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WIN

Journal of the Irish Nurses and Midwives Organisation

World of Irish Nursing & Midwifery

Latest INMO CPD education programme
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Leading the way in children's nursing
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Covid compensation

Reward due for vital role played in pandemic

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Breastfeeding: The best start

Health benefits for infants

Breast milk is the ideal food for newborns and infants. It gives them all the nutrients they need for healthy development. It is safe and contains antibodies that help protect infants from common childhood illnesses such as diarrhoea and pneumonia, the two primary causes of child mortality worldwide. Breast milk is readily available and affordable, which helps to ensure that infants get adequate nutrition.

Long-term benefits for children

Beyond the immediate benefits for children, breastfeeding contributes to a lifetime of good health. Adolescents and adults who were breastfed as babies are less likely to be overweight or obese. They are less likely to develop type 2 diabetes and perform better in intelligence tests.

Benefits for mothers

Breastfeeding also benefits mothers. It reduces risks of breast and ovarian cancer later in life, helps women return to their pre-pregnancy weight faster, and lowers rates of obesity.

Support for mothers is essential

Breastfeeding has to be learned and many women encounter difficulties at the beginning. Nipple pain, and fear that there is not enough milk to sustain the baby are common. Health facilities that support breastfeeding – by making trained breastfeeding counsellors available to new mothers – encourage higher rates of breastfeeding. To provide this support and improve care for mothers and newborns, there are 'baby-friendly' facilities in about 152 countries thanks to the WHO-UNICEF Baby-friendly Hospital initiative.

Work and breastfeeding

Many mothers who return to work abandon breastfeeding partially or completely because they do not have sufficient time, or a place to breastfeed, express and store their milk. Mothers need a safe, clean and private place in or near their workplace to continue breastfeeding. Enabling conditions at work, such as paid maternity leave, part-time work arrangements, on-site crèches, facilities for expressing and storing breast milk, and breastfeeding breaks, can help.

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The Irish Nurses and Midwives Organisation supports breastfeeding

For more information log onto www.breastfeeding.ie

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Permanent vaccination workforce is needed

IN THIS issue of *WIN*, we profile nurses and midwives who are centrally involved in setting up and managing mass vaccination clinics *(see page 16)*. From the outset, the INMO Executive Council took a clear position to promote vaccination among members. The importance of vaccination and the need for a mass vaccination programme for Covid-19 is well documented and the role played by nurses and midwives in the Irish vaccination programme has been central to its success.

Nurses have had a primary role in childhood immunisation programmes, school immunisation programmes and other programmes such as the delivery of flu vaccinations for many years. Peer vaccination programmes led by nurses and midwives have also been very effectively delivered. The organisation of and the delivery of Covid-19 vaccination programme was a challenge due to scale, but the delivery and skill sets required for the programme were available in abundance in our professions.

A recent article in the *Journal of Advanced Nursing* looked at the nursing contribution to vaccine rollout in the UK:

"Critical to the success of Covid-19 mass vaccination programmes is the nursing contribution. Nurses have for a long time been instrumental in the success of immunisation programmes across the life cycle, through key engagement activities concerned with awareness raising, education, vaccine administration, prescribing and policy development. The challenge this time, over and above the scale and urgency of the endeavour, is the need to promote vaccine confidence and acceptance against a background of misinformation and mistrust, arising in part due to the pervasive influence of social media combined with long-standing distrust in public health measures in certain communities' context.

"Vaccinating whole populations quickly is key to control the global spread of the disease, reduce and prevent the long-term effects of Covid-19 and limit the opportunity for mutations of the coronavirus to emerge. After the social restrictions in daily living and the economic upheaval experienced by people across the world, vaccines offer hope and the promise of better days to come, but this can only be fully realised if sufficient numbers of people across all sectors of the population take up the offer of a vaccine. Critical to the success of Covid-19 mass vaccination programmes is the nursing contribution." (**Doi.org/10.1111/jan.14854**)

There is no doubt that the nursing contribution has been a major factor in the successful uptake and rollout of the Irish Covid vaccine programme. The pandemic has not ended however, and many of those who answered the emergency call for vaccinators were retired, redeployed or agency nurses and midwives. Their involvement provided a short-term solution – but they will not be available on an ongoing basis.

Temporary solutions are temporary. We must not accept planning predicated on the redeployment of staff from other busy areas, especially when there is no one to do their work in their absence. It is necessary to have a permanent immunisation workforce. School immunisation teams have over many years been depleted of staff: this must be corrected. It is also likely that vaccinations will be an ongoing and significant part of public healthcare in the future, and we must ensure an agreed workforce plan is in place to meet this need.

Government and the HSE must acknowledge the role played by nurses and midwives in the fight against Covid-19 – including their role in the set up and delivery of vaccination programmes. Surveys confirm that nurses and midwives are trusted by the public and therefore ideally placed to provide trusted information to increase the public's engagement in vaccination programmes. This must translate to real engagement with the professions and a seat at the senior decision-making tables from the outset as an essential requirement for planning and delivery of public health strategies such as this mass vaccination programme.

Phil Ní Sheaghdha
General Secretary, INMO

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EXECUTIVE COUNCIL ELECTION 2022

All members are asked to note that 2022 is an election year for election, to the Executive Council, for a two year period (2022-2024). Elections will be conducted under the revised new Rule Book (Rule 8) adopted at the ADC in May 2021.

ELIGIBILITY FOR NOMINATION TO EXECUTIVE COUNCIL (RULE 8)

Nominations for the Executive Council shall be submitted, on the appropriate form, to the General Secretary, on, or before, 5pm on Wednesday, February 2, 2022. To be eligible for membership of the Executive Council a member must:

i) have been a paid-up member of the Organisation, for not less than two years prior to the date of her/his nomination, and be on the Live Register of the Nursing and Midwifery Board of Ireland (NMBI); and

ii) be proposed and seconded by Officers of their Branch or Section following endorsement of the candidate by that Branch or Section.

