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WIN

World of Irish Nursing & Midwifery

INMO
Journal of the Irish Nurses and Midwives Organisation

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Safe care in a safe workplace

THE public rightly expects that our health service should be consistently improving and adapting to our country's changing needs. But in recent months the HSE's 'recruitment pause' has only further disillusioned health workers and destabilised the health service. HSE management and the government have not learned the lessons from mistakes of the past. It is incomprehensible that patient and staff safety is once again secondary to financial plans.

Employers claim that the frontline is protected from this recruitment pause, but this is clearly not the case. Senior managers don't even bother to look under the bonnet of our health service, where they would see missed care, constant delays and staff exasperation.

This issue was one of the key points INMO members wanted to highlight when we went on strike earlier this year. We needed the government and management to accept that pay and conditions matter when you are trying to recruit and retain staff. Our arguments were validated by the Labour Court and members accepted its proposal. These proposals are now being implemented, but the underlying issues persist.

The health service's workforce plan is quicksand. Determined by budgets, it does not reflect the care that is needed or the skills and qualifications of those who do the work. Budgets introduced by the Department of Health and the HSE in last December's service plan were not adequate to begin with: who can then be surprised if there are overruns?

It seems that whatever the impact on patients or staff, the gloomy message from central government is the same: staff must do more with less and patients have to wait longer. The facade that the recruitment pause is not hurting the front-line services must be shattered.

Over recent months the INMO has worked with directors of nursing and midwifery to highlight two main concerns: staff vacancies and the resulting missed care and unsafe working conditions.

Firstly, the failure to fill the growing list of vacancies incurs significant unnecessary costs for the HSE. In practice, the service struggles to informally fill the roles using more expensive methods, such as agency staff and overtime. The HSE's refusal to look at this dysfunctional process is now a source of cost itself.

Secondly, the vacancies inevitably lead to missed care and dangerously unsafe working conditions. The commonsense conclusion is that there must be a sharp curtailment of services, unless the HSE and government prioritise and expedite recruitment of nursing and midwifery staff.

Commitments to provide safe levels of staffing must be honoured by this government and cannot be secondary to financial budgets outside of our control. Any budget savings that are determined must not pose a risk to patient care and the wellbeing of staff. This lesson should have been learned by now.

Nurses and midwives are not obliged to work overtime or to provide unpaid additional hours. This is only papering over the real gaps in the workforce, ensuring that workforce plans are insulated from these annual predictable budget overruns. We do not accept this system of poor management that compromises the wellbeing – and in some cases the registrations – of our members.

We will use the industrial relations procedures to address these issues: we have recently referred the recruitment pause to the Workplace Relations Commission, to argue these points.

All staff – not just nurses and midwives – must take a stand to defend their rights to work in a safe environment and to provide safe care to patients. The alternative is to allow patient care to be compromised due to financial mismanagement, which is simply not acceptable to us as professionals.

Phil Ní Sheaghdha
General Secretary, INMO

Your priorities with the president

Martina Harkin-Kelly, INMO president

Recruitment pause is morally and ethically wrong

AS SUMMER draws to a close, I know many members' families will have recently received Leaving Cert results. The results are important but in the scheme of things it's the mental health and wellbeing of the young person that is critical.

We also know that many of the results will see a new class of nurses and midwives train to join our professions. There are over 40 courses offered across 13 institutions, with over 1,500 students joining this September.

We all know what rewarding and vital roles we have, both in the health service and wider society, but we are also aware of the challenges we face. The HSE's ill-conceived 'recruitment pause' poses real dangers to patients and our members alike.

Time and time again, scant disregard has been shown towards the 2017 funded workforce plan, brokered with the employers by the INMO in collaboration with SIPTU. The strategic workforce plan contains commitments to provide safe levels of nursing and midwifery staffing. The INMO is clear this cannot be sacrificed in the interest of financial constraints – this is morally and ethically wrong.

Even in the short run, such recruitment pauses are a false economy, compromising care and often racking up even larger bills for agency staff to fill vacant positions. The policy is unacceptable and your union will continue to oppose it.

INMO Nursing Now Developments

THE Nursing Now Ireland national committee held a meeting on Wednesday, August 28 to oversee our country's contribution to the international nursing campaign. The main purpose of the meeting was to review the website and to agree a schedule of events for the coming year. These events aim to promote the voice and visibility of nursing in Ireland. All events will be promoted on the Nursing Now and INMO websites, so stay tuned.

Centenary celebrations continue

WE HAVE now entered phase three of the centenary celebration schedule. A tapestry designed by artist Robert Ballagh is being worked on every Tuesday morning in HQ, by the Irish Patchwork Society. Any member wishing to contribute to the tapestry is encouraged to get in touch and pop along on a Tuesday morning. I'm told that proficiency in needlework is not a requirement as the Irish Patchwork Society will offer help with your contribution. The making of the tapestry will also be catalogued and serve as an historical record for our Organisation. We are also aiming to arrange local civic receptions for nurses and midwives across the country, and branch officers will have received a template letter to send to local councils on this. We are aiming for them to take place towards the end of the year and these will recognise the work of Ireland's nurses and midwives. Finally, November 28 will see a major celebration at HQ to mark the 100th anniversary of the INMO. Further information will follow from the Centenary Committee.

Global Nurses United, Dominican Republic

AS THE president, and on behalf of the Executive, management team and the members, I would like to thank Maura Hickey, IRO for the north west, and Gráinne Walsh, Executive Council member, for representing the Organisation this summer at the Global Nurses United Conference at the end of July in the Dominican Republic. They engaged in debate and discussion regarding the challenges facing nursing globally. They also gave a presentation on the INMO's industrial action campaign *(see page 12)*.

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

Quote of the month

"The enemy fights the hardest when you are closest to your breakthrough. Know that your best days are ahead, and no weapon formed will prosper."

– Germany Kent

Report from the Executive Council

THE National Executive did not have a scheduled meeting for August, but have met several times to set out the INMO response to the HSE's recruitment 'pause', on the unacceptable delays in implementing the strike settlement and on the needless difficulties faced by new graduates seeking jobs in the public sector.

The Executive Council has endorsed the following positions:

- The INMO objection to the recruitment pause has been put on record with the Minister for Health and the HSE
- Clarification and remedial action is being sought on the positions available to new graduates, and on the Minister's pledge that a permanent job be available to all graduates
- Circulars must be issued by the HSE, implementing the full terms of the Labour Court recommendations following our strike
- Directors of nursing, midwifery and public health nursing are being supported by the union to protect their clinical authority and the staff who are now working with insufficient numbers to provide care
- If safe staffing is not provided, services must be curtailed.

The next planned Executive meeting is September 2 and 3.

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

Summer overcrowding calls HSE employment process into question

MORE than 9,000 admitted patients were forced to wait without a bed in Irish hospitals in the month of July, according to INMO trolley/ward watch analysis. The total figure of 9,439 – of which 45 were children – dwarfs every July total since records began in 2006, when only 3,460 hospital patients were made to wait on trolleys.

The hospitals with the highest figures in July were:

- University Hospital Limerick – 1,293 patients
- Cork University Hospital – 1,079 patients
- University Hospital Galway – 707 patients
- University Hospital Waterford – 590 patients
- Mater Misericordiae University Hospital – 560 patients.

INMO director of industrial relations Tony Fitzpatrick said: "Each day there are hundreds of patients languishing in corridors waiting for a hospital bed. Currently, over 700 patients cannot be discharged from hospital. In the meantime, hundreds of frontline nursing and midwifery posts are currently vacant due to the HSE's dysfunctional and bureaucratic employment control processes.

"Vital roles across all services, at all grades, in all hospitals are left unfilled. This has direct negative consequences for patients. We have come to expect increased demands on the health service in winter, but now even summer sees patients crammed into corridors on trolleys."

At time of going to press the figures for August were also worryingly high, with a massive 541 patients on trolleys on August 7 alone, and well over 400 on trolleys most days.

INMO general secretary, Phil Ní Sheaghdha said: "There's no longer a summer respite when it comes to overcrowding. Summer 2019 is as bad as winter was five years ago. Understaffing is driving year-round unsafe conditions."

Table 1. INMO trolley and ward watch analysis (July 2006 – 2019)

Hospital	July 2006	July 2007	July 2008	July 2009	July 2010	July 2011	July 2012	July 2013	July 2014	July. 2015	July 2016	July 2017	July 2018	July 2019
Beaumont Hospital	270	489	701	810	549	605	489	627	580	643	364	357	78	105
Connolly Hospital, Blanchardstown	189	219	283	179	408	321	313	540	295	442	203	197	303	262
Mater Hospital	251	480	497	361	503	236	424	103	262	325	368	455	330	560
Naas General Hospital	152	18	84	424	201	285	136	146	169	310	145	338	164	209
St Colmcille's Hospital	70	65	81	258	162	175	227	101	n/a	n/a	n/a	n/a	n/a	n/a
St James's Hospital	26	38	199	259	66	158	168	85	216	188	117	102	55	101
St Vincent's University Hospital	418	611	537	521	509	497	502	111	167	161	173	125	186	423
Tallaght Hospital	307	314	359	305	657	419	127	290	266	432	442	237	440	557
National Children's Hospital, Tallaght	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Our Lady's Children's Hospital, Crumlin	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	7	15
Temple Street Children's University Hospital	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	13	24
Eastern total	**1,683**	**2,234**	**2,741**	**3,117**	**3,055**	**2,696**	**2,386**	**2,003**	**1,955**	**2,501**	**1,812**	**1,811**	**1,576**	**2,256**
Bantry General Hospital		n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	20	27	12	29	60
Cavan General Hospital	125	232	153	107	264	254	125	169	36	48	38	22	3	102
Cork University Hospital	407	211	247	509	470	388	187	358	228	307	375	318	614	1,079
Letterkenny General Hospital	215	25	30	38	27	27	21	79	382	175	147	237	449	398
Louth County Hospital	1	27	2	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Mayo University Hospital	136	58	111	110	149	9	74	n/a	96	73	137	109	73	98
Mercy University Hospital, Cork	89	145	138	159	143	138	173	135	164	81	156	161	135	210
Midland Regional Hospital, Mullingar	17	4	20	7	131	291	115	244	291	295	498	439	288	208
Midland Regional Hospital, Portlaoise	42	21	44	17	46	88	18	71	109	162	228	219	290	176
Midland Regional Hospital, Tullamore	3	1	3	13	13	111	84	201	208	176	333	309	494	279
Mid Western Regional Hospital, Ennis	66	56	20	55	14	2	5	4	n/a	19	10	n/a	4	5
Monaghan General Hospital	21	3	23	2	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Nenagh General Hospital	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	1	n/a	4	4	41
Our Lady of Lourdes Hospital, Drogheda	201	113	173	304	202	671	482	340	648	769	452	102	36	184
Our Lady's Hospital, Navan	17	48	29	41	53	13	40	57	38	33	49	204	79	62
Portiuncula Hospital	9	8	1	50	59	78	46	42	84	29	44	38	80	41
Roscommon County Hospital	11	7	12	28	50	27	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Sligo University Hospital	44	31	38	107	113	106	93	45	129	172	111	70	246	253
South Tipperary General Hospital	31	32	134	20	32	30	234	284	118	58	304	388	330	509
St Luke's Hospital, Kilkenny	n/a	n/a	n/a	n/a	n/a	118	55	134	186	393	348	325	282	285
University Hospital Galway	76	145	317	269	282	343	213	295	446	654	447	202	457	707
University Hospital Kerry	85	43	18	17	32	25	73	25	71	98	144	134	289	345
University Hospital Limerick	92	18	123	176	371	238	300	260	475	495	649	662	897	1,293
University Hospital Waterford	n/a	n/a	125	66	113	78	168	218	86	94	353	358	323	590
Wexford General Hospital	89	73	194	228	391	286	52	160	38	62	77	229	111	258
Country total	**1,777**	**1,301**	**1,955**	**2,323**	**2,955**	**3,321**	**2,558**	**3,121**	**3,833**	**4,214**	**4,927**	**4,542**	**5,513**	**7,183**
NATIONAL TOTAL	**3,460**	**3,535**	**4,696**	**5,440**	**6,010**	**6,017**	**4,944**	**5,124**	**5,788**	**6,715**	**6,739**	**6,353**	**7,089**	**9,439**
Of which were under 16	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**m/a**	**21**	**45**

Percentage increase/decrease:
2018 compared to 2019: 33%
2017 compared to 2019: 49%
2016 compared to 2019: 40%
2015 compared to 2019: 41%
2014 compared to 2019: 63%
2013 compared to 2019: 84%
2012 compared to 2019: 91%
2011 compared to 2019: 57%
2010 compared to 2019: 57%
2009 compared to 2019: 74%
2008 compared to 2019: 101%
2007 compared to 2019: 167%
2006 compared to 2019: 173%

Enhanced care model yields benefits

Specially trained workforce improves care delivery and cuts agency costs

A REPORT on a model aimed at reducing Irish hospitals' reliance on agency staff to deliver enhanced care was launched recently by Minister for Health Simon Harris.

Last year, Our Lady of Lourdes Hospital, Drogheda was chosen by the Department of Health as a site for a pilot project, having been identified in the research for the Framework of Safe Nurse Staffing and Skill Mix as having a high reliance on agency staff in the delivery of enhanced care.

The aim of the project was to safeguard the patient by ensuring appropriate levels of observation are in place in the acute care setting.

We wanted to have a skilled workforce specifically trained to meet the needs of the patient and ward staff in a cost-effective manner, thus reducing the need for agencies.

Sixteen healthcare assistants (HCAs) were employed directly to the enhanced care team, led by the enhanced care coordinator. All team members attended a bespoke education programme to ensure they had the appropriate training required.

In the first eight months of the project, despite an increased demand for enhanced care only 37% of the staff required to deliver this care has been provided by agencies, compared to 66% prior to the project's implementation.

This has facilitated a stabilisation of the nursing and HCA workforce along with an estimated overall saving, by year end, of €400,000. The development of the education programme has also enabled staff to feel competent and confident in their work.

We have noted an improvement in our care delivery through the monitoring of missed or delayed care events such as pain management, timely medication delivery, communication and education.

Pictured at the launch of the report were (l-r): *Mary Gorman, CNM3; Adrian Cleary, director of nursing, Louth Hospitals; David Miskell, INMO IRO Dublin North East; a group of HCAs (in green uniforms); Karen Clarke, INMO rep, Drogheda; and Health Minister Simon Harris*

Families of patients who received enhanced care also found the project beneficial, with 87% of families rating the service 'helpful' or 'very helpful' compared to just 31% prior to its implementation.

The project has improved the way enhanced care is delivered throughout the organisation. We now have a skilled, stabilised workforce with person-centred care at the core. It has provided an effective and sustainable approach to safe care for this vulnerable cohort.

The Enhanced Care Model has yielded myriad benefits in Irish hospitals, according to Adrian Cleary, director of nursing, Louth Hospitals, who said: "I feel the Enhanced Care Model is adding value for vulnerable patients, their families and loved ones, and for nursing and other healthcare staff, by providing a focus on the needs of patients and providing a framework and mechanism to deliver a care plan to meet those needs. It is another positive outcome from the safe staffing framework."

– Edel Kirwan, ADON, OLOL

Model launched for developing advanced practice

A NEW model for developing advanced nursing and midwifery practice was launched by Minister for Health Simon Harris in July.

The policy document, entitled *The Development of Graduate to Advanced Nursing and Midwifery Practice,* outlines plans to increase the number of advanced practitioners from 420 to 750 and will be critical in implementing the Sláintecare health reform programme and expanding the contribution of AN/MPs, according to Minister Harris.

Launching the policy, Mr Harris said: "In 2017, the first 124 candidate advanced practitioners commenced their education programme as part of the pilot for this policy. Today, between those registered and on the pathway to registration, we have over 420 nurses and midwives practising at advanced level. The aim now is to have 2% of the nursing and midwifery workforce working as advanced practitioners, which would see the number increase to 750 approximately.

"It goes without saying that nursing and midwifery will be critical in implementing the Sláintecare health reform programme. All the evidence shows that when advance practitioners are located in sufficient numbers in specific areas they can have a real impact on some of the key challenges in the health service. These include the management of long-term conditions, improving patient access to services and reducing waiting times."

