoacidosis. The signs of ketoacidosis include fast, deep breathing, abdominal pain, nausea, vomiting, weakness and lethargy and dehydration.

When thinking about the possibility of diabetes in a child, type 1 should always be suspected as being the likeliest diagnosis.[3] If diabetes is suspected, the child should be immediately referred to a multidisciplinary paediatric diabetes care team for confirmation of diagnosis.

Complications

There are several complications which can arise from type 2 diabetes; this risk can be greatly reduced by active management of blood glucose levels and following a self-management programme. Adults with type 2 diabetes are 40 times more likely to die of macrovascular than microvascular complications of diabetes.[5]

Macrovascular complications include cardiovascular disease, cerebrovascular

disease and peripheral arterial disease. Adults with type 2 diabetes are twice as likely to die of a stroke compared to those without,[5] and cardiovascular disease accounts for 52% of deaths in people with type 2 diabetes. Some 20% of all hospital admissions for heart failure, myocardial infarction and stroke are in people with diabetes.

Microvascular complications include nephropathy, retinopathy and neuropathy. About three in four people with diabetes will develop chronic kidney disease in their lifetime, with kidney disease accounting for around 11% of deaths in type 2 diabetes.

Chronic renal disease is driven by uncontrolled blood pressure and glucose, and increases the risk of CVD by four-to-ten-fold.[5] Diabetes is one of the leading causes of preventable blindness in Ireland, responsible for 4% of people who are registered blind. People with diabetes are also 30 times more likely to have an amputation compared with the general population due to chronic painful neuropathy.

Metabolic complications such as diabetic ketoacidosis can arise from poor blood glucose management, along with dyslipidaemia which is a risk factor for CVD. Other complications include psychological issues such as anxiety and depression; reduced quality of life from constant management of blood glucose; reduced life expectancy; and being more susceptible to urinary tract and skin infections, among others.

Assessment

People with diagnosed type 2 diabetes should undergo regular examinations and assessments, usually every four to six months, however some may benefit from monthly visits,[5] for early detection of complications. At every review appointment, the following should be carried out:

- The person's body mass index (BMI) should be calculated to make sure patient is managing their weight appropriately
- A psychological assessment to check for depression or anxiety
- Record smoking status
- The person should be examined for neuropathy and any associated complications
- Every three to six months, the patient should have HbA1c levels measured to check for hyperglycaemia, and once a year they should be screened for retinopathy, diabetic foot problems, nephropathy and cardiovascular risk factors.

Treatment

A care plan for type 2 diabetes should be tailored to the individual and their specific circumstances. This plan should take into account their personal preferences, risks from polypharmacy and ability to benefit from interventions.[2]

Lifestyle advice and drug treatments should be offered to the person to meet treatment targets for HbA1c levels to minimise long-term vascular problems. The recommended HbA1c target for people who are managed by lifestyle and diet with or without drugs not associated with hypoglycaemia is 48mmol/mol (6.5%). For children, the recommended target is 48mmol/mol (6.5%) or lower; the child and carer should be made aware that this is the ideal level to minimise the risk of long-term complications.[3]

Metformin is the recommended initial anti-diabetes treatment for adults with type 2 diabetes, unless this is contraindicated, eg. if the person has endstage renal disease. Anti-diabetes treatment for children should be started by the multidisciplinary paediatric diabetes care team, which in type 2 diabetes is usually standard-release metformin.[3]

Lifestyle advice

The effectiveness of diabetes management ultimately depends on the person's compliance with recommended treatment. Patient education therefore plays a key role in the treatment plan for the person. It is important to stress the need to understand core principles in diabetes management. These principles include a healthy balanced diet, adequate physical activity, smoking cessation, adherence to prescribed medication, foot hygiene and the need for regular assessment.[5]

A structured education programme should be recommended to the person or carer after a diagnosis of type 2 diabetes.[2] Group education programmes are also recommended as the preferred option for this approach to structured education for patients, provided that they meet the cultural, linguistic, cognitive and literacy needs of the person and contain all the appropriate educational components.[2]

Dietary advice should be provided, ideally by a dietitian,[5] centred on the principles of healthy eating with a focus on foods that do not adversely affect blood glucose levels.[6]

Emphasis should be placed on the importance of a balanced diet including plenty of fibre, low glycaemic index foods, low-fat dairy products and oily fish, while controlling the intake of foods high in saturated fats and transfatty acids; saturated fat should be limited to < 7% of calories.[5]

It is recommended that people with type 2 diabetes take a blood glucose test before and two hours after meals. This will enable them to see which foods, and what quantities, are appropriate for them.[6] If the person is overweight, a body weight loss target of 5-10% is recommended.

Increased physical activity should be encouraged as regular exercise may lower blood glucose levels due to muscles using glucose for energy. All adults aged over 19 years of age should aim to be active daily, with three to four sessions of aerobic physical activity per week.[5]

In addition to general health benefits, regular exercise appears to have a beneficial effect on insulin action, can reduce the increased risk of cardiovascular issues in the medium and long-term, and help with weight management.[4]

Other lifestyle choices should be discussed, including the impact on the person's health from smoking and alcohol intake.

For children, additional guidance should be offered on annual immunisations and diabetes identification. Annual immunisation against influenza is recommended for all children and young people with diabetes, and pneumococcal vaccination is also recommended for those who need insulin or oral hypoglycaemic drugs.[3] Diabetes identification should also be worn in the case of emergency, for example a MedicAlert bracelet, necklace or watch (**www.medicalert.org.uk**) or a diabetes ID card (**www.diabetes.co.uk**).

Support groups are available to people with type 2 diabetes, with information on how to contact them and benefits of memberships (see **www.diabetes.ie**)

Ikwuoma Udeaja is a clinical author at Clarity Informatics, Charlotte Bowe is an information analyst 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 prodigy.clarity.co.uk

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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. Type 2 diabetes is due to:
A) Insulin resistance
B) Absolute insulin deficiency
C) Relative insulin deficiency
D) Relative insulin deficiency and resistance

2. Risk factors for type 2 diabetes include:
A) Family history of gestational diabetes
B) White ethnicity
C) Obesity
D) Poor dietary habits

3. What checks should be carried out at every review appointment?
A) BMI
B) Smoking status
C) Retinopathy screening
D) Psychological assessment

4. For an adult with type 2 diabetes the recommended HBA1c target is?
A) 48mmol/mol (7%)
B) 48mmol/mol (6.5%)
C) 53mmol/mol (7%)
D) 53mmol/mol (6.5%)

5. What lifestyle advice should be provided to the patient:
A) Smoking cessation
B) Increase in physical activity
C) Balanced diet
D) Group education

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 = D Question 2 = A,C,D Question 3 = A, B, D Question 4 = B Question 5 = A ,B, C, D

This month we welcome more than 1,500 new nursing and midwifery students who are setting out on their four-year journey to registration. In this issue's student focus, **Dean Flanagan** gives some timely advice to new students; **Megan Maher** and **Ger O'Brien** share their experiences as student volunteers; **Ann Keating** talks to final-year student Caroline Fallon about her experience as a patient; and **Ivan Ahern** helps you with planning your finances. We also have some letters from graduating students, with some tips they wish they'd given themselves back in first year

Make it count from day one

Dean Flanagan welcomes on board all of this year's new nursing and midwifery students

HI EVERYONE, my name is Dean Flanagan, the student and new graduate officer, and I am the link between student nurses/midwives, new graduates and the INMO.

I would like to welcome you into the nursing and midwifery professions, and I hope you find it as thrilling and rewarding as I did when I first became a nurse. I will be visiting all 13 colleges throughout the country in the hopes of meeting you all and taking any questions you may have.