To be eligible for election as an undergraduate student nurse/midwife member of the Executive Council an undergraduate student must:

i) have been a member of the Organisation for not less than six months prior to the date of her/his nomination; and

ii) be proposed and seconded by undergraduate student nurses/midwives who have themselves been members of the Organisation for not less than six months or be proposed and seconded by Officers from their Branch.

COMPOSITION OF THE EXECUTIVE COUNCIL

Clinical: 16 seats

Includes all grades of Registered Nurse and Midwife (other than those eligible to go forward under the Education and Management Categories below), to be filled as follows:

i) Registered General Nurse - at least two seats
Registered Midwife - at least one seat
Registered Nurse Intellectual Disability - at least one seat
Registered Sick Children's Nurse - at least one seat
Registered Public Health Nurse - at least one seat;

Please note persons elected, to these reserved seats, must be on that register and engaged in clinical practice in that discipline.

ii) If these reserved seats are not filled, via the 16 candidates with the most votes, then they must be filled with reference to the next highest candidate, from that discipline, who is engaged in clinical practice in that discipline.

iii) If there are no candidates meeting any of the six reserved seats (clinical) then the seats shall be filled by the candidate with the highest vote in the clinical category.

Education: 2 seats

i) One seat to be filled by members from all grades of Nurse/ Midwifery Teachers, Clinical Teacher, and/or others with a Nurse/ Midwifery Teaching qualification who are actively engaged in nurse/midwifery education.

ii) One seat to be filled from members who are working in the wider field of nurse/ midwife education and its management including Clinical Placement Co-Ordinators/Clinical Placement Facilitators/Specialist Co-Ordinators and Nurse/Midwife Practice Development Co-Ordinators.

Management: 3 seats

Includes all members at, or above, Clinical Nurse Midwife Manager 3 who are actively engaged in management.

Undergraduate Student Nurses/Midwives: 1 reserved seat

Includes all undergraduate Student Nurses/Midwives/New Graduates up to 24 months qualified.

- Provided always that only those grades for whom the Organisation has negotiation rights shall be a member of the Executive Council
- In the event of any of the seats allocated to the Education and Management categories not being contested, then those seats shall be filled by the candidates, in the **Clinical Category,** who receive the next highest vote, or votes, after the initial filling of the 16 seats taking into account the six reserved clinical seats.
- In the event of any dispute, as to the category for which a member may be eligible for election, then the Executive Council shall determine the category under which a member is eligible to contest the election.

ELIGIBILITY FOR OFFICE OF PRESIDENT AND VICE PRESIDENTS (RULE 9)

9.1.1 The President, first Vice-President (Honorary Treasurer) and second Vice-President shall be elected at the 2022 Annual Delegate Conference at which elections are scheduled.

9.1.2 A separate election shall be held for President, first Vice-President and second Vice-President, and such elections shall be by secret ballot of all voting delegates at the Annual Delegate Conference.

9.1.3 The elected candidate must secure an overall majority by exceeding 50% of the eligible votes cast. If no candidate has achieved an overall majority, as aforesaid, then the candidate, or candidates, receiving the lowest vote or votes, if their combined vote is less than the total vote of the highest candidate, shall be eliminated and a further ballot shall take place immediately.

9.1.4 If there shall be a tie, another vote shall be taken, and if the result is still a tie, the outcome shall be decided by lot (drawing the name of the successful candidate) by the chairperson of the Standing Orders Committee.

9.2 To be eligible for election to the office of President or Vice-Presidents she/he shall have been an elected member of the incoming Executive Council and shall have been a member of the outgoing Executive Council for the term immediately preceding her/his election.

9.3 Nominations for the office of President, first and second Vice Presidents, together with their written consent must be submitted in writing to the General Secretary not later than 21 clear days before the Annual Delegate Conference for notification to delegates to that meeting at which the election will take place. (Closing date for nominations is 5pm on Friday, April 1, 2022).

9.4 The President shall preside at the Annual Delegate Conference and Special Delegate Conferences held during the year and at all Executive Council Meetings. In the absence of the President the first Vice-President shall take the Chair; in the absence of the first Vice-President the second Vice-President shall take the Chair.

9.5 The office of President shall not be held by the same person for more than two consecutive terms.

A positive focus with the president

Karen McGowan, INMO president

Overcrowding returns

OVER the summer months nurses and midwives have had to battle increased workloads and heightened emergency department overcrowding. The elusive downtime we had been promised is wearing heavy on members. The INMO has not let up in putting pressure on government and will continue until the response required in relation to our compensation claim is achieved. The health service is busy but we must raise the issues we face in our workplaces and keep the pressure on until we are heard. I have met with a number of branches recently and discussed action plans with them. Mullingar Regional Hospital was first off the mark with lunchtime protests. Unfortunately, this is necessary in order for change to materialise.

Nurse specialist - National Isolation Unit

THIS month I spoke with Eileen O'Connor, clinical nurse specialist for the National Isolation Unit in the Mater Misericordiae University Hospital. The National Isolation Unit is the only national referral centre for high risk infectious diseases like Ebola and viral haemorrhagic fever. This role involves ongoing training of all staff and preparing them to deliver the best standards of care. The responsibility is so diverse and involves liaising with local authorities, ambulance personal, An Garda Siochana, the army, our airports and all of the hospital services.

Eileen O'Connor, clinical nurse specialist at the National Isolation Unit, Mater Hospital, Dublin

Ms O'Connor explained that this new role came to light as a result of what has been learned from the Covid-19 pandemic. She said that working as a lead nurse for the past year has given her huge insight into the potential difficulties that could be encountered.

"You have to be in a state of readiness all the time. The risk associated in this area of nursing is huge, hence why constant training and education is necessary to keep our staff and patients safe. This role involves making people more aware that the containment of infectious diseases is a massive undertaking. The nursing role in this process is paramount," Ms O'Connor told *WIN*.