The chief nurse in the Department of Health, Dr Siobhan O'Halloran, who has been responsible for developing the policy, said: "Upon graduation, an advanced nurse practitioner can provide a full episode of care for a patient: assessing, carrying out an intervention, prescribing medication and discharging. A rheumatology pilot has demonstrated that patients can be seen faster, start treatment earlier and be discharged earlier, having a positive impact on both the patient and on waiting lists.

"In another pilot hospital, an ANP delivering early respiratory specialist care resulted in hospital admissions decreasing from 100% to 22%, with every admitted patient seeing a respiratory consultant within 24 hours. ANPs are also delivering services to older people in the community, resulting in a better patient experience and removing the need to present at an emergency department.

"Until now, advanced practice numbers in Ireland have been low by international standards. This new policy seeks to address this by streamlining the process by which a nurse or midwife can practise at advanced level."

See also page 25

INMO calls for action on health funding

BDC19 sets out ICTU priorities for next two years

INMO delegates pushed for action on health funding, cervical cancer and climate change at the Irish Congress of Trade Unions biennial delegate conference (BDC19).

Delegates from almost 50 unions across the island met to decide the priorities for Congress for the next two years and to vote on motions.

The main motion submitted by the INMO called for long-term guaranteed funding for public health services across the island of Ireland. The motion was proposed by the Royal College of Midwives (RCM) and seconded by the INMO vice-president, Catherine Sheridan, who is a paediatric nurse in Galway.

In her speech, Ms Sheridan said the under-resourcing of Ireland's hospitals was behind many of the safety risks for patients and staff, including assaults on nurses, record numbers on trolleys and long waiting lists for appointments.

A motion brought by Galway Council of Trade Unions, proposed by INMO Galway nurse, Marian Spelman, focused on the cervical cancer check scandal. She called for an end to outsourcing of tests, an expedited second test for affected women, and implementation of the Scally Report recommendations. INMO student midwife, Melissa Plunkett, spoke in support of the motion.

Climate change was front and centre at the conference this year, with an address from former President Mary Robinson, calling on citizens to seek change from government and business.

ICTU's Executive also proposed a successful motion calling for strong government action to prevent further climate change, using a 'just transition' – a policy which protects workers who would otherwise be left behind as our society slashes emissions. INMO general secretary Phil Ní Sheaghdha proposed the motion, on behalf of ICTU, pointing to the obvious health effects of climate collapse and on wider society's obligation to stop climate change.

Ms Ní Sheaghdha also proposed a successful motion, along with the RCM, requiring all ICTU committees and sub-committees to be gender balanced. She argued that as trade union membership was over 50% women, this should be reflected in the movement's structures. The motion passed a majority vote after an intense debate.

Claire Mahon, a member of the INMO and ICTU's disability committee, expressed concern at the government's refusal to sign a protocol allowing disabled people to lodge complaints with the UN.

BDC19 was also addressed by Taoiseach Leo Varadkar, with a strong response from ICTU general secretary Patricia King, who criticised his government's record on housing in particular.

Motions and keynote speeches are available at: **ictu.ie/bdc19/**

Crucial role in fight against human trafficking

THE International Council of Nurses recently launched a pamphlet on human trafficking at its annual international conference in Singapore. The pamphlet is designed to aid health professionals to identify and assist potential victims of trafficking.

Human trafficking: the basics of what nurses need to know was launched with talks from Cindy McCain, co-chair of the Arizona Governor's council on human trafficking, and Kevin Hyland, member of the Council of Europe independent group of experts for trafficking.

The conference, along with the pamphlet, highlight the key role nurses and midwives can play in protecting people who have been trafficked and the importance of training on how to spot the red flags. The pamphlet outlines types of trafficking and the methods of coercive control used by

traffickers. It outlines general and health-specific signs to look out for when determining if someone has been trafficked as well as ways of communicating with the person and how best to progress the situation towards justice. It is designed to empower nurses and midwives to support patients who may be victims of traffickers.

Speaking at the launch, ICN chief executive Howard Catton stressed that nurses and midwives "are well positioned to identify signs in suspected human trafficking victims", as they are on the frontline of healthcare provision and have a "duty to protect those in danger".

The leaflet can be viewed and downloaded at **http://bit.ly/HumanTraffickingLeaflet**

The Irish government launched Ireland's *Second National Action Plan to Prevent and Combat Human Trafficking 2016*. It also recently approved the ratification of the International Labour Organisation's Protocol on Forced Labour, which must be implemented by the end of this year.

The Department of Justice and Equality's Anti-Human Trafficking Unit has overall responsibility for co-ordinating anti-trafficking policies in Ireland. In 2019, the Immigrant Council embarked on an EU-funded project focusing on assisting victims of trafficking called ASSIST. It has been providing legal assistance to victims of trafficking since 2006 while also campaigning and carrying out research in that area.

While the number of reported cases of human trafficking has risen in Ireland in recent years, a recent UNODC report suggested the figure would double if unreported cases were included. Statistics show that while 95 cases were reported in 2016, the real figure was 179. The majority of victims in Ireland are women and girls who have been trafficked for sexual exploitation, while forced labour is also evident and has both male and female victims.

On July 30, the INMO marked World Day Against Trafficking in Persons and is committed to supporting victims and campaigning against the practices that enslave them. For further support in this area, please don't hesitate to contact your INMO IRO.

INMO calls for emergency plan for UHL as trolley numbers continue to soar

With University Hospital Limerick hitting the all time highest number of patients waiting for beds in any one hospital for a second time, the INMO called for the major emergency plan to be activated in the hospital to cope with the crisis.

This record-high figure of 81 patients on trolleys was hit on July 11, as it had previously in UHL on April 3 this year.

The union reported that the hospital is consistently the most overcrowded in the country and July 11 was the third day in a row with more than 70 patients on trolleys in the hospital.

INMO IRO Mary Fogarty said: "This is a hospital in clear crisis. 81 patients on trolleys is the equivalent of three full wards. Nurses expect additional strain on the health service in winter, but in mid-July UHL is in crisis mode. Our members are gravely concerned about the ability of the hospital to provide safe care to patients.

"This level of excess overcrowding requires extreme measures such as the activation of the major emergency plan for the hospital. This will halt all activity at the hospital with the exception of emergency admissions to enable management to bring about a more controlled and safer environment for patients and staff.

"This hospital simply does not have enough capacity for the demands of the region. The INMO wrote to the Minister for Health over ward closures at the hospital, but it is now clearly time for urgent investment in this hospital, and in community and primary care in region."

CHO3 acute staffing shortages

FOLLOWING concerns raised by members in Clare, Limerick and North Tipperary on the impact of the HSE's recruitment pause on older persons in residential care, the INMO has met with senior HSE managers from CHO3.

Arising from this meeting, some progress has been made on agreeing matters of concern to INMO members.

A period of discussion is to occur to seek to move forward as follows:

- Nurses awaiting appointment to CHO3 on the September 2018 recruitment panel will now be processed for appointment to vacant posts
- Management has identified nursing vacancies in each of the nine sites and are to are to provide the INMO with a list of these. This will require further engagement with a view to reaching agreement with the INMO
- Management advised that short term and short notice vacancies that give rise to extenuating circumstances as determined by the director/assistant director of nursing have an approval process, of which we are to receive the details inclusive of how many to date have been approved or not approved and the reason for non-approvals.
- Management will provide us with an update on the current CNM vacancies across the nine sites. Presently eight posts are identified for filling. The recruitment process to fill frontline management posts has commenced
- Significant levels of outstanding annual leave/TOIL from 2018 are confirmed in a number of locations requiring a mechanism to resolve.

A follow-up meeting was pending as we went to press.

– Mary Fogarty, INMO IRO

Bon Secours Limerick parity claim

The INMO, on behalf of members working in Bon Secours Hospital Limerick, has lodged a claim for parity with the wider Bon Secours Group in respect of pension contributions.

The INMO is aware that currently Bon Secours Limerick contributes 2.5% less towards employees' pension than all other hospitals in the group and this anomaly is no longer sustainable. A date for a local meeting is pending.

INMO extends thanks to longstanding rep on her retirement

GER HENNESSY, senior staff nurse, retired in July from St John's Hospital Limerick following almost 30 years of nursing service.

The INMO wishes to acknowledge all of the union work and representation undertaken by Ger on behalf of all INMO members working within the hospital over the years.

Pictured at a function to mark Ger Hennessy's retirement from St John's Hospital, Limerick were (l-r): Mary Fogarty, INMO assistant director of IR; Ger Hennessy; and Margaret Finn, director of nursing, St John's Hospital

At a recent retirement function at the hospital many INMO members, HCAs and doctors spoke of Ger's outstanding ability as a nurse in the delivery of bedside nursing care and the education of junior nurses, doctors and HCAs.

The high standard of nursing care advocated for by Ger led her to be one of the best advocates for nurses at St John's Hospital.

With Ger as rep the INMO had a voice that was solid, strong and honest in engaging with management and members to protect frontline nursing services and patients. The INMO extended its thanks to Ger and wished her the very best of health and happiness for her retirement from nursing.

– Mary Fogarty, INMO IRO

Cork health service plunged into crisis

CORK health services have been plunged into a crisis due to a combination of problems including record overcrowding levels, hundreds of vacant frontline positions, profound shortages in community nursing and chronic recruitment and retention problems. The month of July saw 1,079 patients waiting on trolleys in Cork University Hospital.

The INMO sought urgent engagement with health service management to commence discussions on service curtailment if urgent action was not taken. In correspondence, the INMO has sought an urgent response from the South/South-West hospital management, to what it described as an "intolerable" situation requiring the lifting of budget and staffing restrictions. The INMO also requested urgent action on bed capacity.

The situation arises alongside concerns over midwife-to-patient ratios in Cork University Maternity Hospital, as well as ongoing talks at the WRC regarding staff shortages in community facilities throughout the South-West region.

INMO IRO Liam Conway said: "Our members state that the conditions for patients and staff in CUH are intolerable and unsafe. Health service management must take tangible steps immediately to relieve the misery for staff and patients.

"The recruitment process is being delayed at the local level, leaving an already overcrowded hospital short staffed. Immediate action must be taken to address this issue. We cannot head into the autumn/winter period with no clear plan to address all of these problems."

Agreement secured for out-of-hours GP nurses

THE INMO has secured an agreement for a number of members who had their jobs outsourced by the HSE without consultation.

In 2018, the HSE outsourced part of the out-of-hours GP service in south Dublin to a private service provider. In doing so, it did not undertake adequate consultation with the INMO, which represents a number of nurses currently providing that service, or Fórsa, which represented the administrative grades.

In effect, the HSE outsourced the jobs from under the members, with no discussion or provision for secondment. The unions initially met with management early in 2019 on this issue, and while members' employment status was secured at this point, it required the intervention of the Workplace Relations Commission to reach an ultimate agreement.

Noel Treanor, INMO IRO, said: "The INMO and other unions have agreements in place regarding the outsourcing of services, and there is no question but that the HSE breached this agreement. However, on an individual level, it was a scandalous act on the part of the HSE to effectively sell the jobs of their own employees out from under them. This caused great anxiety on the part of the personnel involved and was poor reward for the long service shown by such committed public servants. It is hoped that there will never be a repeat of this behaviour by the HSE and that they will treat their employees with greater consideration than shown in this instance."

Cavan/Monaghan elderly services

A dispute over deficits in the Cavan and Monaghan older persons service has been referred to the WRC. Despite engagement over a considerable period of time deficits exist within the management structure for Older Persons Services. David Miskell, INMO IRO for the North East, has said that it is regrettable that such a course of action was necessary but there is no other option. "It is vital that the correct structures are in place and we look forward to constructive engagement by the HSE to bring about a resolution to the issue."

Significant improvements gained in Cobh Community Hospital

THIS time last year members in Cobh Community Hospital raised concerns in relation to governance and other related issues which were highlighted in a HIQA inspection report which was widely publicised.

INMO members instigated processes which have resulted in significant improvements within the service. The members have secured new and improved governance structures with the introduction of a CNM1 post for the community hospital. Additional staffing has been approved as part of a recruitment process which was a significant concern. There has also been action in relation to improved hygiene levels within the service.

Members in the community hospital have worked tirelessly and have been dedicated to the service to ensure that the hospital improves standards and is compliant with the relevant HIQA regulations and standards.

The INMO has been actively involved in supporting, advising and representing members to instigate change and improvement. Thankfully, through engagement this improvement has now being achieved through collaboration, with measures sought by members put in by the employer. INMO members are working with local management and the board to ensure progress continues.

– Liam Conway, INMO IRO

Grading of ICU clinical audit team

ICU clinical audit nurses have referred a claim for regrading of their posts to the WRC. Discussions have been ongoing for some time with local management, however no solution could be reached. The posts in Beaumont Hospital are graded at staff nurse level, however the reality of the role is that it is more appropriate to CNM level. The National Office of Clinical Audit recognises this also. David Miskell, INMO IRO for Beaumont Hospital, said that the highly specialised role of the team in Beaumont must be recognised as such and remunerated accordingly.

Gráinne Walsh, INMO Executive Council member, and Maura Hickey, INMO IRO present to the Sinatrae Nurses Conference

Delegates at GNU Conference 2019

United in the face of global challenges

Maura Hickey reports on Global Nurses United annual meeting

LAST month my colleague, Gráinne Walsh, Executive Council member, and I had the privilege of attending the Sinatrae Nurses Conference and Global Nurses United Annual Meeting in the Dominican Republic. This was a very informative, educational and often humbling experience.

The first two days of our visit were dedicated to the Sinatrae Conference which is Dominican Republic's equivalent to the INMO annual delegate conference. Over these two days, we learned of the constant struggle nurses face to earn a living wage.

Nurses who work in an acute tertiary centre told of how there were 40-50 patients on wards with just one or two nurses per day shift, with possibly three healthcare assistants.

Staff to patient ratios in Dominican Republic are very low as are nurses and midwives' salaries. There are no salary increments, with nurses earning not much more than healthcare assistants despite having undertaken a four-year degree programme. Nurses earn the same salary as domestic staff, catering staff and security guards. Nurses working in private hospitals earn considerably less than nurses in the public sector.

The cost of living is not cheap for the citizens of the Dominican Republic, which has only one natural resource, a precious stone mine, Laramar. The country is fighting to prevent multinational mining companies from taking this over. Like many of the Latin American countries, health is seen as a commodity not as a right.

Gráinne Walsh and I gave a presentation to the Sinatrae Conference on the INMO national strike and the outcome, from both the IRO and Executive Council's perspective. I presented on the background and lead up to the strike action, the preparation for the action, the nature of the action and the actual days of industrial action. Gráinne Walsh followed this with a presentation on the outcomes and what we achieved.

The Sinatrae Conference concluded with a visit to a Mother and Children's Hospital set in one of the poorest areas of the capital city of San Domingo, Hospital Materno Infantil San Lorenzo Los Mina. The hospital was spotlessly clean, staff were busy, bells were ringing, and everyone was very friendly. It was interesting to learn that every ward in the hospital has an interventional psychotherapist and psychologist which, we were informed is very effective in minimising trauma and volatile situations.

Global Nurses United

The GNU conference commenced the following day with the welcoming of the newest affiliates to GNU, the United Nurses Association of India, and consideration and acceptance of a further four applications from Malawi, Curacao, Sri Lanka and Rwanda. The GNU is dedicated to working collectively to protect our patients, profession, all labour and union rights, our communities, our work, our health, our environment and our planet. We work together with healthcare workers and other people committed to economic and social justice.

Member organisations from Brazil, Canada, Costa Rica, Curacao, Dominican Republic, Greece, Guatemala, Honduras, India, Ireland, New Zealand, Paraguay, Peru, Philippines, Uganda and the US were all represented.

Over the course of two days we heard how nurses face similar challenges across the world, ranging from safe staffing, the struggle against workplace violence, pension difficulties, medication errors, missed episodes of care, poor outcomes and death due to poor staffing, and the struggle for union recognition.

We received presentations on the plight of migrants, racism, harmful effects of globalisation, stopping the neoliberal threat of privatisation of public healthcare systems, climate change and health. Some of the presentations and videos were difficult to listen to and watch as they highlighted man's inhumanity to man. All the motions proposed and discussed were adopted unanimously.

A speaker from Guatemala, Luis Antulio, who is the general secretary of the healthcare workers of Guatemala, spoke about how earlier this year he successfully negotiated the first ever collective agreement with the government, which was signed by Mr Antulio and his government. However, the government then did a complete u-turn and reneged on the agreement.