To welcome you on board, we are handing out a welcome pack, containing this issue of *WIN – World of Irish Nursing and Midwifery*, which is the INMO's monthly journal, and some merchandise, including a notepad, a mobile phone 4-1 stand and many other student tools.

What to expect in your first year

Studying to become a nurse or midwife is not as simple as just being told what to do and then going out and doing it. The process involves time in lecture theatres and on self-directed study, alongside learning practical aspects of nursing and midwifery taught in simulation departments and on practice placements in a variety of settings.

Academic work

At university you 'read' for a degree. You will have lectures and seminars to attend but you will also be expected to complete background reading and other self-directed work. This will start off as just a small bit here and there, but if you don't keep on top of it, the workload can develop into something huge.

As an independent learner you need to get into the habit of searching for evidence to guide your clinical practice from day one of the course. This will really help you going forward.

To look after the health of others you need to start by taking care of your own health. Plan your study wisely and take up all offers of help you get. A study timetable will allow you to work hard but also give you time to do other things you enjoy.

Above student members at a recent INMO section meeting and top student members on placement at St James's Hospital

Practical skills

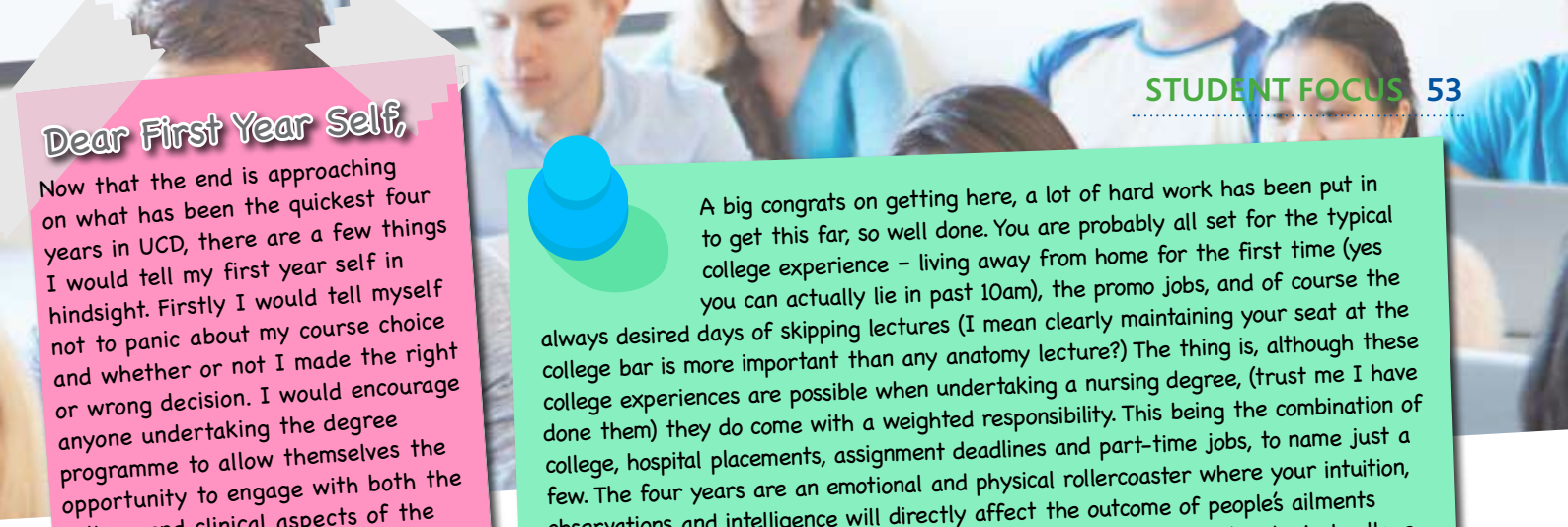
In your first year you will learn practice skills through a mix of supernumerary practice placements and simulation. Simulation is used by universities as a way of reflecting on real-life situations, and plays a crucial part in your self development as a nurse or midwife. It allows for a variety of clinical skills to be taught and practised in a realistic and safe environment before you practise these skills on actual patients.

General tips

Make a plan for studying that suits you and your lifestyle. Try to be consistent to enforce good habits, but allow flexibility so that you can adjust it if an emergency comes up. Stick with your plan and reward yourself when you do. However, remember to look after yourself also. Your college freshers' week is a great way to take up activities and mingle with people outside of your course.

Take notes. If your lecturer refers to certain aspects in a book they are highlighting these for a reason.

Compare notes. It's possible that your classmates will have information you didn't catch and vice versa.



Dear First Year Self,

Now that the end is approaching on what has been the quickest four years in UCD, there are a few things I would tell my first year self in hindsight. Firstly I would tell myself not to panic about my course choice and whether or not I made the right or wrong decision. I would encourage anyone undertaking the degree programme to allow themselves the opportunity to engage with both the college and clinical aspects of the programme for the year. Additionally, I would tell myself not to formulate a perception of nursing based on my first exposure to the clinical area. Each area you are exposed to has both positive and negative elements to it and it is important to experience more than one placement to be able to form an accurate perception of what nursing is. I would tell myself to relax and remember that this is all new and embrace it as a learning opportunity. I would encourage myself to spend as much time as possible with patients. Sometimes what the patient needs most is a listening ear and that can be the greatest help to them at a time when they can be anxious, concerned and feel vulnerable. Utilise this time to interact with patients and learn from them and their experiences. Through this you learn the most important skills, empathy and compassion. Embrace every opportunity and challenge along the way and remember 'when you're a nurse you know that every day you will touch a life or a life will touch yours.'

Stephen Woods

A big congrats on getting here, a lot of hard work has been put in to get this far, so well done. You are probably all set for the typical college experience – living away from home for the first time (yes you can actually lie in past 10am), the promo jobs, and of course the always desired days of skipping lectures (I mean clearly maintaining your seat at the college bar is more important than any anatomy lecture?) The thing is, although these college experiences are possible when undertaking a nursing degree, (trust me I have done them) they do come with a weighted responsibility. This being the combination of college, hospital placements, assignment deadlines and part-time jobs, to name just a few. The four years are an emotional and physical rollercoaster where your intuition, observations and intelligence will directly affect the outcome of people's ailments and their lives. So in effect, you are going to gain a lot more than the typical college experience. You will see life begin, you will see life end and you will see the lives of others changed forever. You will grow up much beyond your years and you will be the better for it. Talk to as many people as you can, learn from those who want to teach, and open your eyes to opportunities. Whether you want to be the next Florence Nightingale, Margaret Sanger or Nora Casey, nursing has endless opportunities, avail of them in any way you wish!

Aoife Kiernan

I'd like to say that it was easy, but it wasn't. Your lectures and clinical practice won't be enough to shape you into the nurse you need to be. The nurse your patients need is not the one who memorised everything from her textbook. Instead it is the nurse who will listen, the one who is patient and takes time to explain things doctors have said. It can be overwhelming to be everything to your patients if you don't give time to yourself. To look after others you simply have to look after yourself too :)

Abosede Allen

Stay informed. Attending class is important. You never know if a question asked by a fellow classmate or a piece of information not found in the book might be found on the next assessment or exam.

Don't be afraid to ask questions. Keep in touch with your lecturer even if on placement, and with your clinical placement co-ordinator. Visit during office hours, send an email or talk by phone – they are there to advise and support you to get the most out of your course.

Stay safe on social media. Don't discuss anything about your work or college (including placement, patients, manager, preceptor or lecturer) on Facebook or other social media sites. Your conduct online could affect your course or worse your registration as a nurse/midwife if it calls your fitness to practise into question. The INMO is running a course for members on social media on October 18 in HQ. For more information log on to www.inmoprofessional.ie or contact Linda on 01 6640641.

Be sure to join the INMO. The INMO can help you develop and learn through numerous resources, including the INMO Professional Development Centre and our web and lecture-based development tool.