There are plans for a new isolation unit and part of Ms O'Connor's role is to influence the planning and decision making stage of this project. Nursing has a key role in the development of this service to ensure future patients are provided with safe care. This will be a state-of-the-art facility for emerging infections. If a case of a disease such as Ebola comes into the country the emergency major disaster mode would be activated but thankfully there has never been a case in Ireland. Ms O'Connor said that with travel opening up to different countries, the isolation unit is automatically put on high alert.

Ms O'Connor is no stranger to acute care having a background in emergency nursing and flight nursing training but infectious diseases is where her passion lies and this has fuelled her research in HIV and hepatitis C in vulnerable patients.

She said that the past year has been a testament to her training. The experience of being a nurse lead through Covid-19 has called on her to use her knowledge and expertise in planning and operation of services – experience that will stand to her in the new isolation unit.

Executive Council update

THE Executive Council last met virtually in July as there was no Executive meeting in August. The problems encountered in different regions were discussed with specific focus on overcrowding and short staffing. Many regions are experiencing increased pressure and the meeting heard feedback from IROs in these areas.

I urge all members to engage with their reps and IROs if there are issues in your areas. I know not everyone checks on every email but engagement at local level is paramount to protecting both your own registration and the safety of your patients.

Discussions on the INMO compensation claim, which has been referred to the Labour Court, were also held. This move was completely justified given the landscape of the hospital service at the moment. Since lodging the claim all health service unions have appealed to the Taoiseach Micheál Martin to intervene and give a commitment to honouring the promises made. Mr Martin has been publicly supportive on the issue but now we need to see action *(see page 8)*.

The members of the Executive Council are elected democratically and if you are interested in getting involved now is the time to start your preparation as next year is an election year for seats on Executive. It is important to note that this union is governed by the Executive Council and your input is important in terms of how we progress as a union. You can be a voice for your peers and professions so please get in touch for further information.

The next meeting of the Executive Council is due to be held online on September 13 and 14.

If you would like to showcase your role or nurse-led initiative on this page please get in touch with president@inmo.ie

Get in touch

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

Tony Fitzpatrick and **Dave Hughes** report on INMO action to ensure the health service comes out of the pandemic fit for purpose

Labour Court asked to adjudicate on claim for pandemic recognition

THE INMO, along with other health sector unions, attended the Workplace Relations Commission over the summer months seeking recognition for the extraordinary efforts of health service workers during the Covid-19 pandemic.

The INMO and other unions were left with no choice but to refer this matter to the Labour Court following months of engagement that ended with no proposal from the HSE or Department of Health on what recognition would be given to healthcare workers (HCWs) for their unprecedented flexibility during the pandemic. With a high level of exposure to the virus, this led to a high incidence of contagion among HSE and other healthcare staff.

The extraordinary and selfless determination of healthcare workers to care for and protect the people of Ireland in the face of the pandemic has been widely and vocally recognised by citizens, politicians of all parties, and senior health service management.

With a view to achieving the recognition that all agree is appropriate, the union group has been engaged with the HSE since November 2020, meeting on numerous occasions without making any progress.

Both the Taoiseach and Tánaiste have indicated that they would support some recognition, but no offer has yet been presented. Just days before the August meeting at the WRC, Health Minister Stephen Donnelly raised the unions' expectations that an offer was on the way when he was asked if healthcare workers should be recognised with "a financial bonus". He replied: "I think our healthcare teams have just been incredible. We're still fighting the fight at the moment, but I definitely want to see some form of recognition for the extraordinary work that they've all put in."

Against the background of the understandable and growing frustration among HCWs, the unions referred the matter to the WRC in March 2021.

However, after further delays in the process, employer representatives told the latest WRC conciliation conference in August 2021 that they had no mandate from government to engage on the union claim for recognition of HCWs' contribution to overcoming the Covid crisis. This greatly disappointed the union group, which has now been forced to refer the matter to the Labour Court.

In tandem with this referral, the INMO has called on its members to help progress the claim by writing to their local TDs to ask for their support.

For our part, the INMO and other health sector trade unions have called on the Taoiseach Micheál Martin "intervene immediately to authorise the HSE and relevant Government departments to engage with health service unions to agree and implement the promised recognition without any further delay."

This would bring Ireland into line with other countries, including Northern Ireland, England, Scotland, Wales, France and most EU countries, where health workers have already seen recognition of their extraordinary efforts and contribution through bonuses and pay increases.

HCWs have given their all in the fight against Covid-19. They adapted rapidly and worked far beyond their normal responsibilities.

Research shows that staff who work directly with Covid-19 patients are 47 times more likely to catch the virus than those impacted through community-acquired infection. Over 30,000 HCWs have been infected with Covid-19 since the pandemic struck in Ireland, with more than 600 infected in the most recent 14-day epidemiological report (at time of going to press).

Morale in the health service is extremely low. There needs to be some hope of genuine reward for frontline staff. Other governments have recognised their healthcare workforce's contribution meaningfully – yet in Ireland HCWs, through their unions, are forced to fight for it.

See next month's *WIN* for an update on this issue.

– Tony Fitzpatrick, INMO director of industrial relations

Rapid return of overcrowding to Irish hospitals

"OUR health service is rapidly swinging from a Covid crisis back into an overcrowding crisis," INMO general secretary Phil Ní Sheaghdha warned last month, as the trolley count in Irish hospitals rose to the highest figure since the start of the pandemic in March 2020.

The worst-hit hospitals were Cork University Hospital, University Hospital Limerick and University Hospital Galway.

The INMO pointed in particular to the dangerous levels of overcrowding continuing in University Hospital Limerick, despite the hospital gaining more than 110 new beds since January. Due to the high number of admitted patients on trolleys, hospital management had to cancel all elective and outpatient services for a week-long period at once stage recently. The INMO has called for direct ministerial intervention in the hospital.