The State police went to the general secretary's house in the dead of night and arrested both Mr Antulio and his wife. They were taken to one of the toughest prisons in Guatemala and held for 12 days. Mr Antulio was informed that he would be provided with a lawyer if he signed a document admitting that signing a collective agreement was illegal. He refused and consequently had to raise US$8,000 to represent himself and his wife. Following an investigation, it was found they had no case to answer and they were released.

There were many more stories like this one that caused me to reflect and be thankful to live in a country where we do not have to fear for our lives for being a member of a union. It poses such questions as what are conditions like for our immigrant brothers and sisters in detention centres? Are we awake to possible covert moves within Ireland to weaken the strength and power of unions? The INMO national strike earlier this year demonstrated what can be achieved if we stand united together, as the old Gaelic saying goes *ní neart go cur le chéile* (there is no strength without unity).

– Maura Hickey, INMO IRO

It is social justice, equality and fairness that will bring lasting peace and prosperity – not nationalist rhetoric, writes **Dave Hughes**

It all started with a click...

REGULAR social media users routinely receive images accompanied by questions such as "like if you agree we should look after our own homeless before sending money abroad" or "homeless before migrants". Such images usually portray a victim of social injustice in our own country and a person, usually of a different colour, looking more prosperous. The presentation is usually quite compelling to even the most moderate and almost instinctively fingers will click the like button.

This will often lead to bombardment with similar types of invitations to take sides. A good example of this is Donald Trump's *'Make America great again'* campaign. Of course, there is no reference to what the *again* he refers to means or what period of time he is referring back to.

What is being appealed to in this modern era of social media is the powerful force of nationalism. Increasingly that instinct is being called upon and can be attributed to many of the conflicts currently raging across the globe. Indeed, even Europe, which has been bound together as one union with a peaceful existence since the end of World War II, where prosperity has neutralised tensions based on nationalism, is witnessing an awakening of such forces. The one currently most relevant to us is BREXIT. That one click on your phone or mouse can lead to an echo chamber re-enforcing the original image to the exclusion of critical analysis.

George Orwell, one of the most influential writers of the 20th century, identified nationalism as a force more powerful than family relationships, religion and economic wellbeing. Orwell wrote extensively on nationalism and what he saw as two related consequences – totalitarianism and fascism – in his celebrated books *Down and out in Paris and London, Keep the Aspidistra Flying, Homage to Catalonia, Animal Farm* and *1984*. In the latter, written in 1948, Orwell predicted the regime of 'Big Brother' where everyone and everything is being watched and recorded at all times via countless interactive televisions. Such technology is now available, and in use in China and many other states without the knowledge of the citizens.

The world is now facing the biggest refugee crisis since the two World Wars. Stirring up nationalistic feelings such as resentment towards migrants or refugees is no solution to a problem which has faced many nations in the past, including Ireland. Nurses and midwives are familiar with working in a multicultural environment or dealing with migrant populations. Anecdotally they can recount tensions even within migrant communities from one country versus another.

So, what causes the flow of migrants or refugees? We in Ireland understand the things that drive mass emigration. Indeed, one of our former ministers for foreign affairs described emigration as Ireland's essential valve for a nation who could not support all of its people. The Famine years saw our people disperse mainly to the Americas out of hunger and poverty. They were not always welcome and were treated in much the same way as today's migrants are treated on arrival in Ireland. Arguably our own performance with direct provision centres is worse for asylum seekers who are prevented from working. The reality is very different to the portrayal often suggested in your Facebook message. The migration of Irish people abroad has often been based on economic need. Waves of people left Ireland through the 1970s, 1980s and 1990s because of lack of employment and opportunity at home.

A tour of Ellis Island in New York shows how the mass immigration from all over Europe into that country was processed. While the tour strongly portrays the miseries that people had left in their own countries and the bureaucratic process they had to go through to get into America, in many ways, the treatment nowadays is worse. There were few reasons to prevent people getting into America – generally a contagious disease or inability to provide for oneself. Today's refugees and asylum seekers are generally fleeing because of war, sanctions against their home country, famine induced by war, and economic necessity.

For many years, tombs of the unknown soldier were a stark reminder to populations and their leaders of the horrible consequences of the two World Wars – lest we forget. Alas, it would appear that many have forgotten and that the interests of the arms industry are now higher in the minds of those with real influence in the world than the horrors of war. Even the international protections for healthcare workers are now being ignored, with nurses, doctors and other healthcare workers finding themselves the targets in conflict zones. It is time to stop glorifying war and conflict and to recognise that the lasting peace and prosperity throughout Europe was based on principles of social justice, equality and fairness, and a raising of living standards for the vast bulk of inhabitants.

There are nationalist movements in almost all European countries, with active groups gaining massive popularity in some of the larger countries. The real actions that stemmed the flow of refugees in all situations has been the willingness of other nations to fund those in difficulty so that their peoples can stay in their own country and prosper. That philosophy did work. However, when applied in certain Middle Eastern, African and central Asian countries it led to apparent peace through effectively totalitarian regimes, which are now crumbling and in disarray with their peoples revolting, often with the military and financial support of the very same governments who funded the despots in the first place.

Ireland has and can lead the way. Irish people led the creation of the United Nations and the International Labour Organisation and our role at the United Nations for Small States has always been disproportionate to our size. We do not get everything right in this country but neither do we have a colonial past legacy with other countries. Organisations and civil society non-governmental groups are important in counteracting the simple propaganda that one click can lead us to.

Hate will not solve the problems of crime, war and the consequences for the populations of the countries ravaged by those problems. Support for development in underdeveloped countries is the only realistic way of dealing with the massive refugee crisis now facing the developed world.

Dave Hughes is deputy general secretary of the INMO

Orthopaedic Nurses Section attends international conference in Denmark

TEN Irish delegates attended the fourth International Collaboration of Orthopaedic Nursing (ICON) in Denmark in May.

The conference had the theme of 'Orthopaedic nurses will walk across borders'. More than 200 delegates from across the world attended with representation from Ireland, the UK, Scandinavia, Portugal, Turkey, China and Hong Kong.

Deirdre O'Kelly represented the INMO Orthopaedic Nurses Section at the ICON meeting, which was an opportunity for networking and discussion.

Members who attended the conference presented posters with a total of 63 posters displayed across the two day conference. The posters covered topics relevant to all aspects of orthopaedics from an elective, trauma and paediatric perspective.

Members of the Orthopaedic Nurses Section pictured outside the Danish Orthopaedic Nursing Museum

Many topics were presented over the course of the two days including enhanced post-op recovery – what it is and why we should do it, fundamentals of care, delirium in the orthopaedic unit, how to put nursing on the agenda through international co-operation, and new strategies in nursing education for fragility fracture nursing, alongside many other thought-provoking topics.

Attendees experienced life in a Danish hospital. They spent a morning in Kolding Hospital and visited the orthopaedic outpatients, emergency department, theatre, orthopaedic ward and orthogeriatric ward.

The staff in these units shared their knowledge and expertise, as well as explaining the various initiatives and projects in which they are involved.

Members also attended the Danish Orthopaedic Nursing Museum, which explores nursing through the ages and how the profession has developed and evolved over the years. The conference dinner was an interesting event, with delegates being treated to a performance from a Danish gospel choir.

All orthopaedic nurses are invited to join the INMO Orthopaedic Nurses Section. For more information on this section, email jean.carroll@inmo.ie

Section update

The Telephone Triage Nurses Section national conference will take place on Tuesday, September 24 at the Richmond Education and Event centre.

Topics to be covered at the conference include: concussion, vaccinations, child and adolescent substance misuse, oncology, the 11-hour rule, and the triage of mental health and postnatal depression.

Dr Chris Luke, who spent much of his career as a consultant in emergency medicine in Cork, will also be speaking at the conference.

Bookings can be made at **www.inmoprofessional.ie** or at Tel: 01 6640648. See *page 58* for more details.

Third Level Student Health Nurses Section recognises stalwart members

Pictured at the recent meeting of the Third Level Student Health Nurses Section meeting, at which a masterclass on STI testing and treatments was held, were: *Margaret Rushe (centre left), the Section's outgoing national secretary and Katherine Cox (centre right), who is retiring. Suzanne Keily from IADT will replace Margaret as national secretary. We would like to thank Margaret for all her time and commitment to the section to date. The group will meet next on October 18, 2019*

Q and A Bulletin Board

With INMO director of industrial relations Tony Fitzpatrick

Query from member

I am a practice nurse working three days per week. One of the public holidays fell on a day that I was due to work and the practice closed down on that day. I recently discovered that my employer deducted one day's annual leave from my annual leave entitlement for this public holiday. Is this correct?

Reply

No, this is not correct. If a public holiday falls on a day that you are scheduled to work and the business closes down, you are entitled to a paid day off on that day. You should not be deducted annual leave for this day as you cannot be on two 'leaves' at the same time. If you are not scheduled to work on a day a public holiday falls you are entitled to one-fifth of your weekly pay for that public holiday.

Query from member

I am a staff nurse and have been approved for cost-neutral early retirement and intend on leaving at the age of 57. I started working in the public health service in April 1997 and I pay class A1 PRSI. I was advised by my employer that my pension is integrated with the OACP and is a deduction of twice the single person's rate of old age (contributory) pension (OACP) from gross pensionable remuneration. I was told that I cannot access the supplementary pension until I reach age 60 because I am leaving early. Is this correct?

Reply

Yes, this is correct. Supplementary pensions, where appropriate, will be paid to a nurse/midwife availing of cost neutral early retirement on reaching the relevant preserved pension age (60 or 65 years, as appropriate), with actuarially reduced superannuation benefits.

When opting for cost neutral early retirement, it should be noted that the actuarially reduced rate applies throughout the lifetime of the payment of a pension subject to adjustments in line with public service pensions.

Midwifery without borders

Laura Henry left for Cambodia with two years of midwifery studies behind her and returned with a fresh perspective on the philosophies and challenges shared by midwives around the world. Interview by **Michael Pidgeon**

"WHAT came as the biggest surprise was that nearly all of the activities of daily living were done by the family. Families fed the mothers, washed them and brought in blankets.

"Every bed in the maternity ward seemed to be surrounded by grannies. In Ireland, we're used to maternity wards with mothers, babies, maybe a partner and an occasional visiting relative. In Cambodia, it's the whole family."

This was perhaps the biggest culture shock for Laura Henry, a student midwife from Dublin, on an observational placement in Pnomh Penh, Cambodia, for the summer.

"My first thought was 'oh my God, none of the family are trained', but I soon began to see the advantages. The hospital was just a nicer, kinder place.

"Kids from different families made friends and played in the corridors. Partners, grannies, brothers and sisters took turns to bring newborns up to be washed. As a midwife, you really get to know the whole family and community – not just the immediate service users. It's real community care, centred on family.

"It has benefits for patients as well. There were so many grannies around who had been through childbirth before. They supported mothers directly and raised issues with us that we might otherwise have missed."

Laura started quickly in the role. Arriving in Cambodia on Sunday, she started in the placement on Tuesday.

"The first thing the ward sister said was that she was looking forward to teaching us but also learning from us. I thought that was lovely but I'm only between second and third-year of studying midwifery so it was pretty daunting.

"To be honest I wasn't sure what to expect. I tried to go in with as little expectation as possible. I'd been planning and researching the placement for a long time – I wanted to avoid being some sort of 'white saviour', gallivanting off to an 'exotic' country and so on. You have this idea that things in Cambodia will be far behind where they are in Ireland, but at the time I didn't have any understanding about the reasons why that might be."

Rebuilding

From 1975, Cambodia was ruled by the Khmer Rouge, an autocratic regime that aimed to reach 'year zero' – purging the country and replacing it with a rural, agrarian society. Over four years, the government killed up to three million people – 25% of Cambodia's entire population. The genocide focused on, among others, those perceived to be urban or educated, a category that often included healthcare workers.

"Initially I made the assumption that Cambodia is 30 years behind the most developed healthcare systems. When you learn about and consider what they went through so recently, it's incredible to see where they are today. The genocide in the 70s, no foreign aid throughout the 80s, the ongoing poverty. Their whole society, including their health system, literally had to be rebuilt from nothing. What they're recovering from – that context is so important.

"In the hospital I was in, one of the researchers was looking at whether it's better for midwives to work 12- or 24-hour shifts. Some of the foreign students were shocked by that, but we have to remember that Cambodia can't just transplant Western research to its service providers. Cambodia has only recently passed labour laws, so you can understand the progress that's being made."

Difference and deference

Laura was also struck by the differences in the public and patient perception of midwives and nurses in Cambodia. Only one in three children in Cambodia complete lower secondary education (the equivalent of the Junior Cert in Ireland).

"In many ways it's the same – you have people gratefully turning to you for skilled care, knowledge and support. But most of the people you care for here wouldn't have had much opportunity for formal education, so they look to midwives – who generally have university-level qualifications – for guidance.

"Midwifery and nursing are seen as well-paid, stable jobs in Cambodia. That impacts on how you relate to other health workers too. Nurses, midwives, doctors and all kinds of students are seen as being on the one level. It's more of a team.

"One of the paediatric nurse students on placement here ended up shadowing a doctor on their rounds, as the roles were more blurred and overlapped than they would be back home.

"The way people talk about nurses and midwives in Cambodia, it reminds me of how you'd often hear elderly people speak about doctors back home. There's a kind of deference there.

"And in Cambodia, it was pretty clear that midwives are running the show in maternity wards. Any good obstetrician will work as part of a team and listen to midwives, but doctors here were more just popping in and out than having the clear structured role they would have in Ireland.

Shared philosophy

Despite the differences, Laura immediately saw how similar the role of a midwife is, wherever they practice.

"When you strip it back, the role is the same. We provide antenatal support, care during the delivery and after the birth. The philosophy behind midwifery – as an advocate for mothers and focusing on their informed decisions – is the same.

"I always say that I didn't pick midwifery, it picked me. I know that sounds a bit lame, but I really like the emphasis in midwifery on consent and informed decisions, not just the clinical side of things. That philosophy is everywhere in midwifery."

Midwives in Cambodia also face some of the same problems as in Ireland.

"Looking at the whiteboard each day with patient numbers, the wards never fell below 150% capacity in the first month of my placement. I think I definitely gained an appreciation for how we do things back home, but it seems like the pressures are similar in both countries."

Future ambitions

Laura returned from Cambodia in July, but she's clear that she'd like her future career to blend working in Ireland and overseas, if possible.

> *"The philosophy behind midwifery – as an advocate for mothers and focusing on their informed decisions – is the same"*

"I had always really wanted to work abroad. I initially started training as an ID nurse, but moved to midwifery. I think I hadn't realised then how transferable our professions are and how you can bring your qualifications with you around the world.

"I had always had this sort of weird notion that I wanted to do work like Doctors Without Borders, but I didn't realise just how many opportunities there were for midwives and nurses around the world.

"I've been really lucky to come to Cambodia. It's obviously a beautiful place, but I hadn't realised how culturally it reminded me of Ireland. People are so friendly and that really shines through everything here.

"That really makes a difference in the hospital too. Every ward has a small Buddhist shrine and is filled with family, children and support. I think that's the main thing I'll take from the placement here: the importance of community and family care.

"It's something that can be easily lost sight of in clinical settings, but family and community are incredibly important, especially when it comes to new lives entering the world."

Before: *To fundraise for the trip, Laura had 18.5 inches of hair shaved off*

...and after

The Killing Fields: *This tree was used to murder children and babies. Horrific though it is to consider, it is important to acknowledge the full extent of what the country is recovering from*

Hand-held doppler – it looks very different to what we're used to using in Ireland

Developing advanced practice

Karen McGowan reports on the new policy on the development of graduate to advanced nursing and midwifery practice

I WAS delighted to attend the launch of the new model for the development of advanced nursing and midwifery practice in July. It was a proud day for advanced nurse and midwife practitioners to bear witness to the changing times we live in.

Advanced practice has come a long way since the National Council approved the first ANP post in 2002, filled by Valerie Small NCNM.[1] At the time there were 29 posts in a number of settings, compared with July 2019, when Health Minister Simon Harris made a commitment to increase the number of nurses and midwives working in advanced practice to 750 – some 2% of the nursing and midwifery workforce.

The development of the new policy could not have come at a better time with the creation of Sláintecare.[2] The model supports the growth and development of ANPs/AMPs by providing a broad approach to education. Therefore, in essence, it is not a 'one size fits all' approach.