The Organisation also hosts one of Ireland's largest nursing/midwifery libraries and has an e-library; visit **www.nurse2nurse.com**

Become an INMO student rep

Student reps act as a two-way link between the INMO and the nursing and midwifery students at your university. Reps make sure students get the most out of their studies while simultaneously getting the best support in their own training. As I visit each college I hope to meet a number of you who will agree to come on board as student representatives.

What's in it for me?

- Be the first to find out about local policy issues and what's happening across the entire nursing field, helping you to stand out to employers
- Be the first to know about upcoming events and training days
- Become better connected with nursing/midwifery and the INMO
- Build a network of peers, gain leadership skills and improve your CV.

What's involved?

Being visible to and supporting your fellow students throughout university and in their placements, by providing direction to them on INMO advice and services.

In the past year the INMO has achieved so much for student nurses and midwives. Internship nurses and midwives were getting less than the minimum wage at €6.86 per hour. The INMO secured the following improvements:

During the 36-week clinical placement the pay of the fourth year shall equal 70% of the staff nurse scale or €9.48 per hour and 16 weeks after graduation the newly registered nurse/midwife will move to the second point of the scale (€29,497) which represents an increase of over €2,000.

Finally the INMO successfully negotiated permanent staff nurse/midwife posts to all fourth-year students who graduate this September, and will continue to push for this every year. All of this was possible due to a strong and active Student Section this year, so please get on board and perhaps even think about coming to Student Section meetings – look out for dates on the INMO website, **www.inmo.ie**

Dean Flanagan is INMO student and new graduate officer

Ger is impressed at the warmth and friendliness of all Ugandans, no matter what the circumstances

'Africa gets in your soul'

UCC nursing student **Ger O'Brien** shares her uplifting account of volunteering for Nurture Africa in Uganda

IT WAS A hot dusty day in the Wakiso district, a busy suburb, an hour's drive from Uganda's capital city Kampala. Leaving the sunshine, my eyes struggled to adjust to the cool interior of the humble home, a one-roomed house where a 23-year-old single mum of twin boys lived. Her HIV status unknown to friends, I felt privileged to hear her story as she shared her struggle to feed her family and pay school fees. As I listened carefully through my interpreter, I thought of my nieces of the same age at home in Waterford, in awe at how different their lives were to their Ugandan counterparts.

I've always wanted to volunteer overseas. When I received an email via college from Irish NGO Nurture Africa last year to volunteer in Uganda, I knew this was my chance. As I was finishing third year of general nursing in UCC, I felt I could offer more, and at 33 years of age already had life experiences that would stand to me. Little did I know Uganda would offer me much more than I could ever offer it.

The charity I travelled with was established by Dubliner Brian Iredale following his own volunteering experience in Uganda in 1997. He was touched by the poverty experienced by locals following the country's controversial leadership by Idi Amin.

So strongly touched in fact, that he returned to Ireland and trained as a paediatric nurse in order to return to Uganda. In 2003, A-Z Children's Charity was born and in 2011, the NGO's name changed to Nurture Africa, but its services are the same: "to provide access to quality healthcare, education and sustainable livelihoods while mainstreaming child welfare and gender equality through all their activities".

Nurture Africa's medical centre is basic compared to Irish standards, but efficient. Patients attend reception and then triage, similar to Irish emergency departments. They attend a nurse-led clinic, clinician or laboratory depending on their presentation. The lab allows for instant testing for tuberculosis, HIV, malaria and sexually transmitted infections, as well as blood groups and haemoglobin (Hb) estimation. In the nurse-led clinics, the local children present with basic complaints – cough, colds, fever, vomiting and diarrhoea, with thankfully few cases of malaria. These cases are mostly as a result of lack of clean water and poor hand hygiene. These appointments allow for patient education so as to prevent these illnesses recurring.

Once a month, a free recurring vaccination clinic is available, while HIV appointments are every Tuesday, Wednesday and Thursday providing free check-ups, counselling and the administering of anti-retroviral therapy (ART). Once a month staff travel to neighbouring rural districts to offer free HIV testing. With results known in just 15 minutes, it gives community workers the opportunity to educate on HIV prevention and service provision at Nurture Africa. The centre also has an antenatal clinic where again education plays a vital role in mother and baby health and prevention of mother to child transmission of HIV (PMTCT). Every Friday, male circumcision is carried out as day cases, as research shows the procedure prevents HIV transmission by up to 60% *(WHO 2016)*.

As well as students and qualified nurses, the charity brings teaching and general skills volunteers; teachers work in local schools and share their Irish teaching methods; I was told teaching 100 kids in one room is an interesting experience!

Following my four week volunteering stint last year, I decided to return this year. I travelled for 2.5 weeks and was delighted to reunite with my Ugandan colleagues. The people of Uganda are incredibly resilient and a proud population. Their warmth and friendliness is apparent as everyone greets you as you pass by on the busy roads. Attempting to say hello in their dialect of Luganda in an Irish accent is guaranteed to return a smile and a laugh!

I'd recommend volunteering to everyone. Men and women from all over Ireland of all ages travel together and come home with a lifetime of memories. Someone once told me 'There's something about Africa that gets into your soul' which couldn't be more true – and what better country to volunteer in than the Pearl of Africa.

I'd like to thank the IMNO for its kind donation towards my fundraising this year. For more information check out **www.nurtureafrica.ie**, my Facebook page 'Ger to Uganda 2016' or my blog **www.gerinuganda.wordpress.com**

Ger O'Brien is a general nursing student in University College Cork

Dear First Year Self,

Nursing is a very stressful career, it is physically and mentally demanding. It is so important not to let placements and college overtake your self care. Take good care of yourself - be physically, mentally, emotionally and socially fit. Learn to prioritise, take timeouts and don't drop your hobbies, fit them in between college work and placements. Learn to say 'no', give yourself some 'me' time, talk to others, eat healthy and exercise! Take opportunities as they arise, join a society and stick with it. Be active in the INMO and inform yourself. Go to the Ball, don't let the years pass by! When in placements ask, ask, ask many questions and seek learning opportunities. Do your best and just do it.

Mary Escoto

Above, l-r: Athlone IT general nursing student volunteers in Uganda – Rudi Sandison, Megan Maher, Gaye Healy and Tomas Nally
(Right): Megan with children from Hope Spring Havens, a safe place for children who cannot go to school

Small steps, huge impact

Megan Maher, a general nursing student at Athlone IT, shares her humbling experience of volunteering for Nurture Africa in Uganda

ON JULY 1, after 24 hours of travelling, myself and four other general nursing students from Athlone IT stepped off the plane in Entebbe airport, Uganda, excited to begin what would surely be a difficult, but humbling, experience as volunteer student nurses.

Decision to volunteer

Volunteering abroad is something I have always wanted to do but the thoughts of going alone was daunting. As third-year general nurses, our class in Athlone IT is very close and great friendships have been formed. When one of these friends mentioned they were interested in volunteer work in Africa I gave it serious thought. We talked more about it and some more students expressed their interest also. We began looking up different charities and found that Nurture Africa offered student volunteering programmes.

Colm and Kevin, the volunteer coordinators from Nurture Africa, came to visit Athlone IT and did a presentation on the work they do in Nansana and surrounding areas in Uganda. On seeing this presentation, our minds were made up – we wanted to go and volunteer in Uganda.

Athlone IT also decided to come on board, hoping to build a volunteer programme for the next set of third-year students. We divided into two groups of five students in each and one lecturer. I was to travel in the July group. The excitement quickly set in and I began to turn my attention to fundraising.

Fundraising

My fundraising began in February with a hugely successful cake sale in my home town of Roscrea, Co Tipperary. I also received a donation from the INMO. The support I received was incredible. Some people thought I was mad, but most people showed their admiration. Once my fundraising was complete, it was time to head to Uganda.