"The HSE said at the start of the pandemic that overcrowding would not be tolerated, but it has been on the rise consistently in recent months," said Ms Ní Sheaghdha.

"Our members cannot withstand the pressures of overcrowding twinned with the pressure of another wave of Covid. If we continue along the current trajectory, patients and staff will find themselves in a dire situation.

"The HSE needs a laser-like focus on hospitals to get overcrowding figures down. That means scaling back services in badly hit hospitals, taking on extra capacity from private hospitals, and supporting GPs to return to their normal clinical work," Ms Ní Sheaghdha added.

Serious concerns raised about clinical and workplace risks

INMO general secretary Phil Ní Sheaghdha has raised the Organisation's serious concerns at the return of hospital overcrowding while staff are struggling to contend with the parallel demands of Covid-19 healthcare and scheduled delayed care.

In letters to the HSE chief operations officer and the chief medical officer the general secretary stressed that hospital overcrowding and excessive workloads – due to Covid and non-Covid areas staffed by one workforce – require immediate attention to the clinical risk issues arising and being reported to the union.

Reports of these issues are now increasing in frequency. The union has several examples of significant clinical risk arising, and significant health and safety concerns. Nurses and midwives are doing their best to provide safe care with depleted staffing levels at a very difficult time.

The union said it appears that the HSE has no planned approach to ensuring staff are not placed in these high-risk situations.

The general secretary highlighted several issues to the HSE chief medical officer including the increase in attendance of patients, not seen or physically reviewed by GPs. Identifying this as being due to the workloads involved in GPs' role in the immunisation rollout and advocating that GPs need to be supported to return to their role in reviewing patients. This could assisted by concentrating the immunisation programme on dedicated vaccination centres and greater use of the role of pharmacists in the programme.

The general secretary also called on the HSE to initiate an immediate review of security. "We have had a number of reports of serious assaults causing long-term absence from work," she said.

Describing the situation as totally unacceptable, the general secretary called for a review of the admission pathway for those known to have violent tendencies or associated mental health issues.

On the lack of social distancing in overcrowded wards and emergency departments, Ms Ní Sheaghdha asked for an independent examination of patient flow systems in each overcrowded area and reminded the chief medical officer that there is an agreed escalation policy which is being ignored.

While serious engagement is in progress at national level, the INMO said progress is painfully slow and the resultant improvements are inordinately delayed in reaching the workplace.

Engagement at the workplace and respectful recognition of safety representatives, as provided for under the Safety, Health and Welfare at Work Act 2005, is the way forward to protect the health and safety of INMO members.

The INMO industrial relations team is on hand to promote dissemination of agreed national safety strategies and engagement with all staff whether in community, ID, maternity or acute services.

The INMO is keen to stress that health and safety is everybody's business and nobody should suffer injury or illness because they cared for others.

– Dave Hughes, INMO deputy general secretary

Health and Safety Act holds key to safer workplace

THE INMO is rapidly developing a network of branch safety liaison officers, safety representatives and Covid lead worker representatives across all work locations.

The Safety, Health and Welfare at Work Act 2005 gives rights to workers and their representatives to insist on mitigation measures to eliminate or reduce risks in the workplace. The Biological Agents Code of Practice 2020 has categorised Covid as risk level 3 – the second highest level under the legislation.

This imposes additional responsibility on employers to protect their workers and safety statements and procedures must be revised accordingly.

While these national policies exist, the INMO believes it is only through the active engagement of safety representatives that healthcare workplaces can be made safer for nurses and midwives.

Safety representative's rights

Workplace safety representatives have a number of specified rights under the 2005 Act. These include:

- To liaise and consult with other safety representatives
- Inspect the whole or part of the workplace, subject to notice
- To investigate accidents or dangerous occurrences (section 25.2.c)
- To be informed of a health and safety inspection (25.6) and to accompany the inspector (25.2.d&e), except where the investigation is into an accident or dangerous occurrence, when the inspector has the discretion to refuse
- To make representations to an inspector (25.2.h) and to receive advice and information from an inspector (25.2.i)
- To receive copies of improvement directions and notices and prohibition notices.
- Protected time – time off work without loss to learn the role (25.5.a) and time off work to discharge functions (25.5.b).

The general role of the safety representative is to encourage members to recognise, identify and conduct risk assessments of hazards in the workplace in relation to their health and safety, identifying and recording both physical but also psychosocial issues such as workload, staffing levels, stress and anxiety.

The safety representative should record and retain accurate records of activities in the safety representative role.

They should consult with the branch safety liaison officer for support when required.

Their role is also to assist initiatives/campaigns on health and safety in the workplace organised by the INMO.

– Dave Hughes

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References:

1. National Institute for Health and Care Excellence. Rifaximin for preventing episodes of overt hepatic encephalopathy: appraisal guidance TA337 for rifaximin. Available from: http://www.nice.org.uk/guidance/ta337
2. TARGAXAN® 550 Summary of Product Characteristics. Available for Ireland from: www.medicines.ie

IE-HEP-XIF-2100002
Date of preparation: May 2021.

NORGINE

INMO director of industrial relations **Tony Fitzpatrick** updates members on recent national issues

Overtime restored and 1% pay increase under Building Momentum

AS PART of the implementation of Building Momentum, the public sector pay agreement, changes to overtime arrangements were introduced with effect from July 1, 2021. This restores overtime arrangements to pre-Haddington Road Agreement (HRA) levels and will mean in the region of a 20% increase in overtime pay rates.

As ever, it is important that all members ensure that they are being paid correctly both at basic level but also if they provide overtime, work additional shifts or work premium hours.

On a weekly basis, the INMO deals with cases of nurses and midwives who were paid incorrectly and were not aware immediately as they had not checked their pay slips.