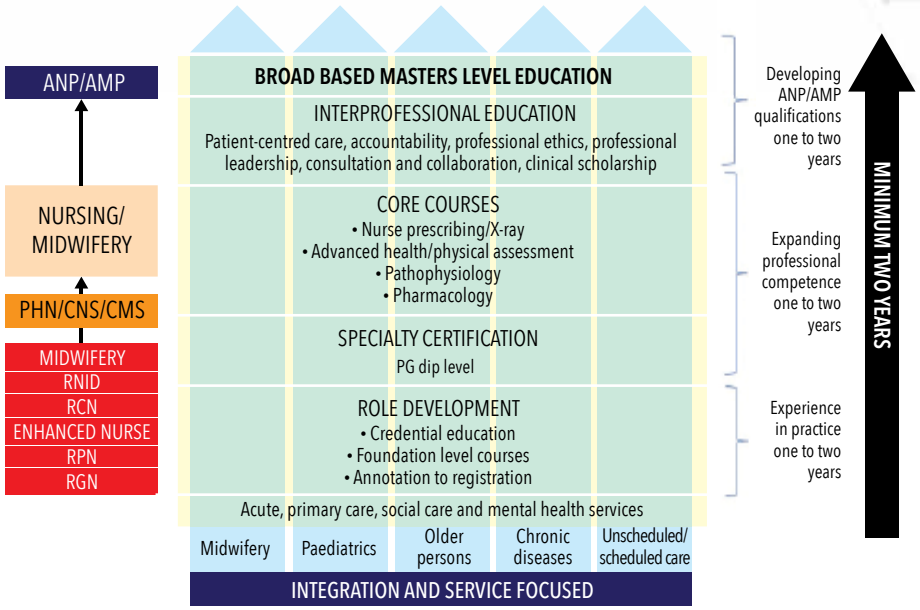
The model fosters a culture of change in how we train as nurses and midwives to an advanced level. The historical framework[3] from novice to expert has transformed into a credentialing system where a capability to practise ensues. The capability of the practitioner progresses through attainment of knowledge and skill. This facilitates their practice as they become protocol driven in the area of practice. The practitioner is empowered to use a strategic approach to patient care, allowing them to manage complex cases safely.[4]

It has been well documented that ANPs/AMPs have a huge impact on patient-centred care. By implementing the credentialing system, this allows the practitioner to respond to the service demands that will ultimately benefit patient care.

Educational pathway

The original pathway would take seven years for the candidate ANP/AMPs to reach registration compared with the new policy, which will be two years post registration. This will suit the focused nurse or midwife who has a passion for advanced practice. The timeframe in the new policy is positive and robust, and includes all aspects of the learning environment. It should lead to a very competent ANP/AMP.

Figure: Educational pathway



Registration requirements

- Candidates must be registered with NMBI
- Evidence of a portfolio of continuous professional development
- Evidence through portfolio of experience in the area of practice equivalent to a minimum of two years
- Evidence of experiential learning necessary for the role to an equivalent of 500 hours
- Evidence of achievement of the core concepts/competencies/capabilities for the role through peer and self reflection
- Evidence of credential education required for the role through portfolio development
- Evidence of formal post-registration/ credentialed education in the area of practice that is equivalent to a level 9 (QQI) major award.

Summary

The new policy sets out a direct route to advanced practice. It has a stringent pathway to encompass all educational components to practice at an advanced level. There were reservations about the two-year timeframe to registration, however there is strong evidence to support this policy as it showed there was no benefit in delaying registration once all aspects of education and training had been accomplished.[5]

The new policy is a breath of fresh air to advanced practice as it not only addresses the issues with the previous model but has also streamlined the approach. The overall plan has also been very strategic in the areas being provided with ANPs/AMPs.

The focus has been on the areas of congestion within the healthcare system, together with creating more ANPs/AMPs and addressing critical areas like chronic disease management (respiratory), waiting lists (rheumatology), older persons care (frailty) and unscheduled care (ED).

Advanced practice is responding well to the ever-changing needs of the healthcare system, because the fields of nursing and midwifery always respond and adapt well to their environments.

Karen McGowan is an ANP at Beaumont Hospital, Dublin and a member of the INMO Executive Council

References available on request by email to: nursing@medmedia.ie (Quote: McGowan K. WIN 2019;27 (7): 25)

Postcard from Singapore

The International Council of Nurses conference in Singapore was a timely reminder that nurses from all over the world share many of the same challenges. **Mary Tully** reports

AFTER a lifetime of involvement with the INMO at all levels, beginning in 1988, I was overjoyed when my application to attend the International Council of Nurses (ICN) biannual conference in Singapore was approved. I was selected to travel along with Edward Mathews, INMO director of professional and regulatory services, Eilish Fitzgerald, INMO second-vice president, Karen Eccles from the Executive Council and Kay Garvey, a former Executive Council member. The five-day conference included lectures, discussions, seminars and large plenary sessions involving delegates from affiliated countries.

The ICN, founded in 1899, is a federation of more than 130 national nurses associations and unions representing 20 million nurses worldwide. Its role is to represent nursing worldwide, advance our profession and advocate for better health policies. It is particularly relevant given that the current president is our very own Annette Kennedy, former INMO director of professional development.

The focus this year was on preventative healthcare and health policy in general. It was noted that we are facing severe shortfalls of nurses for an ageing population. The World Health Organization (WHO) is producing the State of the World Nurses 2020 report, which will provide a global picture of the nursing workforce and hopefully be passed as a blueprint for policies involving deployment and recruitment in affiliated countries.

The point was made that a robust health system, apart from being good for individuals, is also beneficial for the economy. Investment in nursing benefits the health of all people and creates wellbeing in society. It was argued at the conference that nurses have the opportunity to lead an educational and health promotion programme that will limit chronic disease through the reduction of tobacco use, unhealthy diets, physical inactivity and the harmful use of alcohol. The burden of these issues falls mainly on poorer families, who haven't the capacity to break out of this cycle without intervention.

In Singapore were (above, l-r): Sheila Dickson, Mary Tully, Kay Garvey, Eilish Fitzgerald, INMO second-vice president; Karen Eccles, Executive Council; and Edward Matthews, director of professional and regulatory services. (Left, l-r) Delegates in their national costumes

An interesting concept that emerged from the conference was the idea of expert nurse and patient relationships in primary healthcare. Expert patients are patients who have become clinically efficient and effective in managing their own chronic conditions and in mapping and navigating healthcare systems. They have been successful with their own health outcomes and have established long-term professional relationships and collaborations with their nurse. This cohort is an under-recognised asset and should be involved in the formation of healthcare policy.

The ICN will seek a greater voice for the nursing profession in policy making and implementation at national and international level. The Council will seek to enhance our influence in this area and fight for a greater focus on the health and wellbeing of our profession in the area of stress and burnout.

The ICN is developing a strong focus on nurse retention and is researching the factors that prevent it. The outcome of this focus should form an effective response to those countries affected by the nurse retention challenge.

Mary Tully: *"It was interesting to gain an understanding of the vital work that the ICN does and how we can all feed into it"*

It was interesting to gain an understanding of the vital work that the ICN does and how we can all feed into it. It was also interesting and rewarding to meet nursing colleagues from all over the world. Chatting with them was a reminder that we share many of the same challenges and that it is worthwhile knowing how those challenges are met in other countries.

Mary Tully is the INMO rep for Cavan and Monaghan

Cancer in pregnancy

Cancer in pregnancy remains uncommon, but changes in lifestyle and a maturing maternity population is likely to increase its incidence

RECEIVING a cancer diagnosis in pregnancy or soon after birth is difficult for a woman and her family. It is important that maternity practitioners are aware of the issues and how they impact the woman to ensure she receives the most appropriate and timely information and support.

RCM i-learn offers a CPD learning module on 'Cancer in pregnancy and beyond'. The module takes 20 minutes to complete and has been developed to support midwives, student midwives and maternity support workers in caring for women diagnosed with cancer during pregnancy and postnatally. The aim of the module is to enable maternity staff to feel more confident and informed when supporting women in this unusual and challenging situation.

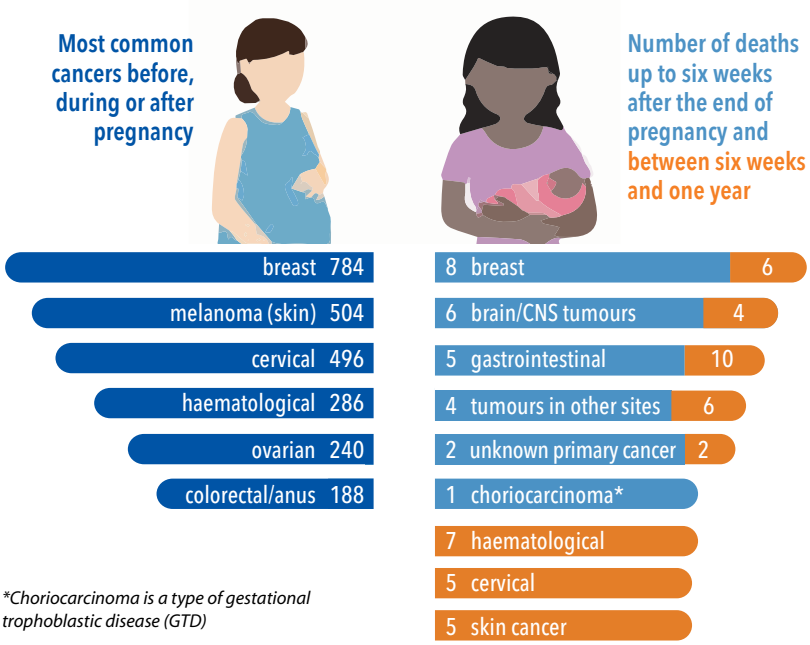
Learning outcomes

On completion of the module, you will:

- Understand that the impact of cancer on pregnant women is complex and multifaceted
- Be able to identify issues affecting women diagnosed with cancer in pregnancy
- Know that cancer symptoms are often similar to common pregnancy symptoms, making a diagnosis more difficult and potentially causing delay
- Understand that maintaining normality and choice is important to women experiencing cancer during pregnancy
- Be able to explain why women experiencing cancer in pregnancy are at a significantly higher risk of poor mental health
- Understand the importance of seeing a midwife as well as a doctor.

Statistics

In the UK, there is a lack of data concerning the number of women diagnosed with cancer during pregnancy and beyond. According to a report published by Public Health England in 2018, the occurrence of cancer during pregnancy is uncommon, with an incidence rate of approximately one in 1,000 pregnancies. The rate of pregnancy-associated cancer is increasing, due in part to a trend in delaying child bearing to an older age. While this number is relatively small, the impact on women and their families is significant. From a public health perspective, the effects on mother and baby can be far-reaching and detrimental.



Choriocarcinoma is a type of gestational trophoblastic disease (GTD)

Maternity staff are ideally placed to provide the type of care that can mitigate these issues and provide excellent support to women, who often don't want their pregnancy to be overshadowed by their cancer diagnosis and treatment. For the majority of women with a medical complication such as cancer, care is primarily with obstetricians and other specialists. This often means that the woman has little continuity with the maternity team. By equipping midwives and support workers with the confidence to provide care alongside crucial medical treatment, women, their partners and families are likely to have a better overall experience during the maternity period, helping to keep the woman and her baby at the centre of care.

Types of cancer

Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE) 2018, found the occurrence of cancer is coincidental to pregnancy; meaning that it would have arisen irrespective of pregnancy. Between 2012 and 2014, there were 3,272 women in England aged 15-44 diagnosed with cancer before, during or after pregnancy. Between 2014 and 2016, 104 women died from cancer during pregnancy or up to one year after in the UK and Ireland. Of this group, 26 women died during pregnancy or up to two weeks after the birth *(see infographic above)*.

Module content

This module covers a range of issues and includes case studies, resources and a quiz to assess your learning.

Module content includes:

- Symptoms and diagnosis
- Mental health issues
- Issues facing women with cancer
- Key issues for women
- Key issues for maternity staff
- Midwifery care
- Mummy's Star.

RCM i-learn access for INMO midwife members

If you are interested in completing the module, visit **www.ilearn.rcm.org.uk** Free access is available to all midwife members of the INMO.

www.inmoprofessional.ie/RCMAccess

Fixing our low pensions saving

Plans to introduce pension auto-enrolment are welcome, but ICTU has some concerns over its implementation, writes **Laura Bambrick**

WE are getting older. Not only as individuals but as a country too. Our birth rate is at the lowest since records began in 1864 and, at the same time, we are living longer than previous generations. Women can now expect to live to an average 83.6 years, and men to 79.9 years of age. As a result of these two trends – fewer babies and increasing life expectancy – almost one in four of our population will be over 65 years of age by 2055. •

Ill-prepared

Recent figures on pension coverage released by the State's statisticians at the CSO show that we are ill-prepared for population ageing.

Less than half of all workers are saving for their retirement in an occupational or private pension - 90% of public sector workers are, compared to only one in three workers (35%) in the private sector. At €248.30 per week, the contributory state pension is only slightly more than the minimum income required to prevent a pensioner from living in poverty.

Consequently, workers without a second pension to supplement their state pension are at risk of a major drop in their living standards in old age. In other words, while the state pension will keep the wolf from your door, it will not stretch to cover the holidays, dining out or other luxuries you had enjoyed on your pre-retirement income.

With the growth in the proportion of the population aged over 65, the importance of discretionary

Government's proposal	Congress's response
Target membership *Auto-enrolment will apply to all employees who are:* • Aged between 23 and 60 years • Earning €20,000 or above • Not a member of a pension scheme	• Include self-employed with no employees • Set lower age threshold same as PRSI – 16 years • Raise upper age threshold above 60 for new entrants • No lower income threshold
Contribution rates • Workers will contribute a minimum 6% gross earnings • Employers will match workers' contribution • State will contribute €1 for every €3 a worker saves • Contributions to be gradually phased in 2022-2027	• Workers' contribution graduated from 1% to 5% on first €20,000. A flat 5% contribution on remaining earnings • Employers contribute a flat 7% on all earnings • State contributes €1 for every €2.50 a worker saves
Opting out, re-enrolment and saving suspension • Participation will be compulsory for six months • Workers who opt out re-enrolled every three years • Workers can suspend contributions in limited circumstances • Employer and State contributions will stop if a worker suspends savings	• Merge the opt-out, re-enrolment and saving suspension features into a time-limited 'contribution holiday', which can be claimed as a single continuous period or any number of separate periods • Employer and State to continue contributing during a worker's contribution holiday
Operational model • Workers will have access to a range of retirement saving products from approved pension providers via a newly established Central Processing Authority (CPA) • Workers contribution will be deducted by employers directly from wages and transferred to the CPA. The CPA remit contributions to the pension provider	• Collect contributions in the same way as social insurance – the employer deducts the worker's contributions at source, the employer and worker contributions are then collected by Revenue and all contributions noted on payslip • Revenue to remit the contributions to a State fund
Service providers • CPA will tender every five to 10 years for four commercial providers for provision of pension saving products • Workers will be responsible for selecting one of the four providers and a saving option • A maximum fee of 0.5% per annum	• One provider, a public fund (eg. the NTMA) • The NTMA to contract out management and investment of proportions of the fund • The 0.5% maximum management fee is excessive
Draw-down arrangements • Workers can draw-down their fund at State pension age as a lump sum, annuity or other retirement products permitted under pension and tax law	• State provision of annuities that take the form of top-up payment on State pension, similar to an earnings related pension. The more contributions made by and on behalf of the worker, the higher their State pension

income in retirement is no longer solely a private matter. It is fast becoming a matter of grave importance to the economy as a whole. If consumer demand is to be maintained into the future, we need pensioners to have sufficient money to continue spending on non-essential goods and services.

Auto-enrolment

Congress has long highlighted the need for a change in policy to fix our low pension coverage. There is currently no legal obligation on employers to provide or contribute to an occupational pension for their workforce. Added to this, pensions are overly complex and not sufficiently understood to get low- and middle-income workers saving towards a financially secure retirement.

In 2022, the government will begin one of the most significant developments in supplementary pension provision by introducing 'auto-enrolment'.

Auto-enrolment will legally require employers to include all employees, who meet certain age and income criteria and who are not already members of an approved occupational pension, into a new retirement saving scheme and to make a minimum mandatory contribution. Workers will also have to make a minimum contribution into their pension pot, and this will be topped up by the State.