Arriving in Uganda

On July 1, after a full day of travelling myself and the other students in my group finally arrived in Uganda. We were met by Colm, our volunteer coordinator who visited Athlone IT, and we bundled into two minivans and headed straight for Nansana. The smells and the bustling streets at 3am in the morning were a lot to take in and I was full of questions. We settled into our basic, but great, accommodation for the first day and the volunteering work was to start on the Monday.

My first impression of the town of Nansana was how different it was from what I was expecting. It was bustling, the streets were alive with markets and the traffic was crazy. Often throughout my trip I used to sit on the main street and just watch people, wondering where everybody was going. The Ugandan people are extremely friendly and so thankful to volunteers for the work they do. Even before I began working, locals were thanking me for coming to Uganda.

On that first Monday morning we headed for the health centre built by Nurture Africa, which offers free services in primary healthcare to vulnerable children, mother and child healthcare, HIV counselling, testing and free antiretroviral therapy, and male circumcision.

We offered our help to staff nurses, got to know the running of the clinic, but more importantly, we spent a lot of time with the children. The children were amazed by the 'Muzungas', a friendly term used to describe white people. They would hold my hand and touch my skin, mesmerised by freckles.

Harsh conditions

Our timetable was a mixture of days in the health clinic or in the local schools giving health talks to children of all ages. We did some first aid, sexual health, nutrition, general health and answered as many of the questions as we could.

In the schools we saw the harsh and extreme conditions students had to sit in but they were so eager to learn and their faces would light up when they saw us coming. Often just their friendliness would be overwhelming.

I took a particular shine to an organisation supported by Nurture Africa called Hope Springs Haven, which provides a safe place for children that cannot go to school for various reasons as well as vulnerable adults who attend for classes, support and a friendly chat. Our group of nurses visited twice and we did a cooking demonstration and provided general health talks to the adults. We also did library outreach with the children.

Learning experience

From my volunteering experience, one thing I learned in Uganda was that although it may seem like a small thing that you are doing for someone, the impact you can have may be huge to them.

Volunteering is a very humbling experience that I would recommend to everyone. We live in a bubble at times and it's good to see another side of the world and experience another culture. Although it can be emotional to see the harsh conditions that some people live in, it is extremely rewarding to be able to make even the slightest of differences to those less fortunate and, through this, the fun of volunteering shines through.

Megan Maher is a general nursing student in Athlone IT

Personal insight into patient experience

Student nurse Caroline Fallon had a stroke at just 20 years of age. She spoke to **Ann Keating** about her frightening experience

Caroline Fallon considers herself extremely lucky and has made a full recovery

CAROLINE Fallon is a 21-year-old student nurse from Leitrim. She is commencing her final year in general nursing in Galway Mayo Institute of Technology (GMIT) and Mayo General Hospital. She is delighted to be going into her final year at last, as she suffered a stroke on August 31, 2015 when she was just 20 years of age.

When Caroline finished third year she opted for the J1 experience with her friends which they enjoyed very much. They went to San Francisco where they worked over the summer. Although she didn't know any of the students who died in the Berkeley tragedy when the balcony collapsed, she was living in Berkeley at the time.

The flight home had been turbulent but she didn't experience any problems. A week later she got a sudden sharp pain in her head, began to get dizzy and blacked out. She came around but began to feel very unwell. She felt confused, dazed and had a total lack of co-ordination. She was drooling from the right side of her mouth and felt the left side of her body become tingly and then numb. She tried to stand up but collapsed and was unable to call for help.

Luckily Caroline's mum was in the house and realised something serious was happening. An ambulance was called and she was taken to Sligo University Hospital ED. Caroline's neighbour Ann, a nurse, reassured her while they awaited the ambulance. During her training Caroline had worked with stroke patients and was extremely worried for her future and the effects the stroke might have on her.

After it was confirmed that she was having a stroke, thrombolytic therapy was administered but the initial response to the therapy was slow and it was decided to transfer Caroline to Beaumont Hospital in Dublin by helicopter. This was an extremely frightening experience for her as being airlifted to another hospital indicated that it was serious and left Caroline feeling negative about her prognosis. All her thoughts diverted to rehabilitation and her family having to care for her.

According to Caroline, the helicopter experience was definitely one to remember. When she landed on the grounds near Beaumont, she was met by numerous people including emergency personnel.

Everyone was awaiting the arrival of the '20-year-old stroke victim'. Local school children were looking on. The whole thing really hit home to her when she saw the words 'CAROLINE FALLON – 20-YEAR-OLD – STROKE' written on a board in huge black writing. Thankfully, by the time she reached Beaumont Hospital the medication had worked, her clot had dissolved and she had regained most of her power. Caroline said she "will never forget the sense of relief at that moment. It was definitely the happiest moment of my life."

She was placed in the stroke unit for a week where numerous tests were carried out to determine the cause and it was discovered that she had a small hole in her heart. She was discharged from Beaumont and referred to cardiology in the Mater Private where she had the hole sealed.

Caroline never knew about the hole in her heart; she considered herself fit and healthy. She got a clot on the flight home from the US, which travelled to her brain via the hole in her heart, causing an ischaemic stroke. It was a difficult time and she had to build her strength back up. She underwent a heart procedure, and she gets migraines, suffers from occasional anxiety and panic attacks and is on aspirin for life. However, she is so grateful that she is physically back to normal. She now considers herself extremely lucky in that being young and healthy made for a quicker recovery. It was all caught and dealt with swiftly and she has made a full recovery. She will be forever grateful to all the medical personnel, her family and friends.

Caroline is part of a musical family and loves to play the flute and fiddle. Following her illness, Caroline had to take a break from traditional Irish music and she is delighted to be back playing in sessions.

Caroline was due to commence her final year in Nursing in GMIT a week after the stroke occurred. She deferred for a year to allow herself to completely recover and is thankful for the support of everyone in GMIT and Mayo University Hospital during that time.

She feels that she has learned a lot from the experience that she can carry with her into her internship and the working world and has gained personal insight into the patient's experience. Asked if she would consider specialising in the area of strokes, she said she would definitely consider it. For now, she is delighted to be back in college and can't wait to be a staff nurse.

Tips to ensure a secure future

A little clever planning can help you build a secure financial future, writes **Ivan Ahern**

DO YOU ever get post-shopping guilt or that gut wrenching feeling that you spent too much after a night out at the latest social spot? If you answered yes, you are not on your own.

In a recent study, 78% of Irish Public Sector employees under age 35 said they need to organise their finances, with only 36% saying they had a long-term plan.*

Life is for living. So have fun, explore the world and enjoy the finer things. But what about your future? You can plan ahead without compromising your current lifestyle. Sounds too good to be true? All you need is a proper plan. If you're a student or a young nurse or midwife, the chances are you have probably already started to think about paying off debt or starting to save for something – like a big trip, a new car or a house. But you only have so much disposable income and you may be wondering where to start? It's easier than you think.

Fran has a plan

Let's take Fran as an example. When she started working in 2012 as a nurse, the first thing she did was put together a plan. Fran's plan is set out in *Table 1*. Fran always wanted to see the world so she worked that into her plan setting aside €100 per month for her dream trip. She also allowed herself a 'treat' fund of €520 per month to socialise and treat herself. Then she looked at starting a pension. When she realised that she would have to rely heavily on the State Pension, which only pays €226 per week from age 68, she decided to put aside €50 a month towards a better future and the possibility of retiring at a younger age. I know it's difficult to think about retirement when you're young but the sooner you start saving, the less you'll have to sacrifice in the future, and working will become an 'option' rather than a 'necessity'.

Top three tips

You own your future so:

- Create your plan
- Look closer at your daily expenses
- Think long-term.