It is important that all nurses and midwives check their payslips on a regular basis to ensure that they are receiving:

- The correct basic pay with all increments applied
- Premium pay entitlements for working evenings, nights, weekends, bank holidays etc.
- Appropriate overtime rates in compliance with the national overtime agreement.

Any member who requires advice on this can contact the INMO Information Office Tel: 01 6640610/01 6640619 or their local INMO office.

The recent changes to overtime arrangements were detailed by the HSE in July in *HR Circular 031 2021 Revised Arrangements re Compensation for Overtime and Twilight Payments in the Public Health Sector. Restoration of the Tool Allowance*.

Under this circular with effect from July 1:

- Weekday overtime between the start of day duty and midnight will now be paid at time-and-a-half at your full increment (they have been paid at either a time-and-a-quarter, or time-and-a-half based on a lower increment)
- The same change will apply to the first four hours of Saturday overtime.

Note that all overtime paid at double pay (such as weekday overtime after midnight) will remain at the same level. The INMO has already negotiated the return of twilight payments for our members, therefore their mention in this circular grants to others what the INMO had already achieved for members.

1% pay rise on October 1

Under the Building Momentum agreement members are due to receive a 1% pay rise on October 1, 2021. It is important that all members check their payslip to ensure that this pay rise is implemented correctly.

Sectoral bargaining

Under the terms of Building Momentum, there is a specific section that deals with outstanding claims called 'sectoral bargaining'. A sectoral bargaining fund has been established and one element to be addressed under this is the pay differential for managerial and analogous grades, ie. PHN, CNM2, CNM3, DON, ADON and grades that are analogous to those including for example, CNS and ANP/AMP.

The Expert Review Body on Nursing and Midwifery released its Module 1 report outlining the pay differential in December 2020 and this will be addressed as part of the sectoral bargaining discussions which will commence in September 2021 for implementation in February 2022.

Restoration of pre-HRA hours

The restoration of pre-HRA hours (ie. a 37-hour week) is also to be addressed as part of Building Momentum with the Hours Body, which has now been convened and is examining the matter of implementation. The unions made a submission to the Hours Body during the summer and further engagement will take place throughout the autumn to ensure implementation in 2022.

New graduates' pay scale

THE INMO has secured that all new nursing and midwifery graduates will be offered employment by the HSE this year and a circular to this effect has been issued

It is important that new graduates are aware that they will be placed on the first point of the scale for 16 weeks; this 16 weeks should include any period of pre-registration employment. After 16 weeks, new graduates should ensure that they skip the second point of the scale and are placed on the third point of the staff nurse/midwife scale. After one year at that point of the scale, they become eligible to proceed to the fourth point of the scale and ultimately onto the first point of the Enhanced Salary Scale.

All new graduates should ensure that they are being paid correctly. Furthermore, any new graduates working in an area that attracts the location allowance should ensure that they are paid this. Please check this on your payslip and if you have any questions, do not hesitate to contact the INMO.

Enhance your salary

ALL STAFF nurses and staff midwives who have an excess of one year and 16 weeks service, should be on the Enhanced Salary Scale.

If for any reason you have not applied to change to the Enhanced Salary Scale, please be advised that you are depriving yourself of a significant pay increase that the INMO secured as part of the Labour Court Recommendations to resolve the dispute in 2019.

It is important that you seek to have the Enhanced Salary Scale applied to you if you meet the eligibility criteria. No staff nurse or staff midwife should allow themselves to remain on a lower basic salary scale when a higher salary scale is available to them.

If you require any advice with regards to the Enhanced Salary Scale, please do not hesitate to contact the INMO information office on 01 6640610/01 6640619 or your local INMO office.

The current salary scales can be viewed and downloaded from the INMO website at **inmo.ie/Salary_Information**

Service managers seeking pay parity in St Michael's House

THE INMO is currently representing members who work as service managers in St Michael's House services for people with disabilities who are seeking pay parity with colleagues carrying out a similar role.

This issue has failed to progress locally and was referred to the Workplace Relations Commission last year. Following engagement with the employer, the INMO was advised that a decision was made by the HSE to regrade the role, resulting in a number of service managers being paid significantly less than their colleagues within the service, although carrying out the same role and function.

The employer further advised that the role nationally has been regraded, however the INMO, who is working closely with Fórsa on this issue, has challenged this by producing evidence that a number of such positions have been advertised at a higher grade (Grade 8) in similar organisations such as St John of God Services, Daughters of Charity and HSE sites over the past year and in recent months.

While the employer has acknowledged that members represented by the INMO carry out the same role as their colleagues who are in receipt of higher pay, no progress has been made to resolve this issue.

The simple issue is that these members are being treated less favourably, in that they are graded and paid less than their colleagues within St Michael's House for like work. Therefore, the union is seeking pay parity for them.

At this juncture, together with Fórsa, the INMO has advised the employer of the dissatisfaction and frustration with the lack of progress and meaningful engagement to address this issue and will be organising our members to assert their rights in order to seek a resolution.

– Karen Clarke, INMO IRE

Back pay of location allowance for LIU and MAU being pursued

FURTHER to the agreed settlement in March of the INMO claim on behalf of members for application of the location allowance in the local injuries unit (LIU) and medical assessment unit (MAU) in Nenagh and Ennis hospitals, the union is still pursuing payment of back monies due from November 1, 2020.

Anomalies arose within University Hospital Limerick Group regarding the payment of the location allowance. The INMO reached a local settlement in respect of this matter which secures payment of the allowance to all nurses working in the LIU and MAU of both hospitals.

At time of going to press management had agreed to revert to the INMO by August 24, regarding payment dates.

– Mary Fogarty, INMO assistant director of IR

WRC enables move to new theatre suites in Croom Orthopaedic Hospital

AGREEMENT was reached with the HSE at the Workplace Relations Commission in July to enable INMO members to fully cooperate with a move to the new theatre department in Croom Orthopaedic Hospital from July 26.

The move incorporates a doubling of the theatre capacity at the hospital.