> *"Auto-enrolment has proven to be hugely successful at increasing pension coverage in many countries, including Australia, New Zealand and the UK"*

There will be a limited opportunity for workers to opt out of the scheme after a short period of compulsory membership. Upon opting out their personal contributions will be returned to them and their employer, and the State will cease making contributions to their pension savings. After three years, the worker will once again be automatically enrolled into the scheme by their employer, with the option to opt-out after the compulsory period has passed.

Auto-enrolment has proven to be hugely successful at increasing pension coverage in many countries, including Australia, New Zealand and the UK – countries with very similar pension systems to the Irish system.

Saving

Auto-enrolment will be an additional pension instrument alongside all existing measures.

It is not being introduced to replace or undermine either the State pension or tax relief on pension contributions.

The purpose of auto-enrolment is to get workers and employers who are currently not contributing to an occupational pension scheme to start saving for a financially secure retirement.

While we do have concerns around some features of the draft system the government has proposed *(see Table)*, Congress agrees in principle with the introduction of auto-enrolment as the most appropriate way of increasing pension coverage, income adequacy for pensioners, and employer responsibility to contribute to their workers' living standards in old age.

Laura Bambrick is social policy officer with the Irish Congress of Trade Unions

Advice for first year students

INMO student and new graduate officer, **Neal Donohue**, compiles the top 10 tips for nursing and midwifery students starting their first year of college

THE INMO Student Section and Youth Forums extend a very warm welcome to first-year students commencing their studies this month. You have entered a profession that can be as challenging as it is rewarding, and while you are busy learning to take care of patients and service users, it is imperative that you also learn to take care of yourself.

The INMO is a professional trade union that specialises in supporting and promoting the interests of nurses and midwives. I advise all students to avail of free INMO membership as you will often need advice and representation.

For those who do not know what a union is, we are a group of people who have joined together with a common interest to promote our profession and achieve the best possible standards for our members in the workplace and in society.

As the student and new graduate officer, I will update you on local, national and international issues affecting our professions. I will advise you on your rights and entitlements and on issues that affect you in third-level institutions and in hospitals and care facilities on clinical placement.

Members of the INMO Student Section and Youth Forums have offered their advice and experiences to help you in beginning your career.

Student tips

- You will face lots of challenges both in college and while on placement. Always remember why you started on this journey. It will help you to stay motivated and focused on the exceptional job a nurse/midwife does in helping people
- As a student nurse/midwife your experiences will differ from other third-level students. Plan well in advance for your accommodation and transport for clinical placements. This can be difficult for many students
- You will be expected to act in a professional manner all the time. Get used to reading policies and NMBI standards and guidelines such as the Code of Professional Conduct and Ethics for Nurses and Midwives. It is also essential to be aware of the NMBI guidelines on social media use for nurses and midwives
- Familiarise yourself with college supports and resources: college counsellors, students union, staff liaisons. People will always be available to help out if you have questions or need help
- Be organised. Use a diary, set reminders and never leave anything until the last minute. Stay on top of studying and assignments to avoid stress and always have your assessment documents ready for placement
- Someone's life may depend on your ability to ask for help. Nurses and midwives are required to have a diverse and specialised knowledge, but we work as part of a greater multidisciplinary team. Learn to be part of that team and people will be glad to help you learn
- Find balance between study, work and your social life. Try not to work too many hours or your grades and attendance will suffer. Get enough sleep, eat healthily, and if you find you are struggling, ask for help sooner rather than later
- Challenge everything. You will be expected to critically analyse everything. Do not be afraid to question what you see. New and innovative practices develop because people are not afraid to ask the question, 'why?' Whether you are applying for a grant or appealing academic decisions, there is a process of appeals that you may use. Know your rights and entitlements. Join the INMO and talk to the student and new graduate officer. You will have a better understanding of the system if you do
- On placement always have the basic equipment you need: a pen, notebook, scissors, fob watch and a good pair of shoes. Always carry a spare pair of gloves in your pocket. You will understand the need for this in time
- There will be placements that you don't like, and there will be times when you question whether or not you want to carry on. You will not always get on with your colleagues. Look for support – people are there to help you pass, not to watch you fail. There are many areas of the profession that you will love, and everyone finds a place where they feel at home. Work hard and be patient, you will get there.

If you are interested in learning more about the INMO, contact me. The student rep acts as an advocate and organiser for their peers and is a contact for the INMO. You will gain leadership skills and enhance your CV. You will also have the opportunity to positively influence your profession.

Neal Donohue is the INMO's student and new graduate officer. If you have a question about the above article, or need support or information, you can contact him at email: neal.donohue@inmo.ie or Tel: 01 6640628

This article was written with help from the INMO Student Section and Youth Forum representatives: Corinne Rushe, Niamh Donohoe, Roisin O'Connell, Niamh Pilcher, Melissa Plunkett, Laura Henry, Aoife Byrne, Jessica Collins, Elaine Smyth, Saoirse McGrath, Shannon Gilligan, Shauna Keevans, Lisa McGann and Susan Williams

Quality & Safety

A column by Maureen Flynn

Introducing changes to the National Open Disclosure Policy

IN THIS month's column, we bring nurses and midwives information on changes to the HSE National Open Disclosure Policy. Open disclosure is an essential element of all healthcare provision. Nurses and midwives have a vital role to play in being open and participating in open disclosure processes.

Why open disclosure is important

The ethos of open disclosure is to ensure that the rights of all people, patients and staff involved in and/or affected by patient safety incidents are met and respected, that they are communicated with in an honest, open, timely, compassionate and empathetic manner and that they are treated with dignity and respect.

Matters arising in CervicalCheck have again highlighted the importance of open, honest and empathic communication with patients during all the stages of their healthcare journey.

Communicating effectively with people in a compassionate, empathetic and thoughtful manner is a crucial part of the therapeutic relationship and can mitigate anxiety and enhance trust in the staff, organisation and healthcare system.

Revision of the policy

The Open Disclosure Policy was first launched in November 2013. It has now been revised and was relaunched by HSE CEO, Paul Reid on June 12, 2019. The revised policy[1] incorporates: the provisions of part 4 of the Civil Liability Amendment Act (CLA) 2017; the regulations accompanying part 4 of the CLA Act 2017; the Assisted Decision Making Capacity Act 2015; the recommendations made in the Scally Review 2018;[2] the HSE Incident Management Framework 2018;[3] learning to date from the open disclosure national programme.

The Open Disclosure Policy (2019)[1] recognises that "when things go wrong it may be due to a combination of factors including the vulnerability of those receiving care, the fallibility of those providing care and the dynamic and complex nature of the healthcare environment".

Principles of open disclosure

1. Acknowledgement
2. Truthfulness, timeliness and clarity of communication
3. Apology/expression of regret
4. Recognising patient and carer expectations
5. Staff support
6. Risk management and systems improvement
7. Multidisciplinary responsibility
8. Clinical governance
9. Confidentiality
10. Continuity of care

The policy applies to patient safety incidents and reflects the primacy of the right of patients to have full knowledge of their healthcare as and when they so wish and to be informed about any failings in that care process, however and whenever they may arise *(see box)*. Patient safety incidents include harm events, no harm events and near miss events.

Open disclosure legislation

The independent evaluation of the open disclosure pilot programme in Ireland[4] identified fear of litigation and fear of being reported to a professional body as two of the main barriers for staff to open disclosure. Part 4 of the Civil Liability Amendment Act 2017 was commenced in September 2018. This Act contains certain protective provisions for staff when they engage in open disclosure in that the information and apology provided shall not be admissible as evidence of fault or liability in civil proceedings in a Court of law, and/or fault or professional misconduct in a fitness to practise hearing and shall not invalidate medical indemnity insurance. To avail of the protections of this Act open disclosure must be managed strictly in accordance with the procedure set out within the Act and the eight regulations which accompany it. The regulations are a series of prescribed statements that must be completed, signed and provided to patients or relevant person throughout the process. The forthcoming Patient Safety Bill, which is currently being drafted, makes provisions for reporting and disclosure of serious harm events becoming a mandatory legal requirement.

Opportunity to get involved

The open disclosure policy provides excellent support to nurses and midwives in upholding the quality and safety of the healthcare environment. Our code of professional conduct and ethics expects that "safe, quality practice is promoted by nurses and midwives actively participating in incident reporting, adverse event reviews and open disclosure".[5] At our next team meeting we might consider:

- Does our service operate an open disclosure policy?
- Have we attended training in open disclosure, which is now mandatory for all HSE staff?
- Do we record open disclosure in the patience healthcare record and national incident management system?
- Is open disclosure on the agenda for our quality and safety committee?

Further information

The HSE has established a National Open Disclosure Office which can be contacted at opendisclosure.office@hse.ie if you need advice or support. A national steering committee has been established to oversee the implementation of the open disclosure programme.

Maureen Flynn is the director of nursing ONMSD, QI Connections Lead, HSE National Quality Improvement Team

Acknowledgements
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Spotlight on: Emma McGorman

EMMA McGorman is a newly qualified general nurse working in Letterkenny University Hospital in geriatric specialised care. She loves working with older people and often forms a bond with her patients. When Ms McGorman was younger, her grandmother lived with her family and looked after her as a child. However, when her granny became ill in later life, their roles were reversed and she took on much of her care. Their bond was strong and Ms McGorman realised that she wanted to go into nursing.

Previously, Ms McGorman worked as a care assistant in St Joseph's, Monaghan. This gave her a foundation in healthcare and alerted her to the need to provide safe and effective care in a timely manner. She is passionate about caring for people and campaigning for better healthcare resources, particularly in Donegal. She decided not to leave Ireland to seek work abroad, but to stay and fight for a better system. She sees great potential in the Irish health service and the nursing and midwifery workforce.

"We train so hard and it is difficult to watch people forced to move abroad or change professions. We need to keep our newly qualified nurses here otherwise there is no future for the health service."

Ms McGorman is an INMO rep in her workplace and has been a trade union member since she was a student. She feels that the union is the backbone of any workforce.

"Nursing is changing every day but to see more effective change we need a strong union and proactive members supporting one another.

"Being a member of a union gives us some relief knowing that the union will provide a voice for our profession. It also provides a great network of peer support and opportunities to develop skills and access up-to-date learning and education for my own professional development. More newly qualified nurses should join the union, not only for the support it brings but for the professional development opportunities it offers."

Emma McGorman: "Every day is a challenge – you go in not knowing what might happen but you give it your all regardless"

Ms McGorman is also a member of the European Nursing Student Association (ENSA), an organisation for co-operation between national nursing student organisations or colleges of nursing in Europe. The purpose of ENSA is to bring together European nursing students and representatives from all countries across Europe to discuss both practical and theoretical elements of education, look at the differences and similarities, give and receive advice, and help each other understand the world of nursing.

Ms McGorman believes that without informed and supported student nurses and midwives, our healthcare system cannot move forward. She sees her role with ENSA as one where she can share the knowledge she acquires from her colleagues in the network with student nurses and midwives back in Ireland, in order to better support them.

Ms McGorman would like to see greater clinical responsibilities for nurses with more focus on research and audits. She feels that a preceptorship for newly qualified nurses and midwives would be useful to help them with their transition. She would also like to see increased focus on care plans for patients and more time allocated to taking a personal approach when dealing with patients, their families and student nurses and midwives. She feels there is a need to start developing leadership skills as part of nursing and midwifery training.

"Every day is a challenge – you go in not knowing what might happen that day, but you give it your all regardless. You need good communication and the ability to work as part of a team. That personal touch and ability to connect with patients is so important. We go above and beyond our role daily and make clinical judgements."

Ms McGorman works in Letterkenny and dedicates much of her time to highlighting the need for greater supports and resources for healthcare provision in Donegal, which she calls "the forgotten county". She will be representing Europe (ENSA) in Brussels at the European Commission on Vaccinations Summit on September 12.

This article is part of our Nursing Now series. Nursing Now is a worldwide campaign that aims to achieve recognition of nurses' contribution to healthcare, gender equality, the economy and wider society. The aim of the campaign is to improve health globally by raising the profile of nurses worldwide and influencing policymakers and supporting nurses to lead, learn and build a global movement. For more information visit ***www.nursingnowireland.ie***

Combating heart failure one nurse at a time

The Irish Association of Heart Failure Nurses is constantly expanding the scope of its practice, writes **Norma Caples**

HEART failure is common, costly and progressively life limiting. It is estimated to affect about 90,000 people in Ireland and approximately another 160,000 people are living with impending heart failure. These numbers are on the rise due to our ageing population and increased survival following myocardial infarction. However, many people have asymptomatic left ventricular dysfunction, uncontrolled hypertension and diabetes. This, along with improved treatment for those with established heart failure, is leading to these people living for a longer time period.

Members of the Irish Association of Heart Failure Nurses attending the Heart Failure Meeting in Athlone in May

Despite proven efficacy, heart failure therapy is under-prescribed and, as a consequence, the role of the heart failure nurse became notable during the 1990s when many studies showed a significant benefit in care to both the patient and the health care system using specially trained nurses as part of a structured disease management programme. These programmes have led to well documented reductions in hospital readmission and structured follow up care that focuses on the optimisation of therapy, out-patient follow up and education for self-care. Self-care in a heart failure context is commonly poor and vulnerable to challenges such as advancing age, cognitive decline, poor health literacy and low levels of social support.

There are currently 66 heart failure nurses working in the HSE. Within this group there is one ANP, two candidate ANPs and 30 registered nurse prescribers. The majority of these nurses work in the acute setting with a few working in the community. A recent review of heart failure services showed that we now have over 11,200 patients attending our services.

Many heart failure centres operate with just one nurse specialist. This can be incredibly isolating in practice development terms as communication between our nurses was limited to attendances at educational meetings until 2018 when we set up a WhatsApp group. This group chat has facilitated an informal networking bond. Sharing of experience now flows easily among nurses, who can now seamlessly share knowledge, practical advice and recently published evidence. This is especially useful for those who don't have another heart failure nurse in their service. This connectedness facilitates peer support, the sharing of ideas and promotes a solution-focused problem solving approach.

In March 2019, we formed the Irish Association of Heart Failure Nurses as a subgroup of the Irish Nurses Cardiovascular Association (INCA). Our inaugural committee comprises Norma Caples, president; Cathy Farrell, vice president; Tara Mannion, secretary; Mairead Lehane, treasurer and Sarah Fall, PRO. Sarah Fall established our Twitter (@IAHFNurses) and Facebook accounts where we post updates on heart failure care and aim to raise public awareness of the signs and symptoms of heart failure. We feel that it is important for every cardiology nurse to be part of their national association. The networking, sharing of knowledge and experience is invaluable to creating a uniform standardised care. Bursaries are available to help nurses further their education through college or attendance at cardiology conferences.

The initial goal of this first committee was to establish the association and share education among heart failure nurses nationally, promote the work of our nurses with the aim of achieving cohesive and equitable services for all our patients. Our next goal is to support the travel of some of our heart failure nurses to the European Heart Failure Congress 2020 in Barcelona. What better way to keep our knowledge and skills at the cutting edge of European and international best practice than to experience it first hand by interacting with the primary investigators and authors? This opportunity to update the group on new developments will also benefit practice development opportunities locally.

Our group is committed to improving services for our patients and we showed this enthusiasm when we commenced our first national project in 2018. The project focused on auditing the practice of treating heat failure patients with intravenous iron as per the 2016 ESC guidelines on heart failure. Our aim was to submit a poster presentation at the Heart Failure Congress in Athens 2019. We surpassed this aim when ours was chosen for 'moderated poster'. Michelle Carey from Tallaght University Hospital did us proud with the presentation of our work. We plan to use the results to work on improving this area for our heart failure patients.

We are currently working with the team for the National Clinical Programme for Heart Failure on developing educational resources for nurses about the management of heart failure patients. Combining the collective knowledge, skills and experiences of 66 heart failure experts should prove an engaging resource.

Current updating of the heart failure model of care is timely as we brace ourselves for a substantial health service challenge and embrace the principles of Sláintecare in making care as patient-centred as possible.

Norma Caples is the nurse lead on the National Clinical Programme for Heart Failure

The business case for breastfeeding

On purely economic grounds it is in government's interest to promote and support breastfeeding. **Alison Moore** reports

A NEW mother faces choices whether or not to breastfeed her baby, exclusively or in combination, and for how long. While there are myriad complex reasons why breastfeeding rates in western countries, particularly in Ireland, remain poor, according to health economist Dr Subhash Pokhrel, like any other "lifestyle decision", this choice offers both incentives and disincentives, of which cost is one.