Table 1: Fran's plan

Monthly disposable income	**€1,933**
Monthly expenses	**€1,930**
– Rent, including household bills	€700
– Car costs	€160
– Groceries	€400
– Treat fund / socialising	€520
– Long-term savings (pension)	€50
– Dream trip savings	€100

As the saying goes, time flies when you're having fun. But when time catches up with you, wouldn't it be nice to be able to keep enjoying life? The sooner you create your plan, the wealthier you will be. It's that simple.

Top tips for students

In the meantime, if you are a student, here are our top tips for making the most of your college years with less money stress:

- *Plan your spending* – now is the time to build good habits. Know how much money you need to carry with you before you leave the house and only bring that amount of cash with you to avoid impulse buying
- *Pay with cash, not card* – the easiest way to save money is to only spend what you have, which means avoiding credit cards and high interest rates
- *Meal prep* – it's the new buzz-word in the fitness world. Aside from the health benefits of planning your meals in advance, it will save you a lot of money too. And it doesn't mean slaving over the stove for hours. Instead of cooking something different every day, consider making three different big batch meals, freeze them and alternate to avoid boredom
- *Use your student card* – keep your student card and other reward cards in your wallet and clock up the points. With a student Leap card you can get 10% off in a wide range of retailers (**www.studentleapcard.ie**). Make a habit of asking if they take a student card at every till and use it where you can. The savings will quickly add up. Boots Reward card is also especially great value
- *Save money on energy bills* – take shorter showers; switch to energy-efficient bulbs; turn off all lights/devices when you leave a room; don't leave devices on stand-by or charging when battery is full.
- *Shopping list* – always write a list before you go shopping and follow it
- *Sell what you don't want* – college is a great time to de-clutter and sell any unwanted clothes, unused electronics, etc. Gather up all your unwanted items and sell anything that's still in pretty good condition. Visit **Adverts.ie** for unwanted goods and **Depop.com**, the new trendy site for buying and selling second-hand clothes.

Ivan Ahern is a director of Cornmarket Group Financial Services Ltd.

For a free Financial Planning appointment when you graduate, phone Cornmarket on 01 470 8081

For more great tips visit www.cornmarket.ie/blog

** Source: Amarach Research survey conducted on 250 Public Sector employees under age 35, 13/02/16. This information is intended only as a general guide and has no legal standing. Please be advised that Cornmarket cannot be held responsible for the content contained on the websites listed in this article. Cornmarket Group Financial Services Ltd. is regulated by the Central Bank of Ireland. Cornmarket is part of the Great-West Lifeco group of companies, one of the world's leading life assurance organisations*

Normalising birthing

Paula Barry sets out some examples of how midwives promote normality by creating a 'safe space' for women to birth their babies

MIDWIVES are the experts in normality.[1,2] The publication of the *National Maternity Strategy*[3] promotes the role of the midwife by supporting the normalisation of pregnancy and birth. It also recognises the importance of the birth environment and the benefits of a positive birthing experience for women. Midwives have an important role in promoting and facilitating physiological birth.

The *National Maternity Strategy*[3] does much to strengthen the role of the midwife. It maps out how improvements can be made, ensuring that maternity care is safe and of a high quality. The overarching theme is based on the principle that childbirth is a natural, physiological process. It acknowledges that because women are unique, their needs will vary, some requiring more specialised care, but ultimately "insofar as possible all pathways should support the normalisation of pregnancy and birth".[4]

The strategy strongly recognises the importance of the birth environment. Evidence shows that the birth environment affects birth outcomes and the woman's experience.[5,6,7,8,9] Environment is an encompassing term, which not only includes the physical nature of the birthing space, but also the emotional and psychological space –the 'inner emotions' of labouring women, which are created between the midwife and the woman.

In the birth environment, layout of the physical space can increase movement and maximise positioning during labour and birth, ultimately improving the potential for normal birth.[7,10] Simple reorganisation of the labour room can help, such as dimming the lights, moving the bed, or raising the level of the bed to allow a woman to stand or use it as a head support should she wish to sit on a birthing ball. Having a policy of closing labour room doors, avoiding unnecessary interruptions and minimising the number of people present creates a sense of privacy and security.

According to Odent[5,6] this is essential for women to labour effectively. Women who feel afraid or anxious produce stress hormones such as adrenaline and cortisol that inhibit the release of oxytocin and prolactin, adversely affecting labour.[5,6] Anderson[8] supports this stating that the midwife must create an atmosphere of safety allowing a birthing woman to "disconnect mind from body". In essence, safety extends far beyond the physical reality of drugs, machines and technology; it is about privacy, security, a sense of belonging and being cared for by compassionate people who believe in physiological birth.[7]

Key points

- Midwives are the experts in normality
- The Department of Health supports the concept of 'normality' and acknowledges the role of the midwife
- The midwife's role is to facilitate a 'safe space' to optimise physiological birth
  - Physical space – move the bed, dim the lights, close the door
  - Psychological space – reduce noise level, minimal interruptions and people

Be passionate and aim high

At the Coombe Women and Infants University Hospital (CWIUH), physiological birth is supported by encouraging mobility and advising women to adopt upright positions during labour and birth. Aides such as birthing balls and stools, bean bags, floor mats and ceiling slings are available. Women with risk factors who require continuous foetal monitoring (CTG) are offered telemetry CTG, and similarly women requiring intravenous fluids/medication are facilitated to use a birthing ball/bean bag.

CWIUH midwives aim to introduce a sense of normality for all women, even those with risk factors and/or specialised needs. The use of hydrotherapy is facilitated in the form of showers and a birthing pool. The CWIUH is one of four units in the Republic of Ireland with a birthing pool, and also facilitates water birth. Since 2013, more than 270 women have used the pool for pain relief, and 80 women have opted to have a water birth. Since January 2016, the service is being provided under the remit of a Water Immersion Study, which aims to compare water to land for labour and birth for healthy women with uncomplicated pregnancy. Although similar studies have been conducted internationally[11,12,13] and much has been written about the potential benefits and risks of water birth,[14,15,16,17,18,19] it is the first of its type in Ireland.

Those who choose to use hypnobirthing are supported and women are encouraged to bring their choice of music or they can listen to music available in the room. In order to support natural oxytocin[5,6] production, doors are closed and lights are dimmed. Noise and unnecessary interruptions are kept to a minimum. Women's choices are respected, and some write a birth preference list. This is drawn up in the antenatal period between the woman and her midwife/doctor. Some women opt to have two support people present during labour. The first is usually their partner and the second a doula (or birth companion), who can be either a professional employed by the woman, or someone who the woman feels will be a support through the labour and birth such as her mother/sister/friend.

It is evident from the publication of the *National Maternity Strategy*, that the Department of Health acknowledges that improvements need to be made on the provision of maternity care in Ireland. The strategy recognises the valuable role the midwife has in bringing about these changes. Challenges exist in the service, but midwives need to be passionate in their pursuit of high quality services that meet the needs of the women, babies and families in their care.

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References available on request (Quote: WIN 2016; 24(7): 63)

Core values reaffirmed

A position paper from the Chief Nurse's Office reaffirms compassion, care and commitment as the core values that underpin nursing and midwifery practice in Ireland

At the Values conference held in Farmleigh, Dublin recently were (l-r): Mary Wynne, director, Office of the Nursing and Midwifery Services Director, HSE; Dr Siobhan O'Halloran, chief nursing officer, Department of Health; Essene Cassidy, president of the NMBI; Simon Harris, Minister for Health; and Dr Anne-Marie Ryan, Dr Philippa Ryan Withero, and Susan Kent, deputy chief nursing officers at the Department of Health

THE first position paper of the Chief Nurse's Office at the Department of Health, *Reaffirming Nursing and Midwifery Values in Ireland,* was launched by Health Minister Simon Harris in June. This was prepared in partnership with the HSE Office of the Nursing and Midwifery Services Director (ONMSD) and the President of the Nursing and Midwifery Board of Ireland (NMBI).