In summary the INMO secured:

- Improvements in governance with a dedicated CNM2 and CNM1 for each theatre and the recovery room
- A significant increase in nursing and clerical administration hours for the admissions unit from July 26
- The appointment of a director of nursing and six assistant directors of nursing to cover both day and night duty governance on-site.

As the four theatre suites open over the coming months, this agreement ensures that Croom Orthopaedic Hospital is well placed as a leading specialist orthopaedic service in Ireland from a nursing perspective.

The INMO wishes to thank Mary O'Grady CNM2, Gerri Ryan CNM2 and Joanne Hanley CNM2 for supporting the members to meet the needs of future patients.

– Mary Fogarty, INMO assistant director of IR

Dispute over temporary contracts in CHO3 referred to WRC

THE failure by the HSE in CHO3 to convert nurses from temporary to permanent contracts where permanent vacancies exist has been referred to the Workplace Relations Commission.

The HSE in CHO3 failed to comply with an agreement from 2020 with previous managers to convert such temporary contracts for nurses where vacancies exist. The nurses in question are working across services in CHO3 as community nurses and in older persons services.

This dispute also includes INMO members who have built up the entitlement to a contract of indefinite duration under the Protection of Employees (Fixed-Term Work) Act, 2003.

Any member in CHO3 who is working in a service in a temporary capacity, where permanent colleagues were employed after them, or where permanent vacancies exist, should send an email to: inmolimerick@inmo.ie.

– Karen Liston, INMO IRE

Mullingar lunchtime protest at unsafe staffing levels sparks closure of beds

INSUFFICIENT progress to address severe staff shortages at Midlands Regional Hospital Mullingar sparked INMO members to stage a lunchtime protest in July to highlight the unsafe conditions for both patients and staff.

This followed two weeks of intensive negotiations with the hospital's senior management team, with the INMO demanding the closure of a number of beds to reduce activity in the hospital until unsafe staffing levels were addressed.

This was resisted by hospital management. However, the number of unfilled shifts on medical wards made the situation unsafe and, following talks in the Workplace Relations Commission, management took the decision to close 20 beds. The situation had reached a point of up to 1,000 unfilled staff hours. The closure of beds has resulted in some staff being redeployed.

Management said that, as a consequence of the cyber attack on the HSE, there was no recruitment in Mullingar for a period of about six weeks. The agreement reached at the WRC provided that recruitment efforts would increase and a joint management/union group would be established to review progress weekly on staffing and related matters.

INMO members held a lunchtime protest to highlight unsafe staffing levels at Midlands Regional Hospital Mullingar

WIN can now report that 12 nurses recruited internationally commenced work in the hospital in recent weeks. The INMO wishes them every success and hopes that they have a long and rewarding career in Midlands Regional Hospital Mullingar.

The INMO lunchtime protest was attended by a number of local politicians and ministers, and received widespread media coverage.

– Albert Murphy, INMO assistant director of IR

WRC talks restore pension benefits in Mater Private

TALKS were held in the Workplace Relations Commission on a number of changes which the Mater Private Hospital introduced to ancillary pensions benefits for its staff.

Due to increased insurance costs the employer decided to make a number of changes to the pension benefits which included the requirement for those staff who are on income continuance to pay their pensions contributions. This meant that the amount of benefit that employees in the Mater Private Hospital receive would have been reduced by 6.5%.

It was agreed at the WRC that this change would be reversed and that there would be an early review of this benefit in 2024. The WRC was highly critical of the way in which the Mater Private Hospital introduced these changes and there is a commitment by the hospital going forward that any changes to benefits would be discussed in advance with the unions representing staff.

INMO assistant director of IR Albert Murphy said: "While we were not entirely happy that we did not manage to have all these changes eliminated, the fact that we have secured the reversal of the change for staff who are on income continuance from paying their pension contribution is a significant victory for the members and the INMO and it is therefore to be welcomed."

Nurses compensated over public holiday pay

Significant finding for part-time nurses and midwives

THE INMO recently took a case on behalf of three part-time nurses working in the Mater Private Hospital in relation to the calculation of public holidays.

The nurses complained that the system for calculating public holidays was changed with effect from January 2020. This resulted in their receiving less pay than they would normally receive when a public holiday fell on a Monday, a day they would normally be expected to work.

It meant their pay for a public holiday was calculated on a pro rata hours basis rather than pay for the hours they normally worked. The employer argued that, as the employees' contracts were flexible, this was in accordance with the Organisation of Working Time Act 1997.

This was disputed by the INMO at the WRC hearing, with the union showing evidence of the nurses' working patterns. The INMO stated that as there was an expectation that the nurses would normally be rostered to work on a Monday, they were entitled to receive the normal day's pay for bank holidays.

The adjudicator in this case ordered that the three nurses would receive the difference in pay in respect of the period in which the claim was taken and also awarded each of the claimants €1,000 in compensation. The hospital accepted this outcome.

This is a significant case for part-time nurses and midwives who work long days and means that they cannot be simply paid one-fifth in wages on a day which they are normally expected to work but their unit is closed.

– Albert Murphy, INMO assistant director of IR

Bantry General reopened following INMO pressure and public protest

FOLLOWING joint pressure from INMO members and the public, Bantry General Hospital reopened to new admissions effective from August 11, 2021.

The hospital had scaled back services and was closed to new admissions due to an acute shortage of hospital consultants. The INMO called on the South/Southwest Hospital Group to find immediate consultant cover to get services back running and urgently recruit locum and permanent consultants to address the ongoing problem.

INMO members in Bantry come together with the community in west Cork to ensure this vital service remains open.

INMO IRO Liam Conway said: "Bantry General Hospital plays a vital role and service in the region. Patients across west Cork deserve better, and the closure unfairly put extra pressure on nearby hospitals.