Speaking at the 14th international breastfeeding and lactation symposium held earlier this year in London, Dr Pokhrel, head of the department of clinical sciences at Brunel University London, argued that health economists assert that a new mother is more likely to choose to breastfeed if she feels there are more incentives than disincentives.

"My interest is in return on investment analysis in public health and this includes breastfeeding. Breastfeeding is protective in a number of diseases in infants, for example, the infections of the gut and lower respiratory tract. Also, in preterm babies, there is a condition called NEC (necrotising enterocolitis) and breastfeeding is protective against that.

"If more women chose to breastfeed their babies, then there would be less incidence of those diseases. And therefore healthcare systems will have to spend less money in treating those diseases. And that money could be freed up to spend somewhere else," he said.

Dr Pokhrel told those attending the symposium that in 2012 he was involved in a UK study which showed the NHS could save a significant amount of money if breastfeeding duration was improved.

"We found out that the NHS could save about £40 million a year by improving breastfeeding rates. And that is simply by supporting those women who have already chosen to breastfeed to continue longer and to breastfeed exclusively," he said.

In other words, if the UK government invested in support services to assist those women who are already choosing to breastfeed to sustain breastfeeding for longer, there is a straightforward cost benefit to the exchequer reflecting a positive return on investment.

Dr Subhash Pokhrel, speaking at the breastfeeding and lactation symposium in London

Dr Pokhrel said that this was the first time the cost benefit of breastfeeding to the health service had been quantified, as while everyone assumed an economic benefit, it had not actually been demonstrated.

"It was a study that quantified that breastfeeding is a lifestyle choice that is made by the woman. But, you know, we can support women to make that decision and there are a number of facts that need to be provided to women so that they can make the right decision," he said.

Due to other factors that have an influence on whether a mother chooses to initiate breastfeeding, Dr Pokhrel said that these disincentives need to be addressed.

"Because it is a choice, women actually look at the incentives and disincentives, such as breastfeeding being time consuming and that the time spent breastfeeding could be used to do something else. Also, there is a negative relationship between employment and breastfeeding, etc, so we need to look at all those disincentives and then think about how to incentivise women to breastfeed, to breastfeed more and to breastfeed for longer," he said.

Dr Pokhrel added that if women heading into maternity leave know that they will be returning to a breastfeeding friendly workplace it will encourage them to first choose and then to persevere with breastfeeding as they won't be forced to start weaning from the breast in a shorter timeframe. The knock-on benefit of this to the economy is fewer cases of illness among babies.

"What turns out to be disincentive in the first instance can be turned into incentives for women to choose to breastfeed. Breastfeeding is good for infants, but breastfeeding is also good for mothers. And breastfeeding is good for healthcare systems and for society. One of the ways to look at it is that breastfed children usually have better cognitive outcomes, which will eventually lead to better national income, because they have better productivity.

"So, in the long run, breastfeeding actually pays back all the support costs that we provide to improve the breastfeeding rates now," said Dr Pokhrel.

How low should you go?

Deciding on a safe threshold is one of the challenges in managing blood pressure in diabetes, writes **Niall Hunter**

PROF Maeve Durkan, consultant endocrinologist at the Bon Secours Hospital, Cork and incoming president of the European Union of Medical Specialists Board of Endocrinology, told this year's DICE conference that 140/90 has been the traditional benchmark for blood pressure (BP) treatment but the question was: how low to go and is there a J curve? Is there a point below which we do not go?

"If we have a patient at 115/75, we know that it's the threshold epidemiologically in literature. If your patient is at this level and they feel well, the physician may well ask 'ultimately am I not doing a good job here?' However, ultimately you are not."

Prof Durkan said there was a clear J curve, probably at 120 in the absence of microalbuminuria. If a patient gets to 115, and a diastolic value of 75 and you are driving under that, you are probably creating harm.

"Why are we managing hypertension in diabetes? A patient may say he feels well, but the bottom line is avoiding the clinical endpoints – early heart disease, heart failure, kidney disease and microalbuminuria."

Prof Durkan said in type 1, glycaemic control is focused on, but in type 2 it is not all about sugar control, and there has been a tendency to be very 'glucocentric' in type 2.

"The STENO-2 trial on mortality in type 2 showed we need to look at sugars but we also need to look at BP and cholesterol, and if there is multifactorial intervention we will do better with management."

Prof Durkan said trials have shown if you have good A1C reduction and good BP control, you will get better effects than if you are targeting each independently.

"Cardiovascular mortality rates and events are coming down, and they are also reducing in people with diabetes, but the problem is they are not coming down as quickly as in the general population, so we still need to be aggressive about interventions in people with diabetes."

On the measurement of BP, Prof Durkan said a single office reading is useless as this is a single moment in time and not representative. The ideal way to measure is through automated office blood pressure monitoring over a period of time, while the gold standard is 24-hour monitoring, which should be part of the annual diabetes visit.

Once the patient is confirmed as hypertensive, the older guidelines will say target to 140/90; previous evidence was not compelling to drive down hypertension to 130/80 in patients with diabetes; however, more recently, this has changed. The American Heart Association has in the past year recommended a target of < 130/80 if the patient is consistently above this and the American Diabetes Association recommends a target of 125 to 130, while the European Society for Hypertension has recommended targeting < 130/80 for both type 1 and type 2.

Does treating to 120/80 impact positively or negatively on risk? Prof Durkan outlined the many recent clinical trials in this area, including ACCORD, ADVANCE, HOT and INVEST. However, she said if you are looking for a signal on benefit versus harm, you can't rely on a single study, especially in terms of recommended drug treatment.

"You'll need to look at consistencies in terms of benefit and in terms of thresholds for benefit versus harm. The HOT trial included diabetes patients and looked at diastolic hypertension. It found that in patients with diabetes, the lower the diastolic value achieved the better, and indicated a 50% relative risk reduction in events when the diastolic BP was lowered to < 80."

In the ACCORD trial in just under 5,000 diabetes patients, BP was titrated to < 120 versus 140. In the latter arm the average achieved blood pressure was 133.9, while in the more intensive reduction arm BP of < 120 was achieved.

"What unexpectedly emerged from this trial was a relative risk reduction in stroke of 41% in the < 120 systolic blood pressure arm. This was a very interesting signal that potentially within the stroke risk group a threshold of 120/80 may be an appropriate target. This has also been indicated in at least two other trials."

On patients with nephropathy, Prof Durkan said macroalbuminuria is always concordant with a decline in GFR.

"If you can halt progression of microalbuminuria you will halt the progression of renal failure. And if you can facilitate regression of macroalbuminuria, it will follow that the GFR will improve. Achieving a BP of 120/80 appears to favour macroalbuminuric CKD in diabetes; however, GFR level needs to be watched."

Prof Durkan said it was not just about pharmacological management in hypertension, as diet, salt intake and alcohol for example were also significant factors.

On obesity and hypertension in diabetes, Prof Durkan asked if in a hypertensive and obese patient with type 2, in which the obesity is driving the hypertension, can one choose a treatment that addresses both?

"If a patient is 140/90 and needs to go on a blood pressure tablet, it is advisable to look at A1c to see if they have heart failure, kidney disease or microalbuminuria, and you might ask if there is a drug that can address all of those as well as weight loss. There is a circular relationship between diabetes, heart disease and CKD."

On whether to use a single or double therapy in hypertension, Prof Durkan said she would always start with one agent.

"If the patient has a side effect then I know it is that drug and I move on to another one. There is data that suggest maybe you should start with a combination drug at a lower dose. Every time I pick a drug, if I am picking a single agent to start with, I will pick an agent that's available in combination, as this aids compliance (if the number of tablets needs to be increased)."

Looking at BP drugs, Prof Durkan referred to A, B C and D:

- *A* – ACE inhibitor or angiotensin receptor blocker
- *B* – Beta-blocker
- *C* – Calcium channel blocker
- *D* – Diuretic (thiazide).

NICE and the British Hypertension Society provide a four-step guide on using these drugs singly or in combination.

"You're fitting the suit for different patients, targeting different therapy or combinations according to the patient."

Prof Durkan said in general, BP targets for those at risk should be:

- 130/80 – lifestyle changes recommended; but failing that, start treatment
- 130/80 without microalbuminuria
- 130/80 for stroke prevention
- 120/80 with microalbuminuria.

In most cases the lower the better, but kidney function needs to be monitored.

Managing psoriasis

People with psoriasis need sound guidance on how to self-manage their condition to best maintain quality of life, writes **David Buckley**

PSORIASIS is a common, chronic, skin condition that usually presents as scaly plaques in the elbows, knees or scalp. However, psoriasis can affect any part of the body. It affects about 2% of the population and approximately 50% of patients with psoriasis will have another family member who is affected as there is a strong hereditary component. There may also be environmental triggers such as streptococcal throat infections and medication such as lithium, beta blockers, antimalarials or sudden stopping of oral or potent topical steroids *(see Table 1)*.[1]

In many cases, psoriasis can begin with no obvious trigger. Chronic plaque psoriasis most commonly occurs in adults with two peaks: one in the late teens and the second in patients in their fifties. Some patients have very mild psoriasis that is barely visible while others can have extensive psoriasis covering large areas of their body. Psoriasis can also affect the face, genitalia, nails and joints. Treatment will depend on the severity of the disease, the location and the age of the patient.

Many patients with mild psoriasis may choose to ignore it which is perfectly acceptable as they often learn to live with the disease. It is important to assess the patient's ideas, concerns and expectations with regard to their psoriasis. Some patients with even mild psoriasis may be very upset with their perceived unsightly appearance of the rash and may have unrealistic concerns or expectations regarding treatment.

Many patients with mild psoriasis can manage their own disease by moisturising with a good greasy moisturiser such as emulsifying ointment or Epaderm ointment which should be rubbed downwards, twice a day, on the affected areas. These moisturisers are very greasy but are very effective at reducing the silvery scale that makes psoriasis so obvious *(see Table 2)*.

Psoriasis can often affect the scalp and can be linked with underlying dandruff or seborrhoeic dermatitis. A good dandruff shampoo such as Head & Shoulders, Nizoral or Stieprox may help to control the underlying dandruff and improve the psoriasis affecting the scalp. These should be used regularly at least three times a week and should be left to soak into the scalp for a few minutes before rinsing out. Patients with psoriasis on their scalp should avoid wearing dark clothes as these will make the dandruff more visible.

For more resistant scalp psoriasis in adults Etrivex shampoo may help but the treatment should not normally be used for more than one month. It contains a super potent topical steroid (clobetasol propionate) which is also found in Dermovate.

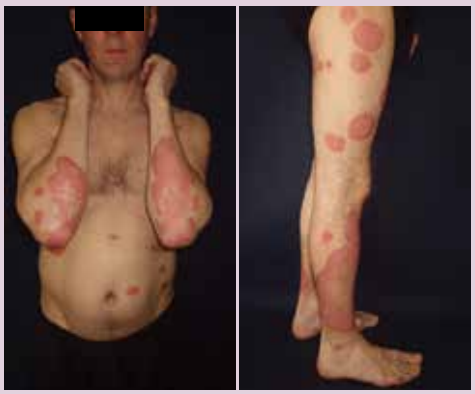
Most patients with chronic plaque psoriasis will improve with sunlight. However, 10% may get worse in the sun. For those who improve in the sun, natural sunlight is probably best but they should avoid getting sunburnt as this may make their psoriasis worse as a result of the Köbner phenomenon. Artificial sunlight from sunbeds should be avoided as these are predominantly UVA and can sometimes aggravate psoriasis. Some patients with severe extensive psoriasis may benefit from phototherapy in hospital dermatologist outpatients using narrow-band UVB or PUVA phototherapy.

Psoriasis is a chronic, inflammatory condition which increases the risks of developing the metabolic syndrome as a result of chronic, subclinical vascular inflammation which results in

Table 1: Drugs that may trigger or aggravate psoriasis or cause an psoriasiform eruption[1]

- Alcohol in excess
- Antimalarials, eg. chloroquine and hydroxychloroquine
- Lithium
- Beta adernegic antagonists, eg. Atenolol
- Angiotensin-converting enzyme inhibitors (ACE inhibitors)
- Sudden withdrawal of potent topical or systemic steroids
- Antibiotics, eg. tetralycline
- NSAIDs
- Interferon
- Terbinaifine
- Benzodiazepines
- Nicotine may aggravate palmoplantar, pustular psoriasis (also known as palmoplantar pustulosis)

Figures 1 and 2: Chronic plaque psoriasis in a 44-year-old man



arteriosclerosis. This increases the overall risk of cardiovascular disease and type 2 diabetes. Patients with the metabolic syndrome are at two to four-fold increased risk of stroke, a three to four-fold increased risk of myocardial infarction and a two-fold increased risk of dying from such an event when compared to those without the syndrome, regardless of previous history of cardiovascular events.[2] Treatment of the metabolic syndrome is lifestyle modification including weight loss, low sugar, low-fat diet and more aerobic exercise.

Psoriasis is not caused by food allergy. However, rare cases have been linked with coeliac disease and it may be worth considering a gluten-free diet in patients with positive coeliac antibodies or a positive family history of coeliac disease.[3] A healthy diet rich in oily fish, green leafy vegetables, carrots, tomatoes and fresh fruit may help.[4] Recent studies have suggested that a Mediterranean diet may also help psoriasis.[5]

Alcohol in excess is well-known to aggravate psoriasis so patients should be encouraged to keep their alcohol intake to a minimum and certainly not to exceed the recommended limits of 14 units per week.

Depression is more prevalent in people with psoriasis. Patients with severe psoriasis are more than three times more likely to suffer depression compared to controls.[6] Treatment of the psoriasis may help the patient's mood. Patients with psoriasis and depression may need counselling or medication to control their depression while they are trying to improve their psoriasis using various treatments. Stress reduction techniques, meditation and exercise may help their mood.

Patients need to know how to use the various medical treatments for psoriasis. The most common treatment for chorionic plaque psoriasis affecting the body is either Dovobet gel or Enstilar foam. Both of these products contain the same ingredients which is betamethasone (a potent topical steroid) and calcipotriol (a vitamin D analogue). The foam preparation seems to be more cosmetically acceptable and more effective than the gel formulation, which is easier to use on the scalp.[7]

The advantages of Dovobet and Enstilar are that they are relatively quick to improve the appearance of the psoriasis plaques and can be used in a convenient once a day application which usually does not burn, sting or stain the skin. The disadvantages are that they are expensive and do not work on all patients with psoriasis.

Table 2: Top 10 self-care tips for people with psoriasis

1. Moisturise liberally with a safe, greasy moisturiser at least twice a day
2. Wear light colour clothes as they will help hide dandruff and silvery scale
3. Avoid excessive alcohol (keep to < 14 units per week) and do not smoke
4. If you are overweight, try to lose some
5. Try a 'Mediterranean diet' for at least three months
6. Get plenty of aerobic exercise
7. Ask your doctor to check your cholesterol, blood sugar and blood pressure annually if you are over 35 years old
8. Remind yourself and everyone else that psoriasis is not contagious
9. Try a to stay positive; psoriasis is very common and treatable
10. Carefully follow the instructions about your treatment from your doctor or nurse. If you are unsure, ask questions. Return for your follow up visits

For more information, visit www.irishskin.ie

They cannot be used on the face and they are not licensed for people under the age of 18 years old. The maximum dose of Dovobet in adults is 15g a day or 100g a week for acute management of psoriasis in the first month of treatment and it should not be used on more that 30% of body surface area. It should be applied once daily for the first two to four weeks and then gradually reduced to alternate days or twice a week as the psoriasis improves. Enstilar Cutaneous Foam can be applied up to 15g per day (0.5g covers the equivalent of an adult hand; 0.5g corresponds to the amount administered from the can if the actuator is fully depressed for two seconds). If the psoriases affects 12% of the body surface area (1% BSA is equivalent to the size of the palm of the hand), an adult patient would need 6g a day or three cans over a month.

Dovobet and Enstilar contain potent topical steroids that may cause skin atrophy which can look like partially treated psoriasis and there may be systemic absorption with adrenal suppression particularly if high doses are used. A rebound flare of psoriasis can occur if these potent steroid combinations are stopped suddenly. If possible, the patient should be slowly weaned off Dovobet gel or Enstilar foam and onto Dovonex cream which contains only calcipotrol but no steroid. This can be used daily and indefinitely until the psoriasis is fully cleared or improved to an acceptable level.