Values are the ingrained principles that guide the actions of nurses and midwives. Both personal and professional values guide how professionals practise and our behaviours are determined by our values. Identifying the behaviours associated with these values creates the expectation that nurses and midwives make choices on care options based on these values.

The position paper supports other initiatives of individual healthcare providers to contribute to the development of a culture of safe patient care. The National Leadership and Innovation Centre for Nursing and Midwifery in the ONMSD is leading out on the 'Florence Nightingale Programme' across the health system and the values project complements this work. Compassionate and competent nursing care of the sick and injured has a long and valued tradition in Ireland. However, reports such as those on Leas Cross and Portlaoise Hospital have challenged this concept of professional nursing and midwifery practice. Nurse/midwife leaders have collectively embraced the need for an initiative to address these breaches of trust and create a culture for practice management, regulation and education that reaffirms and commits to a set of core values that are the cornerstone of nursing and midwifery practice in Ireland.

The development of this position paper demonstrates the common and shared understanding by the Department of Health in partnership with the main employer (the HSE) and the regulator of nursing and midwifery (the NMBI).

Development of the position paper

A national consultation process asked nurses and midwives to identify a set of core values that underpin practice in Ireland. Following extensive consultation the professions identified *compassion, care* and *commitment* as their core values. These values and their associated behaviours are the very essence of nursing and midwifery practice and form the basis for professional decision making and actions.

Compassion means showing empathy and respect for the person. The nurse/midwife upholds the person's trust by providing care that is based on integrity, genuineness, kindness, comfort and presence. Behaviours identified to demonstrate compassion in practice include: showing kindness and patience; being non judgemental; developing trusting relationships; promoting dignity and comfort.

Care means having the required knowledge, skill and competence to connect with a person by listening to and communicating with the person, demonstrating safe, evidence-based and collaborative practice. Behaviours identified to demonstrate care in practice include: listening attentively; ensuring an evidence-based approach to care; assessing carefully and making precise clinical decisions; advocating for the person; providing quality and safe care.

Commitment means having a person-centred approach to professional practice. Commitment is demonstrated by a work ethic that is underpinned by a passion and drive for professionalism to develop self and support teams with diligence and resilience. Behaviours that demonstrate commitment include: being professional; working within one's scope of practice; displaying professional courage; developing nurse-patient relationship; and engaging in evidence-based practice.

Reaffirming the core values

A symbol was created to denote the values. This is the Celtic symbol of the trinity knot, which represents the infinity and eternity of compassion, care and commitment as the core values. This symbol contains no beginning or end but the intertwined connection and dependence of the values on each other. Embraced within the trinity knot is a heart that denotes health and care.

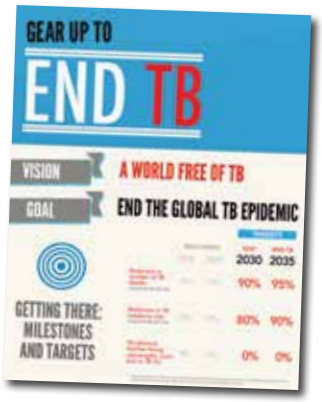
Embedding the values in practice

Each of the partners to the initiative has committed to supporting the values in practice. The strategies and mechanisms for embedding these values throughout the health system are shared across the policy, education, practice, management, employment and regulatory areas. These include: creating a culture for learning and developing the values in practice; developing managerial systems that support a culture where the values are fostered and create environments where they can flourish; and supporting people in the system to demonstrate the values in their practice.

People expect to receive nursing and midwifery care from compassionate, caring and committed professionals who demonstrate the behaviours that convey compassion, care and commitment. Nurses and midwives need to constantly review and assess that they are doing the right thing for their patients at all times, and to reconnect and balance these values as their unique contribution to safe quality patient care.

Key role of nurses in TB control

Carrie Tudor discusses the *End TB Strategy*, a 20-year global strategy by the WHO to combat tuberculosis



SINCE 1990, the global tuberculosis (TB) mortality rate has declined by nearly 50% and the World Health Organization (WHO) estimates that 43 million lives have been saved due to improved TB case detection and treatment over the past 14 years.[1]

While these are positive developments, there are still 9.6 million new cases of TB each year and 1 million of these cases are in people also living with HIV. Moreover, nearly 500,000 patients with TB will be diagnosed with multidrug-resistant TB (MDR-TB) each year, which is more difficult and expensive to diagnose and treat.

While TB mortality has decreased over the past 24 years, more than 1.5 million patients continue to die from TB each year. TB is the second leading cause of death due to a communicable disease worldwide and in some areas is the leading cause of death – even greater than HIV.[1]

Although TB can affect anyone, it remains a disease of poverty and more than 80% of TB cases are in 22 high-burden countries. All of these factors combined place a tremendous stress on already overburdened health systems.

Role of nurses in TB care

Globally, nurses make up the largest cadre of healthcare providers and provide the majority of care to patients with TB. In some parts of the world a patient with TB will never see a doctor – all care is provided by a nurse from diagnosis to treatment completion. Nurses play a crucial role in improving case detection, getting patients on appropriate treatment, providing patient-centred ongoing care and support, and improving treatment outcomes.

End TB

The WHO has just launched a 20-year global strategy to fight TB called the *End TB Strategy (2016-2035)*. This new strategy builds on the progress made in recent years and consists of three main pillars:

- Integrated, patient-centred care and prevention
- Bold policies and supportive systems
- Intensified research and innovation.[2]

Nurses are uniquely qualified to take the lead in the implementation of integrated, patient-centred care and prevention as laid out in the new WHO strategy. Nurses are trained to provide holistic care to patients by assessing not only the patient's illness and comorbidities, but also their family, environment, psychosocial needs, nutrition, etc. and plan the care for the patient taking all of these issues into account.

In most cases, nurses are the first healthcare providers to see and assess a patient to identify potential signs and symptoms of TB, to collect sputum to test for TB, and to counsel and educate the patient about the disease. They also build a trusting relationship with the patient and family members, and screen family and contacts for TB. Nurses will provide ongoing support for patients throughout their treatment and this includes assessing, treating and managing any comorbidities or side-effects.

While the second pillar of the *End TB Strategy* focuses more on a higher policy level to ensure there is political commitment to fight TB, there is still an important role for nurses to play. Nurses can have a significant impact on advocacy and lobbying for political support for TB patients and programmes at a local, regional, national and international level.

The third pillar of the *End TB Strategy* is important for nurses as it focuses on research. While this pillar has a strong focus on basic science, there is also an emphasis on the need for operational research to design, implement and scale up innovations in TB care.[3]

The *End TB Strategy* has numerous targets to reach by 2035, a few of these are to reduce TB mortality by 95% and to reduce TB incidence by 90% compared with 2015 figures. Another important target is for no patient or family affected by TB to suffer catastrophic costs due to it.[3]

Training for transformation

The International Council of Nurses (ICN)-Lilly TB/MDR-TB project is working to strengthen the global nursing capacity in the prevention, detection, care and treatment of TB and M/XDR-TB through a 'training for transformation' (TFT) initiative. The initiative trains experienced nurses working mainly in the TB and HIV fields, who then cascade information to their colleagues in local healthcare facilities as well as in the communities they serve.

The TFT courses are run in countries with a high burden of TB and MDR-TB where the ICN has a strong working relationship with the national nurses association. Using this approach, the ICN has prepared more than 2,000 nurses in 14 high-burden countries. These nurses have in turn rolled out the training to over 125,000 nurses, allied health workers, patients and community members and the general public.