INMO members at public protest in Bantry: *INMO members from Bantry General Hospital came together with the community to ensure services remained open at the hospital*

"Our members and the staff in Bantry are exceptional and highly skilled. The service in Bantry should be expanding and continued developments in nurse-led services made a priority. Bantry has seen significant support and investment in ANP and CNS posts over the last number of years. The wards play a key role in acute services, while Bantry also has a fantastic unit for older people.

Mr Conway continued: "The INMO will continue to support members in the region to not only maintain services but to advocate for their expansion."

The medical assessment unit (MAU) at Bantry must be protected also to control attendances in other emergency departments in the region. The INMO warned that the closure had not only been bad for west Cork, but diverted patients to already-stretched hospitals such as Cork University Hospital, Mercy University Hospital and University Hospital Kerry.

"We saw the consequences over recent weeks of not having Bantry fully operational. Cork and Kerry acute hospitals saw additional overcrowding while people in west Cork had to endure hours travelling in ambulances to Cork City or Tralee when care could have been given in Bantry," said Mr Conway.

Concerning conditions in Mayo University Hospital

STAFF at Mayo University Hospital, Castlebar are under alarming pressure due to unsafe staff-to-patient ratios, the INMO warned last month.

The union reported that workload and safety concerns were exacerbating the stress and strain of Covid-19, with some staff reportedly unable to take breaks, finish shifts on time or take holidays.

The INMO sought the scaling back of some services to increase safe staffing levels, but despite appeals to both hospital management and the Saolta University Health Care Group, effective action was yet to be taken.

Calling on the HSE to intervene, INMO IRO Anne Burke said: "The situation at Mayo University Hospital is at crisis point. We've had meetings, but nothing has changed. The INMO has raised a list of staff grievances with management, but the scaling back of some services and the opening of a step-down facility in the region only took much-needed staff away from the hospital. The facility is now left without its vital escalation team, which has led to further overcrowding problems."

Call for curtailed services in Sligo and Letterkenny

PRESSURE is mounting in Sligo University Hospital and Letterkenny University Hospital due to additional workloads and unfilled nursing and midwifery shifts, the INMO warned last month.

Both hospitals have experienced exceptionally high demands since the onset of Covid-19, with members citing compromised care due to gaps in staffing and high demands on the service.

The union has raised very serious health and safety concerns of staff with management in both hospitals and is calling for the urgent recruitment of nurses and midwives across the hospitals to keep essential services running safely and the curtailment of all non-emergency care in the meantime.

INMO IRO Neal Donohue said: "The northwest is under serious pressure. Healthcare staff work as a team, but numbers are now severely depleted. The INMO has raised very serious health and safety concerns with management at both hospitals. Our members now require senior HSE intervention. Retaining the current staff will become impossible if the situation is not improved."

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- Stockley's Drug Interactions
- Martindale: The Complete Drug Reference
- Palliative Care Formulary
- Martindale's ADR Checker
- Critical Illness
- Clarity's Diagnosis and Treatment Guidance
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- Stockley's Interactions Checker
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Meet the vaccinators

Freda Hughes caught up with some of the nurses and midwives co-ordinating the 37 Covid-19 vaccination centres across the country

Noreen O'Leary – City Hall, Cork

NOREEN O'Leary manages the vaccination centre at City Hall in Cork city. The centre vaccinates around 1,900 people per day. It has 30 vaccination booths and is staffed predominantly by nurses and midwives but also has a large cohort of GPs, medical students, retired health professionals and consultants who help with administering vaccines.

As lead co-ordinator of the centre in conjunction with two deputy leads, Ms O'Leary manages the whole team including staff and volunteers from the defence forces, St John's Ambulance and the Order of Malta. She works closely with the leads in admin, security and cleaning staff, and liaises with City Hall's maintenance team and management regularly to ensure the upkeep of the centre as well as the health and safety of her staff.

Ms O'Leary was seconded from her post as assistant director of nursing for the perioperative department at Cork University Hospital (CUH) prior to taking up her current position. Her work in CUH involves strategic planning and management of staff and resources. She feels this left her well prepared for taking on her role at the vaccination centre.

"On a personal level, the challenge of moving from a hospital setting where I was very comfortable in my role to a completely new setting with lots of variables was a bit daunting. We were all strangers to each other at the start but we have built a strong and highly functional team. I have huge support from the South/Southwest Hospital Group. We boost each other's confidence and morale and we're all aware of how important the work we are doing here is.

"Another challenge for us is the lack of time we can spend with each person we vaccinate. As nurses, we are used to focusing on patient care so sometimes this feels a bit like a conveyor belt, but it is so important that we process people in an efficient manner. I have an enormous multidisciplinary team around me, but it is very much nurse-led," she said.

They begin vaccinating around 9am every morning and administer the final vaccine each day just after 4pm. She said that a few people don't show up each day, but that those who attend are happy to get their vaccine. Her team always has at least two doctors on site to answer questions that people may have. These doctors also administer vaccines.

CUH was hit hard during the second wave of the pandemic. At one point all the staff and patients of one ward had contracted Covid-19. Ms O'Leary witnessed some really heart-wrenching events during that time, but also the sacrifices nurses made. They upskilled and were redeployed to areas they had never worked in before. She saw theatre nurses retrain as ICU nurses to help their colleagues who were under strain there; she saw how ED nurses oversaw the pandemic-related changes

to their department and how directors of nursing fought hard to secure PPE.

"From the beginning, it has been nurses leading the way during the pandemic. It has been up to nurses to implement the necessary changes throughout the health service. We've also borne the brunt of healthcare workers' infections too. When I look back I don't know how we did it. Nurses make executive decisions daily about care, about implementation of new systems, about safety. We have to think on our feet. I think nurses multitask naturally. Our huge workload is not reflected in our pay and this has to change. We can't walk away from a sick patient when our shift changes by the very nature of our work so years of understaffing takes its toll. We are constantly expected to do more with less," said Ms O'Leary.