Dovobet and Enstilar are safe and effective but will only work in up to 60 to 70% of patients with chronic stable plaque psoriasis. They are not suitable for children. In these cases, dithranol is extremely safe and effective, although more messy and time consuming to use. Dithranol contains anthralin which is a chemical of plant origin taken from the bark of a South American tree. Short contact treatment using a preparation called Dithrocream is the most convenient way to use dithranol for home treatment. The weakest strength (0.1%) is applied for 30 minutes daily for one week to the plaques on the body and scalp but not on the face or genitalia. If the psoriasis does not clear and the Dithrocream does not burn the skin, patients should increase to the next strength. There are five strengths, so it takes five weeks to get up to the maximum strength of 2%. Up to 90% of patients will clear their psoriasis with this treatment but it causes considerable brown staining of the skin which may take a few weeks to fade once the treatment is stopped. It may also cause burning of the skin and if this happens the patient has to stop the treatment and go back to their previous strength.

The patient needs careful instructions about how to safely use these topical agents and the advice should be supported with written information that they can take home. This should help with improving compliance and reducing the risk of side effects.

Psoriasis on the face and flexures is usually less thick and scaly than other parts of the body and will often respond to 1% hydrocortisone ointment. More resistant psoriasis on the face or flexures may respond to tacrolimus (Protopic), although this ointment is not licensed for this indication.

More extensive, severe or resistant forms of psoriasis will probably have to be referred to hospital for phototherapy or systemic treatments such as methotrexate, fumaric acid or some of the new biological agents.[8]

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References available on request. email nursing@medmedia.ie (Quote Buckley WIN 2019: 27 (7): 53-54)

Focus on: ulcerative colitis

Helen O'Donovan and Valerie Byrnes discuss case studies of patients with ulcerative colitis who presented at the emergency department

A 21-YEAR-OLD man presents to the emergency department with a two-month history of diarrhoea, *pr* bleeding and abdominal pain. His bowels were opening at least 10 times per day with resultant weight loss and expected effect on his work and social life. Colonoscopy performed at this time showed features of left-sided colitis predominantly in the rectum and rectosigmoid junction. Biopsies were in keeping with a diagnosis of ulcerative colitis (UC).

He was treated with mesalazine enemas which led to symptomatic relief for a month. Unfortunately, his symptoms returned, and he was again admitted to hospital. Repeat colonoscopy revealed moderately inflamed, erythematous and haemorrhagic mucosa. He was treated with IV hydrocortisone 100mg *qds* steroids initially but did not respond. The decision was made to commence biologic therapy using infliximab. Infliximab is an effective second-line therapy in acute severe UC, with 85% of patients responding by day seven and improvement in colectomy-free survival.[1]

Infliximab is anti-TNF therapy and is one of the biologic therapies available for the treatment of acute severe UC. Other anti-TNF options include adalimumab and golimumab. Vedolizumab is an alternative biologic therapy that exerts anti-inflammatory properties by binding to a gut specific integrin.[2]

These therapies are used to induce and maintain remission, as well as avoid prolonged corticosteroid therapy. It is vital to perform a biologic screen prior to starting treatment. This includes ruling out latent tuberculosis (TB) and viral infections.

Infliximab is an IV infusion. The recommended infusion regime is with infusions given at weeks zero, two and six, and then eight-weekly thereafter. The recommended dose for treatment of UC is 5mg/kg. Higher doses of up to 10mg/kg have been found to have similar efficacy.[3] Some patients get accelerated protocols. Drug and antibody levels can be checked to guide the appropriate dose of treatment and monitor response. The patient responded well to treatment with a marked improvement in symptoms.

Since discharge, the patient reports ongoing improvement. Bowel motions returned to normal and there was no further bleeding or abdominal pain. He was advised to continue infliximab infusions and will be followed up regularly in the outpatients department.

Case 2

A 31-YEAR-OLD man with a diagnosis of ulcerative colitis since 2010 presents to ED with increased bowel frequency, > 20 times per day, *pr* bleeding, lower back pain and tenesmus. He had not required any treatment up to October 2017. He received oral and topical therapy initially in the form of mesalazine as well as three courses of prolonged-release budesonide (Cortiment).

Approximately 90% of orally administered budesonide undergoes first pass metabolism resulting in low bioavailability and resultant reduction in the conventional systemic side effects of corticosteroid therapy.[4] Cortiment tablets have a gastro-resistant coating that dissolves in lower intestinal fluids with a pH of > 7, acting topically on the colon and minimising systemic absorption. Despite three courses of steroids in a short period of time the patient failed to respond.

The decision was made to commence biologic therapy. He was started on adalimumab, an anti-TNF therapy administered by subcutaneous injection every two weeks. There was a suboptimal response to this, so the frequency of treatment was increased to weekly. However, the patient became symptomatic in July 2018 requiring a further course of steroids. Colonoscopy at this time revealed severe colonic ulceration and ulcer slough. Signs of chronic active inflammation with crypt abscess formation were seen.

He was switched to infliximab in an effort to elicit a response. He continued to have persistent diarrhoea and began to lose a significant amount of weight. He was admitted due to symptoms in September 2018. X-ray of the abdomen was performed due to concern regarding toxic megacolon. This revealed marked colonic wall oedema of the transverse colon. The discussion regarding surgical options was broached with the patient. He was initially reluctant but remained quite symptomatic.

Colonoscopy revealing severe colonic ulceration and ulcer slough. Signs of chronic active inflammation with crypt abscess formation visible

Surgery for ulcerative colitis can be emergency, urgent or elective.[5] This patient fulfilled the criteria for urgent colectomy. It is estimated that 15-20% of patients hospitalised for a flare of UC will require surgery in the same admission.[6,7] When urgent surgery is indicated, a total colectomy with end ileostomy is usually performed.

Following surgery, the patient remained well. He gained weight and was managing well with the ileostomy. He was reviewed in clinic two months post surgery. Inflammatory markers had normalised. He was passing normal contents through the stoma and did not have abdominal pain. He did not require medication.

UC can have varying degrees of severity depending on the duration and extent of disease. Response to treatment is variable and can be relatively unpredictable. Fortunately, today, there are a number of treatment options available with new therapies emerging. Surgery remains a curative and sometimes life-saving option.

Helen O'Donovan is a gastroenterology senior house officer and Valerie Byrnes, is a consultant gastroenterologist at University Hospital Galway.

References available on request by email to nursing@medmedia.ie (Quote: O'Donovan H. WIN 27; 7:56)

Postpartum psychosis: Knowing the warning signs

Early identification is key to the outcomes of women with postpartum psychosis, writes **Pauline Walsh**

FOR most women, having a baby is a time of great joy. For a small minority, however, the birth of a baby can result in a major mental health condition, perhaps for the first time. The National Institute for Health and Care Excellence (NICE) guidelines estimate that up to 20% of women will experience a perinatal mental health disorder with a depressive disorder being the most common.[1] The National Perinatal Mental Health Report in the UK states that mental health in the perinatal period is a major public health concern.[2]

In Ireland, the Confidential Maternal Death Enquiry in 2015 found that the incidence of deaths in the first postnatal year due to suicide was higher than the incidence of deaths resulting from pre-eclampsia and eclampsia.[3] The report further states that the incidence of maternal suicide is equal to the incidence of maternal deaths due to thrombosis and thromboembolism.

The Scottish Intercollegiate Guidelines Network highlights that postpartum psychosis is a devastating mental health condition that affects approximately one in every 1,000 births.[4] It is considered a severe and potentially life threatening condition for both mother and baby with approximately 5% of these women ending their life by suicide and 4% committing infanticide. The risk of developing the condition rises significantly to 20-30% for women with a history of bipolar disorder or who have a history of postpartum psychosis.

In the Irish context, the 10th revision of the WHO International Classification of Diseases (ICD-10) is the nationally accepted diagnostic framework. The ICD-10 considers the postnatal period to be the first four weeks post delivery in the context of postpartum psychosis.

Causes and risk factors

The risk factors for postpartum psychosis, as outlined by the NICE guidelines, centre around a history of mental illness, specifically bipolar affective disorder and a first degree family history of a postpartum mental health issue.

The NICE guidelines further emphasise that factors unique to the perinatal period that increase the risk of developing a mental health disorder relate to discontinuation or changes in medication during pregnancy. Lewis et al establish that sleep deprivation or sleep cycle disruption around the time of labour and birth, as well as the huge hormonal shifts following birth, are risk factors unique to the perinatal period.[5] Di Florio et al identified that first pregnancies may be a risk factor in their own right.[6]

Morrison et al determined that psychological risk factors for all types of psychosis include a history of trauma, difficult life experiences and personality factors.[7] Frissen et al found that people with psychosis reported more childhood trauma than their siblings or the non psychotic control group.[8]

Kuipers et al advises that social risk factors for all types of psychosis are considered to be age, ethnicity, gender, low educational achievement, history of drug use, income and belief system.[9] The authors further state that these psychosocial factors may impact on the person's help seeking behaviours and treatment engagement.

Presentation

The ICD-10 uses the code F53 to describe mental and behavioural disorders associated with the perinatal period. It states that diagnostic criteria for psychosis should be fulfilled and that once these diagnostic criteria are reached and the perinatal time period is applied, only then can the code F53 be used. Bergink et al studied almost 7,000 postpartum women with perinatal mental health issues and found that the median timeframe for the emergence of psychotic symptoms is eight days post-delivery.[10] The study also found that the median duration of the psychotic episode was 40 days. Several research studies, including Verinder and Dwight, have detailed the rapid progression of the illness and many state that from first report of early symptoms, there can be as little as 48 hours until a fully established postpartum psychosis.[11]

According to Monzon et al, the clinical features of the condition can be categorised into the following features:

- Cognitive – poor concentration, impaired orientation
- Behavioural – agitation, hyperactivity, emotional distance, coldness or perplexity
- Mood – elated, labile, dysphoric or occasionally depressed.[12]

The authors also advise that the woman's facial expression and body language would most likely be flat or incongruent and that her speech may be rambling. They state that there can be serious thought content changes, including thought broadcasting, ideas of reference, thoughts of the infant being harmed or killed, persecutory ideas, jealousy or the thought that she is being controlled. The woman's thought process would be disorganised and she might also have flights of ideas.

Monzon et al further advises that perceptual disturbances can take the form of visual, olfactory or tactile hallucinations and the woman may experience command auditory hallucinations. Sleep disturbances

are present in almost all cases. In Lewis et al, research involving 870 women found that 95% described sleep loss in the period before the onset of symptoms.

Treatment

Unfortunately, most women who develop postpartum psychosis will require hospital admission. The Health Research Board reported that 18 women were admitted to psychiatric units in Ireland in 2016 with a primary diagnosis of postpartum psychosis – ICD-10 code F53.[13] Another six women with postpartum psychosis were treated in maternity units, according to the Hospital In-patient Enquiry for the same period. The Specialist Perinatal Mental Health Services Model of Care for Ireland says that this number under-represents the true figures due to discrepancies in how the data is recorded and collected.[14] It further states that should an admission be required, the woman should be offered admission in a mother and baby unit. Such a unit has been proposed for Dublin but no such unit currently exists in Ireland.

The treatment of postpartum psychosis initially centres around pharmacology. Bergink et al highlights that due to the severity of the condition and the increased risk to the life of the mother and her baby, pharmacological treatment is initiated immediately.[15] The study highlights that no formal treatment guidelines exist for this condition so clinicians treat based on the woman's symptoms.

Bergink et al reported on a study of 64 women who were treated for Postpartum Psychosis that found using a staged approach of benzodiazepines first, followed by anti-psychotics and then the mood stabiliser lithium, the women's mood stabilised and they achieved symptom remission within three months. None of the women required electro convulsive therapy (ECT). However, in a later review of the literature by Bergink et al in 2016, the authors advise that ECT is the recommended treatment for women with postpartum psychosis who present in a catatonic state.

Outcomes

Rai et al reports that the possible consequences of postpartum psychosis can be serious and long-term, and have impacts on bonding, psychological wellbeing and the development of the child.[16] Stein states that the babies of women who have postpartum psychosis are at a higher risk of being harmed due to unintentional neglect or aggressive behaviour.[17] Robertson et al highlights that once a woman has experienced a postpartum psychosis, they are more vulnerable to developing a later psychotic episode during subsequent pregnancies and outside of the perinatal period.[18]

There are also consequences to the woman's relationship with her partner. Wyatt et al conducted a qualitative study into the impact of postpartum psychosis on the woman's relationship. In most cases they found that an episode of postpartum psychosis can cause both parties to reappraise their relationship and that for a period of time, the strength of the relationship was threatened.[19]

The role of the nurse

The National Maternity Strategy 2016-2026 recommends that in Ireland, any healthcare professional working with pregnant or postnatal women should be skilled at identifying women who are at an increased risk of developing a perinatal mental health issue.[20]

Raynor and England's research states that midwives' role is essential antenatal screening for all mental health issues, but especially for postpartum psychosis.[21] The NICE guidelines also state that routine screening in the perinatal period can have value for the woman's prognostic outcome. Given that the mean onset of postpartum psychosis is eight days post delivery, the NICE guidelines advise that PHNs need to be skilled at assessing for mental health issues. Rafferty advises that not only should all healthcare professionals be able to screen for mental illness in the postpartum period, there is an onus on them to inform themselves of local services and referral pathways.[22]

The Specialist Perinatal Mental Health Service Model of Care for Ireland advises that in cases where there is access to a perinatal team, the woman should first be referred to this team. Should a woman disclose a history of a major mental illness or report the onset of psychotic symptoms, the NICE guidelines recommend these women be referred to the appropriate service.

Conclusion

Postpartum psychosis is considered to be a major mental health condition. Women who are considered to be at high risk of developing the condition should be referred to the appropriate services. As healthcare professionals and women themselves become more aware of the condition, they are more likely to identify patients who are more at risk or who are experiencing early symptoms of the condition. Early identification may result in early intervention, which is likely to reduce the severity and duration of the psychosis.

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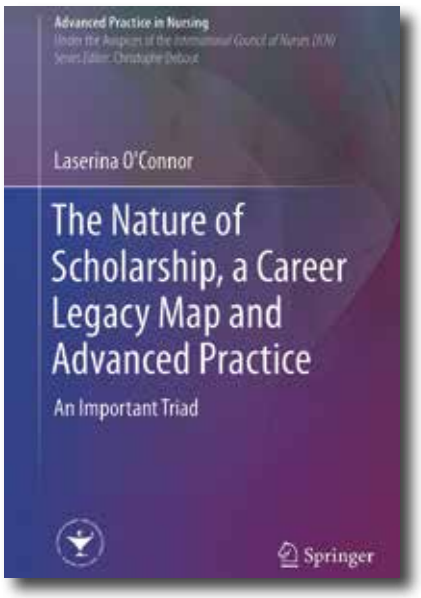
A guide to advanced practice

The Nature of Scholarship, a Career Legacy Map and Advanced Practice: An Important Triad by Prof Laserina O'Connor, professor of clinical nursing at the Health Sciences Centre at UCD, is for educators, professional regulators, advanced nursing practitioners (ANPs) and those considering or aspiring to move into this distinguished profession.

Endorsed by the ICN, the book explores a new conversation around scholarly talents for ANPs/aspirants that comprise a variety of forms such as teaching, synthesis, discovery, engagement and application. It offers an expansive view of Boyer's scholarship with a call to action for practitioners/aspirants to thoughtfully plan their personal goals and capabilities, that will mark them as professionals and scholars needed in today's changing professional workplace.

Prof O'Connor showcases the importance of patient-centred care, its relationship to advanced practice and the connection to clinical scholarship.

According to O'Connor, communities of practice come to life when collaboration



and thinking together happens with academics, ANPs and key stakeholders at the interface of clinical practice.

The meaning of a patient story is narrated through the eyes of the author, who is also an ANP with prescriptive authority in pain medicine. The capabilities expected of a clinical professor in practice are put to the test as the case unfolds, using a patient-centred framework. Prof O'Connor aims for the outcome to provoke a robust conversation among ANPs/aspirants on the skills that nurses bring to the bedside in the context of 'what matters most to the patient as an individual' is 'what matters most to the nurse'.

This book sets a challenge for the profession. Prof O'Connor, through the exploration of the various dimensions of scholarship, compels us to think differently. It highlights a vision that seeks to increase nursing contribution to the shaping of health services by encouraging education, innovative and creative thinking and scholarly activity.