Not only do the nurses trained through the TFT courses train other nurses, healthcare professionals and members of their communities, they also change their practice and improve the care and services provided to patients through a patient-centred approach, as well as improve infection prevention and control in their workplaces to protect healthcare workers, patients and visitors.

The ICN training provides much needed knowledge on all aspects of TB/MDR-TB but just as importantly, it empowers and gives the nurses the confidence to improve their practice, to negotiate with superiors and colleagues to make improvements such as changing infection control practices through the procurement of N95 respirators for staff or the construction of sputum booths.

TB control

Nurses have a very important role to play in the next 20 years of TB control according to the WHO *End TB strategy*. Nurses are at the forefront of patient-centered care and we can have a great impact on global TB control by providing and advocating for patient-centred care in all healthcare settings.

The ICN TB project is supported by a United Way Worldwide grant made possible by the Lilly Foundation on behalf of the Lilly MDR-TB Partnership.

Carrie Tudor, PhD, MPH, RN, TB project director, International Council of Nurses

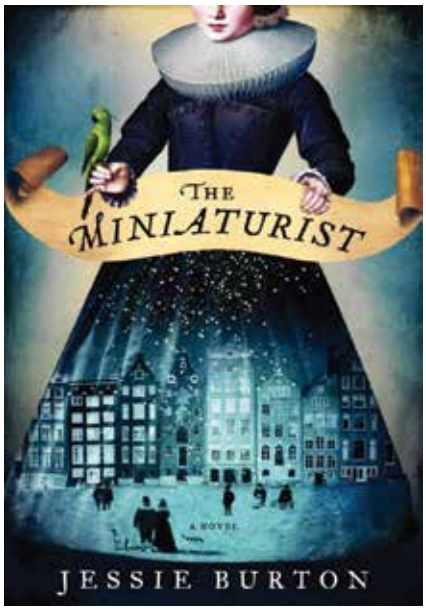
References available on request (Quote: Carrie T. WIN 2016; 24(7): 67)

A portrait in miniature

IN HER debut novel, Jessie Burton transports us to 17th century Amsterdam, to the world of newly-married Petronella (Nella) Brandt, as she navigates her marriage and the bureaucracy of a city steeped in wealth and ruled by religion, all the while being constantly surveilled by the elusive miniaturist who seems to hold Nella's fate in her hands.

Arriving from the small town of Assendelft, 18-year-old Nella is eager to begin her life as the wife of wealthy merchant, Johannes Brandt. This excitement quickly fades when she realises that her new husband, who barely acknowledges her presence, does not share the same hopes for their marriage as Nella had envisioned. To make matters worse, Nella's new sister-in-law, the pious Marin Brandt, runs the Brandt household under a very tight rein and Nella, despite being the mistress of the house, has very little say.

As a wedding gift, Johannes buys Nella a cabinet-sized exact replica of their house, which she can furnish any way she wants. To do this, Nella employs the services of a miniaturist, writing to her to request specific items. However, with these items also come



unwanted items, which bear an uncanny resemblance to what's going on in her own life, and Nella must figure out if the miniaturist is warning her of things to come or if she is in control of Nella's fate.

Meanwhile, as the story of the miniaturist and her pieces unfolds, many other major character developments occur simultaneously, reflected through the pieces the miniaturist sends. As the secrets of the Brandt household begin to unfurl, Nella discovers that her husband and his sister have brought her here as a guise; a desperate attempt to cover their illicit secrets.

Throughout *The Miniaturist*, many of the characters are the subject of shocking plot twists, where readers find themselves asking whether certain things actually happened. While these twists certainly surprise, they seem almost randomly inserted, because the story doesn't have any other direction in which to go. The plot also deals with a lot of modern day issues, from racism and homophobia to gender equality, and it is interesting to read about issues that were a significant part of 17th century society and still echo through to today.

The Miniaturist, while an enjoyable read, did not live up to expectations. It was the intriguing character of the miniaturist that kept me reading in anticipation of a dramatic climax, which unfortunately is never reached.

Sinéad Makk

The Miniaturist by Jessie Burton, published by Picador (Main Market Ed) RRP €11.70, ISBN 9781447250937

Crossword Competition

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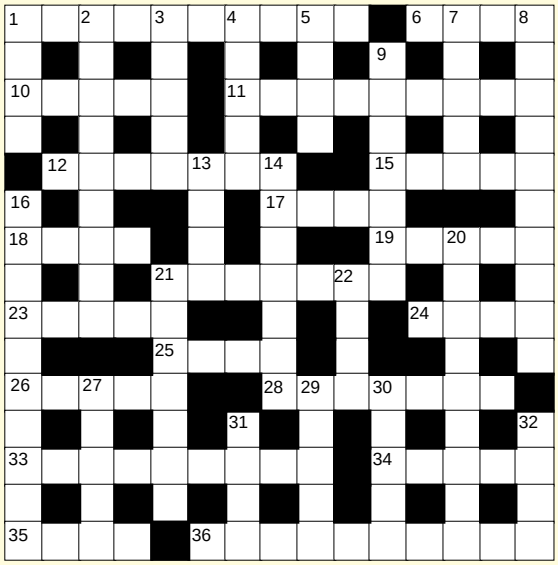

Across

1. Office communication (10)
6. Aria (4)
10. Mislays (5)
11. Such a bruise may be given to nuncios (9)
12. Picture taken while the drinking vessel is at high temperature, it seems (3,4)
15. Cruise ship (5)
17. Woodwind instrument (4)
18. Traditional board game (4)
19. Jewellery for the fingers (5)
21. This shop sells material per yard ordered (7)
23. Move sideways (5)
24. Legal document (4)
25. Ceremonial procedure (4)
26. Tenet, fundamental item of belief (5)
28. Protracted dry spell (7)
33. Chalice sought by the knights of the Round Table (4,5)
34. Inn (5)
35. Shells out (4)
36. Crustacean found on the web? (6,4)

Down

1. Traditionally stubborn beast of burden (4)
2. Being misled, somehow I died smug (9)
3. Popular flowers (5)
4. Mexican snack consisting of some Carolina chocolate (5)
5. Funereal vases (4)
7. Chopping this may bring tears (5)
8. Willingness to share or give away (10)
9. Knives, forks and spoons (7)
13. German equivalent of the English 'Mr' (4)
14. Overbalanced (7)
16. Company that will employ only union members (6,4)
20. Liam Neeson, for example, would make a heavenly guide! (5,4)
21. Madden by exploding a grenade (7)
22. City in Nevada that describes itself as "the biggest little city in the world" (4)
27. Ravine (5)
29. Angered by disturbing an idler (5)
30. Cinema attendant (5)
31. Stinging insect (4)
32. Unwanted weight (4)

Name: .....
Address: .....
.....
.....

The prize will go to the first all correct entry opened.
Closing date: Monday, September 19
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Solutions to July/August crossword:

Across:
1. Columbanus 6. Stow
10. Laser treatment 12. Anglers
15. Timer 17. Peru 18. Argo
19. Reach 21. Cyanide 23 Hitch
24. Brie 25. Aloe vera 26. Ricer
28. Lobster 33. Waistcoat
34. Obese 35. Sobs 36. Terracotta

Down
1. Colt 2. Last night 3. Mural
4. Attar 5. Used 7. Therm
8. Water wheel 9. Stature
13. Edgy 14. Spaniel
16. Hash browns 20. Agreement
21. Charity 22. Drab 27. Climb
29. Outer 30. Stoic 31. Hole

The winner of the July/August crossword is: Susanne Foxton, Arklow, Co Wicklow

Call for volunteers for VSO Ireland

VSO Ireland, a development organisation that works through volunteers in 24 countries across Africa, Asia and the Pacific, is calling for nurses and midwives to volunteer to share their skills overseas to help in the fight against poverty.

VSO's projects and volunteers help healthcare workers, communities and governments to improve access to quality health services. There is a particular focus on maternal and neonatal health as each year, 2.6 million babies die within the first 28 days of life. Health volunteers for VSO Ireland work at community, district and national level, training local counterparts, improving processes and influencing policies surrounding health.

Siobhán Neville, a paediatrician from Dublin, who has volunteered for VSO said: "My placement has enabled me to share my skills to improve the lives of women and children in Tanzania and the experience has also made me a better clinician. Without the same amenities as you have at home, you have to be flexible and think outside the box to get the job done, which future employers also view favourably.

Pictured above paediatrician Siobhán Neville who volunteered for VSO Ireland. Siobhán's placement enabled her to share her skills and to improve the lives of women and children in Tanzania

"But the impact volunteering has goes beyond the programme and community's inhabitants – it also affects your own development. You don't just add successes to your CV, you experience a level of personal growth that is not possible at home."

Last year, VSO worked with 127 partners to train 31,000 local health practitioners and helped almost one million people receive adequate healthcare services.

Nurses and midwives who are interested in volunteering for VSO Ireland can visit **www.vso.ie** for further information or email: annette.osullivan@vso.ie

Breastfeeding benefits

WORLD Breastfeeding Week, which took place last month, aimed to highlight the many advantages of breastfeeding for babies and their mothers. This year's events also aimed to raise awareness on the links between breastfeeding and sustainable development goals. In recent years, Ireland has seen a rise in the number of women breastfeeding, with an increase of 9.2% in the proportion of women recording any breastfeeding over the decade. Benefits of breastfeeding for babies, include less risk of stomach upsets, coughs and colds, diabetes, asthma etc; better mental development and better mouth formation and straighter teeth. There is also less risk of breast and ovarian cancer for women who breastfeed.

Intercultural fest

BLUEFIRE STREET FEST, a family-friendly intercultural festival with world music, street performers, arts workshops and a children's area, takes place on September 17, 2-8pm at Smithfield Sq, Dublin. Further information: **www.bluefiredublin.ie**

Retired nurse honoured by INMO president

MARGARET Burke, a nurse of 42 years, was honoured on her retirement by INMO president, Martina Harkin-Kelly during a special function in Sligo on June 23.

Ms Burke worked as a nurse and educationalist for 42 years and is a longstanding member of the INMO. She has worked at local level as a member and branch officer, and at national level as a serving member of the Executive Council and Nurse Education Section.

Ms Harkin-Kelly presented Ms Burke with a token of appreciation on behalf of the INMO, which was carved from the ash tree and symbolised Ms Burke's roots in the field of nursing, with the ash representing and replicating the qualities of sacrifice, sensitivity and higher awareness inherent in Ms Burke.

Ms Harkin-Kelly said: "Margaret is the embodiment of all that the union espouses – loyalty, commitment and justice.

"The INMO acknowledges Margaret's membership for many years. She has always given tirelessly of her time at local and national level."

Pictured at the event to honour retired nurse Margaret Burke were (l-r): Mary Leahy, INMO first vice-president; Margaret Burke, retired nurse; and Martina Harkin-Kelly, INMO president

September

Wednesday 7
RNID Section meeting. 11am. INMO HQ. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Saturday 10
Midwives Section meeting. 2pm. Limerick Regional Maternity Hospital. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Saturday 10
CNM/CMM Section meeting. INMO HQ. 11am. Contact jean.carroll@inmo.ie for Tel: 01 6640648 for further details

Tuesday 20
Emergency Department Nurses' Section meeting. INMO HQ. 11.30am. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Thursday 22
Retired Nurses/Midwives Section meeting. INMO HQ. 11am. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Thursday 22
Commencement date of UCD programme "Enhancing Clinical Practice". Contact Tel: 01 716 6448 or email: lucia.suchorova@ucd.ie to register

Saturday 24
School Nurses Section meeting. INMO HQ. 10am. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Wednesday 28
Telephone Triage Section annual conference. Castletroy Park Hotel, Limerick. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

October

Wednesday 5
CPC Section meeting. INMO HQ at 10.30am. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Saturday 8
PHN Section meeting. INMO HQ at 11am. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Saturday 8
ODN Section meeting. 11.30am. Midland Regional Hospital, Portlaoise. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Thursday 13
All Ireland Annual Midwifery conference. Crowne Plaza Hotel, Dublin. Contact linda.doyle@inmo.ie or Tel: 01 6640641 for further details

Saturday 15
Third Level Student Health Nurses Section meeting. INMO HQ. 10am – 3.30pm. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

November

Thursday 3
ADON Section meeting. INMO HQ. 11am. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Friday 4
Nurse Midwife Education Section meeting. INMO HQ. 11.30am. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Wednesday 9
Research Nurses Section meeting. Venue to be confirmed. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Tuesday 15
National Childrens' Nurses Section meeting. INMO HQ. 11am. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Tuesday 22
RNID Section Conference. Crowne Plaza Hotel Santry, Dublin. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Reunions

- Reunion of past Meath Hospital Nurses at DoubleTree by Hilton Hotel, (Burlington),Dublin at 5pm on **Saturday, October 1, 2016**; €50 per person. Contact Mary Kelly, Tel: 01 4142805
- Late 1970s St James's student nurse reunion, Parnell Suite, Red Cow Moran Hotel, **Saturday, October 1, 2016,** 12.30pm. Contact Bernadette Campion, Tel: 087 6847066; E mail: bficampion@gmail.com or Maura Doyle, Tel: 087 2645423; Email: mauradoyle22@gmail.com
- Class reunion for nurses who trained at the Limerick University Hospital from February 1976 to May 1979, **Saturday, October 15, 2016**, Bunratty Castle Hotel. Overnight stay with dinner. Contact Eilish Fitzgerald (née O'Doherty), Tel: 086 8423301; Email: ellenfitzgerald@hotmail.com

INMO Membership Fees 2016

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

Condolences

- The INMO offers its sincere condolences to Dave Hughes, deputy general secretary, and Freda Hughes, assistant media relations officer, on the recent death of their mother/grandmother Maureen Hughes. RIP
- The Cork HSE Branch would like to extend its deepest sympathy to Mary Forde, former first vice-president, on the recent passing of her mother Mary Forde. May she rest in peace
- Sincere sympathy, from all her INMO colleagues, to Rosemary O'Sullivan on the recent death of her mother, Rose Irwin.
- The INMO Athlone Branch would like to extend their deepest sympathies to Mary O'Brien on the death of her father.
- The INMO offers its sincere condolences to Ena O'Mahony, treasurer of the Irish Senior Citizens Parliament on the sudden death of her husband, Barry. RIP

Congratulations

- Congratulations to Leona Donovan on the recent birth of her baby boy Dara Leo Donovan

Conferences and training programmes

- A special one-day conference on maternal morbidities will take place on Tuesday, November 8, 2016. The conference theme is 'Minding Mothers with Morbidities'. For more information see **www.trinityhirc.com**
- One-day ear irrigation training programmes with Category 1 NMBI approval and four CEUs will be held on September 22 and November 17, 2016 in the Education and Conference Centre, Royal Victoria Eye and Ear Hospital, Adelaide Road, Dublin 2. For further details contact Sabrina Kelly, nurse tutor at Tel: 01 6644652 or email: sabrina.kelly@rveeh.ie
- The 9th Annual Diabetes in Primary Care Conference will be held in Oriel House Hotel, Ballincollig, Cork on September 21, 2016. This conference is a collaboration between DiGP, the HSE, UCC and the IPNA and booking is open to the multidisciplinary diabetes care team and is free to attend. This year's conference theme is 'prevent, detect, intervene: Focus on prevention and early intervention'