The Nature of Scholarship, a Career Legacy Map and Advanced Practice: An Important Triad serves as a catalyst for robust conversations among scholar practitioners on the very nature of clinical scholarship.

The Nature of Scholarship, a Career Legacy Map and Advanced Practice: An important Triad is published by Springer. ISBN 978-331991695-8 eBook from €35.69 Hardcover $45.77. Available on Amazon

CROSSWORD Competition

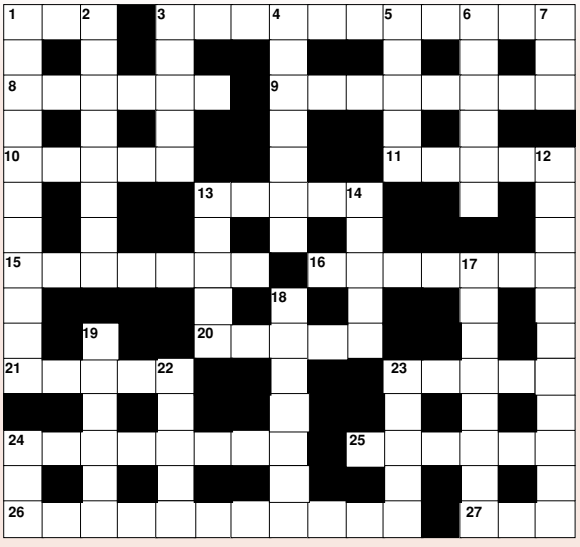
WIN a €50 gift voucher

Across

1 Variety of lettuce (3)
3 & 20a How to radically torture a huge truck (11,5)
8 Underground passageway (6)
9 & 23a Performing a stock-take of ewes and rams – it's enough to make you drop off! (8,5)
10 Celia may be confused with her
11 Ceremonial garments (5)
13 Loses vividness of colour (5)
15 Spotted cat (7)
16 & 24d Variety of fedora made with a hot kipper
20 See 3 across
21 Unit of Swiss currency (5)
23 See 9 across
24 Cypriot variety of cheese (8)
25 Regained consciousness (4,2)
26 One who stuffs and preserves dead animals (11)
27 Ask about music of Jamaican origin (3)

Down

1 Bakery product named for a small dwelling (7,4)
2 Diagnose difference in a Californian city (3,5)
3 Make Cain's brother point to a white poplar (5)
4 Count in (7)
5 One who shuns company (5)
6 Type of hat (6)
7 Canine creature (3)
12 Is this condition a result of a breathlessly exciting dream? (5,6)
13 Such an animal has reverted to a wild state (5)
14 Tale (5)
17 Mountains lying on the French-Spanish border (8)
18 Element which is a source of atomic energy (7)
19 The big toe is essential to Paschal luxury! (6)
22 Throng, host (5)
23 Let the southern floozy begin (5)
24 See 16 across



July/August crossword solution

Across: 1 Hun 3 Shakespeare 8 Martin 9 Tool shed 10 Icing 11 Sinew 13 Scuba diver 15 Blarney 16 Hard hat 20 Spelt 23 Tiger 24. Well-bred 25 Trivia 26 Sweet potato 27 Roy

Down: 1 Humming bird 2 Nursing a hangover 3 Suing 4 Ketchup 5 Poles apart 6 Aching 7 End 12 West Germany 13 Seers 18 Peridot 19 Evolve 22 Rabat 23 Torso 24 Was

The winner of the July/August crossword is: Mary Cunningham Headford Road, Galway

You can now email your entry to us at nursing@medmedia.ie by taking a photo of the completed crossword with your details included.
Closing date: Friday, September 20, 2019
If preferred you can post your entry to: Crossword Competition, WIN, MedMedia Publications, 17 Adelaide Street, Dun Laoghaire, Co Dublin, A96E096

Name:
Address:

MONEY MATTERS

Insurance tips for young drivers

Ivan Ahern offers advice to new and young drivers on choosing the right car insurance

THIS month we look at car insurance, with the top seven tips for new and young drivers.

Do your research

Research, research and then research some more. The internet is a resource, so use it. The vast majority of insurance companies have quote-checking options on their websites. Look up a list of car insurance providers, check your specifications and compare all of the prices. If you're brave, you can call your insurance company and barter with them. It won't always work, but there's no harm in trying.

Avoid high-performance vehicles

Sports cars might be fun to drive, but they are notoriously expensive to run and cost a small fortune in car insurance and fuel. There are plenty of quality car insurance deals for high-performance cars but you're likely to have to pay through the nose for a solid plan. If you're a new or young driver, a Subaru is going to cost you a lot more to insure than the old banger you got when you were 17.

Go easy on the car modifications

Unnecessary modifications/alterations might look impressive, but they'll cost you in the long run.

Install an alarm and immobiliser

The cost of your car insurance can be driven up by factors that you have not even thought of. Security is something that slips most people's minds, experienced drivers included. Investing in a car alarm or high-tech immobiliser may reduce the cost of your car insurance premium. If nothing else, at least you'll know that your car is safe.

Hold on to your no claims bonus

This is an obvious one but hold on to your no claims bonus and clean licence for as long as you can. A safe driving record tells your insurance provider that you're trustworthy. Over time, your premium will dip when your no claims discount comes into play.

Third-party insurance

Choosing the right car insurance plan can be tricky. There's a lot to consider and much of it comes down to your budget. Young drivers' car insurance is known for being expensive, but choosing the right plan could save you a small fortune.

Third-party, third-party fire and theft, and comprehensive cover all vary in price and all cover different things. Whatever plan you go with, make sure you go through your policy in full with your broker so there'll be no unpleasant surprises waiting for you on the off-chance that you're involved in an accident.

Be sure to check your policy options in depth to make sure that you're not paying for something that you don't actually need and cancel any non-relevant extras.

Get on a parent's policy

Your premium will be lower if you're on a parent's cover. If you have siblings who nabbed the available spots before you, adding a more experienced driver to your cover might lower your premium by 'spreading' the risk associated with young drivers.

We want to help you by providing the best value products with a great range of benefits – that deliver when it matters the most. For more information, please visit **cornmarket.ie/car-insurance**

Ivan Ahern is a director at Cornmarket Group Financial Services Ltd

INMO member wins Fulbright award for rare disease research

Dr Suja Somanadhan is a previous winner of the CJ Coleman Award

INMO member Dr Suja Somanadhan has been awarded the Fulbright HRB Health Impact Scholar Award 2019-2020 to undertake research in the area of rare diseases in the US.

Dr Somanadhan, who also won the INMO CJ Coleman Research Award in 2017 for her PhD thesis, *Parents' experiences of living and caring for children, adolescents and young adults with mucopolysaccharidosis (MPS),* is an emerging leader in the field of healthcare provision for rare diseases in Ireland, with several publications and ongoing research programmes to her name. She is currently heading up the rare disease research partnership model 'RAinDROP', designed to shape the future of research studies that have been chosen with a life course perspective in mind.

Having trained at Children's University Hospital, Temple Street, Dr Somanadhan is currently a researcher and assistant professor in children's nursing at the UCD School of Nursing, Midwifery and Health Systems. She holds an honorary research associate fellowship with the Faculty of Nursing and Midwifery, RCSI.

In her Fulbright scholar award programme, Dr Somanadhan will examine integrated care and services for children, young people and their families living with rare diseases at the Centre for Rare Disease Therapy at UPMC Children's Hospital of Pittsburgh.

Dr Suja Somanadhan received her award from Fulbright Commission board chairperson Dr Sarah Ingle at the 2019 Fulbright Awards Ceremony at Dublin Castle

Dr Somanadhan will use this analysis to compare and improve the provision of integrated care and support services for people living with rare diseases and their families in Ireland and the US.

She will also explore the programme of work used to engage the rare disease patient community throughout the translational science process at the National Center for Advancing Translational Sciences (NCATS) at the National Institutes of Health (NIH).

A rare disease is defined as a disease that affects fewer than five people in 10,000. Rare diseases are usually life-threatening, chronically debilitating and are mostly inherited.

INMO receives Jim Kemmy Award

Labour Youth has awarded the INMO with the 2019 Jim Kemmy Thirst for Justice Award, which was presented by Labour Party leader Brendan Howlin, on July 13, 2019. Accepting the award, INMO general secretary Phil Ní Sheaghdha said: "The health system must take the central position alongside housing in public discourse". The INMO is honoured to receive this award."

Three Irish specialists recognised at international respiratory meeting

Dr Ruth Cusack, Dr Daniel Ryan and Dr Padraig Hawkins, all specialist registrars in respiratory medicine, were awarded bursaries by the Irish Thoracic Society / A.Menarini Pharmaceuticals to attend the American Thoracic Society (ATS) meeting, which took place in Dallas in May. The trio were selected based on abstracts submitted to the ATS. Pictured at the meeting were (l-r): Dr Marcus Butler, treasurer, Irish Thoracic Society; Dr Daniel Ryan, SpR in respiratory medicine/Irish Thoracic Society educational officer; Dr Ruth Cusack, SpR in respiratory medicine; Francis Lynch, general manager, A. Menarini; and Dr Aidan O'Brien, vice president, Irish Thoracic Society

New cancer centre offers patients advanced radiotherapy services

The centre is part of a €77 million expansion at Bon Secours Cork

A NEW cancer centre has opened in Cork, offering patients the most technologically advanced radiotherapy services in the south of Ireland.

As part of a €77million expansion, Bon Secours Cork has opened the Cork Cancer Centre, which is available to patients in Cork and the rest of Munster.

The centre will provide integrated care, with medical, surgical and radiotherapy services all under one roof. It includes 81 private rooms, four additional operating theatres, a new 23-bed day infusion ward and a new critical care unit.

According to the manager of the Bon Secours Hospital Cork, the new centre is a "one-stop shop for all critical cancer services". Patients will have access to rapid screening, timely diagnosis and advanced treatment.

The new radiotherapy service available at the centre will be provided to patients as part of a joint venture between Bon Secours and the UPMC Hillman Cancer Centre, one of the largest cancer treatment networks in the US. This new service is being led by consultant radiation oncologist, Dr Paul Kelly.

"It's a real honour for me as a radiation oncologist to offer state-of-the-art radiotherapy, including stereotactic technology, to patients in the region for the first time. Providing access to care in a timely manner with the support of the world-leading experience and quality assurance of UPMC is a very exciting opportunity," Dr Kelly said.

Stereotactic radiotherapy is a non-surgical form of radiation therapy that uses concentrated radiation beams in high doses to destroy tumours in hard-to-reach areas of the body, while minimising damage to surrounding healthy tissues. This lowers the risk of side-effects.

However, this type of treatment is not available at all hospitals because it needs specialist equipment and skills. Until now, it has not been available in Munster and patients in the region in need of advanced radiotherapy services would previously have had to travel to Dublin.

Meanwhile, the new centre also features a state-of-the-art oncology department and an onsite pharmacy compounding unit, which allows for the preparation of specifically tailored chemotherapy for individual patients.

"Our new state-of-the-art Bon Secours Cork Cancer Centre offers best-practice, technologically-advanced radiotherapy services, which were previously unavailable to patients in the region.

"Complementing our established medical and surgical oncology services, this development greatly enhances our capacity to provide a world-class cancer service to patients in need of advanced medicine in this area," commented Bill Maher, group CEO of the Bon Secours Health System.

The centre is already caring for its first patients.

Irish Nurses Golf Association 40th anniversary

The Irish Nurses Golf Association held its 40th anniversary Irish nurses and midwives golf tournament at Thurles Golf Club recently. The top prize went to Mary Norton and Mary Corcoran took second place – both are members of Kilkenny Golf Club – while Kathleen Maher came in third place. Next year's event will take place at Adare Manor Golf Club in Limerick. Pictured on the day were Delia Carroll (captain) with winner Mary Norton

'Mind your ticker': 2019 diabetes in primary care conference focuses on CVD intervention

THE theme of the 12th annual diabetes in primary care conference, taking place on September 25 in Cork, is *'Type 2 diabetes is a cardiovascular disease: Mind your ticker: Timely Intervention for a Healthy Heart'*. This theme highlights that while glycaemic control is important to prevent cardiovascular disease – particularly in the first 10 years from the onset of Type 2 diabetes – we also need to target other CVD risks.

Organisers are delighted to have Dr Diarmuid Quinlan, ICGP integrated care lead for diabetes to chair the conference.

Dr James O'Mahony, a cognitive behavioural psychotherapist, will open the conference with 'Promoting psychological wellbeing of patients with diabetes' to offer some suggestions on how to support the person who is coping with living with a long-term condition.

Dr Maeve Durkan, endocrinologist in the Bon Secours Hospital Cork, will present on 'Management of hyperglycaemia and hyperlipidaemia in type 2 diabetes' and Prof Sean Dinneen, national clinical lead for diabetes will facilitate a workshop on foot protection with Paul Gardiner, a diabetes podiatrist from CUH.

Local and national facilitators will host nine workshops. Delegates can attend two of the following: foot protection and diabetes; cardiac rehab post myocardial infarction; Is type 2 diabetes remission a realistic target? Realistic goal setting and practical dietary guidance; Hypertension and diabetes; Pre-diabetes walkaway programme; Renal disease and diabetes; Smoking cessation – to vape or not to vape?; Diabetes review visits in general practice; Starting injectable therapies and the use of glucose meters in the management of type 2 diabetes.

To book a place at the conference, email Katie Murphy, diabetes nurse facilitator with Diabetes in General Practice, at: katie.murphy@ucc.ie

September

Tuesday 10
National Care of the Older Person Section annual conference. Richmond Education and Event Centre

Saturday 14
School Nurses Section meeting. Midland Park Hotel, Portlaoise. From 10am. Education session with protocols, policies and procedures

Thursday 19
ED Section workshop. See *page 29* for further details

Thursday 19
Retired Nurses and Midwives Section meeting. Richmond Education and Event Centre. 11am. Educational talk on mindfulness

Tuesday 24
Telephone Triage Section conference. Richmond Education and Event Centre

October

Saturday 12
PHN Section meeting. Richmond Education and Event Centre

Saturday 12
Community RGN Section
Richmond Education and Event Centre. 11am

Saturday 12
CNM CMM Section meeting, following the study day

Thursday 17
All Ireland Midwifery conference. Armagh

Thursday 17
Student Allocation Liaison Officers meeting. INMO HQ. 12pm

Friday 18
Third Level Student Health Section meeting. Richmond Education and Event Centre

Wednesday 30
Directors of Nursing and Midwifery and Assistant Directors of Nursing and Midwifery Section masterclass. See *page 68* for further details

November

Tuesday 12
Care of the Older Person Section meeting. INMO Cork office. 10.30am

Thursday 21
OHN Section conference. Richmond Education and Event Centre

Wednesday 27
CPC Section meeting. Richmond Education and Event Centre

Saturday 30
ODN Section conference. Richmond Education and Event Centre

Saturday 30
PHN Section meeting. Richmond Education and Event Centre

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

INMO Professional DEVELOPMENT CENTRE

Library Opening Hours

September
Monday-Thursday:
8.30am-5pm
Friday:
8.30am-4.30pm
by appointment

For further information on the library and its services or to make an appointment to visit, please contact
Tel: 01 6640 625/614
Fax: 01 01 661 0466
Email: library@inmo.ie

INMO Membership Fees 2019

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

Condolences

- It was with deep sadness that general secretary Phil Ní Sheaghdha, president Martina Harkin-Kelly, Executive Council and INMO staff learned of the loss of Madara 'Maddie' Sulaine, a colleague working in Our Lady's Children's Hospital, Crumlin. We wish to express deep sympathy to Maddie's parents, family, friends and colleagues at this difficult time. Our thoughts are with Maddie's family and friends. *Ar Dheis Dé go raibh a h-Anam.*
- Everyone at the INMO would like to send their deepest condolences to the family and friends of Jacinta Heneghan, CNM2 in Sacred Heart Hospital, Castlebar. IRO Anne Burke, Executive Council member Donna Hyland and everyone who worked with Jacinta are deeply saddened by her passing. Jacinta was an outstanding INMO member; she was proactive in her workplace, raising concerns on behalf of the collective and seeking justice and fairness. She was entirely dedicated to nursing and always looked to improve the conditions for her colleagues.

OHN Section conference

INMO

Thursday, November 21, 2019

Richmond Education and Event Centre

Please contact **jean.carroll@inmo.ie** for details