Karn Cliffe – Citywest, Dublin

THE vaccination centre at Citywest has been responsible for 10% of the national total of vaccines administered so far. In July alone it hit 250,0000. Vaccinators there work 12-hour shifts from 8am to 8pm daily and the centre is open seven days a week.

Karn Cliffe is vaccination lead for Citywest and the Dublin Midlands Hospital Group. She has a background in both nursing and midwifery and has a doctorate in midwifery. She worked in many disciplines in a number of countries before taking up her role back home as sepsis assistant director of nursing and midwifery with the Dublin Midlands Hospital Group.

When the pandemic hit, Dr Cliffe initially supported Naas General Hospital with its track and trace system, subsequently working with nursing homes and residential care facilities in the area of infection prevention and control.

She was involved in the early stages of the national COVAX system before being asked to assist in planning the vaccine rollout to Dublin Midlands Hospital Group's catchment of seven public hospitals and two private hospitals along with numerous nursing homes and community facilities.

She set up the clinical lead roll in Citywest and now has a team around her.

"As a nurse and a midwife, I would never have had reason to work with the national ambulance service or the defence forces before so that's been an absolute privilege. We're all pulling together to vaccinate our little portion of the nation. We're contributing positively to the recovery phase of the pandemic," she said.

The operation is heavily nurse led but is multidisciplinary and multi-agency so vaccinators can be nurses, doctors, midwives, pharmacists, physiotherapists and that list is growing. ED technicians, paramedics, people who came out of retirement and nurses and midwives working overtime have all joined the team.

"Nurses are very familiar with the needs of people in vulnerable situations and that's completely transferable to members of the public. There has to be a huge emphasis on communication and empathy in this role. A huge part of our role is health promotion. We want to improve outcomes for people

by vaccinating them so they'll be free to move about as they did before the pandemic.

"The sense of togetherness is really rewarding. The support from the directors of nursing and the hospitals in the Dublin Midlands group has been brilliant. It's not just nursing, it's the HR, finance, ICT and operational elements too. It's been a huge team effort. We talk about fast tracking Sláintecare but we've actually seen it in action here at Citywest," Dr Cliffe told *WIN*.

Jean Kelly – Galway

JEAN Kelly grew up opposite the Mater Hospital in Dublin and always wanted to become a nurse. She trained in Our Lady of Lourdes Hospital, Drogheda and the Coombe and worked abroad before settling in Galway where she became chief director of nursing for the Saolta University Health Care Group. Recently retired, in January Ms Kelly was approached by the head of the Saolta group and asked to assist with vaccine rollout in the region so she took on the role of operations manager of Galway's largest vaccination centre at Ballybrit Racecourse. The centre vaccinates up to 3,000 people per day depending on vaccine availability.

"At the beginning we were vaccinating cohorts of patients who had long-term illnesses or disabilities as well as those who are terminally ill. It was wonderful to be able to vaccinate these people and allow them to start engaging with society again," said Ms Kelly.

The centre is staffed by a team of approximately 70 nurses, midwives, doctors, pharmacists and physiotherapists who administer the vaccines and are supported by clerical, cleaning and security staff, the Irish Army and volunteers from the Irish Red Cross and the Civil Defence. All staff and volunteers report to Ms Kelly.

She said the biggest challenge in setting up this centre was that they were not working in a purpose built health centre with a HR department and medical stores.

"There are loads of things that we take for granted every day in hospitals. We realised that we were quite isolated as a stand-alone unit outside the hospital setting. The support of the defence forces was absolutely integral to the success of the vaccination centre. They have the experience of setting up field hospitals in conflict zones so they knew the logistics of starting from virtually nothing and making it work."

There is also a satellite centre in Clifden where they send staff one day a week. Ms Kelly said that 99% of people who come through the door are delighted to get their vaccine but they have a lot of questions and some are fearful.

"I think that nurses are born multitaskers. We're able to think outside the box. We look at the whole picture. If you look at the depth and scope of a CNM's role you can really see the wealth of skills nurses and nurse managers must have to carry out

their work. Nurses make brilliant leaders because they have a connection with the patient but they also have an eye on policy and what needs to be done strategically.

"I've never seen nurses as solution-focused as during this pandemic and I couldn't be more proud of my peers and my profession. It's really important that people start to understand and appreciate the value of nursing going forward after this pandemic. In every country nurses are leading the way since the pandemic began," said Ms Kelly.

Noel Cullen – Donegal

NOEL Cullen is one of the clinical leads at Donegal's vaccination centres. The main centre for the county is in Letterkenny Institute of Technology, with Carndonagh Community School as a satellite centre. The satellite was set up to facilitate people living in rural areas along with a few temporary walk-in clinics around the county too.

"There is so much scaremongering on social media so we try to counteract that through education. We can understand people's hesitancy when they are being misinformed. It's about directing people to reliable sources of information so they can educate themselves. Our goal is to try to get as many people vaccinated as possible," he said.

Mr Cullen worked in gerontology for many years but had moved into the area of infection prevention and control just before the pandemic. He praised the team in Letterkenny University Hospital (LUH) where he works and the overall Saolta University Health Care Group for the way it has managed the pandemic.

Initially he was involved in administering vaccines at LUH to health professionals and people with underlying conditions before becoming one of the two clinical leads in the vaccination centre.

"The most rewarding thing was vaccinating people who had been isolated for so long. Some people were in tears they were so thankful. Facilitating vulnerable people to get their lives back and grandparents seeing their grandkids again really is the icing on the cake for us in this job. Knowing that we're part of a larger global movement to get the world back to normality feels good," said Mr Cullen.

The Letterkenny centre can vaccinate up to 1,800 people a day. The Carndonagh centre is smaller and can accommodate about 200 people a day. Due to the large geographical area they cover, staffing is a challenge. Transporting the vaccine can also cause problems and staff often stay late so as not to waste vaccine.

The two centres are run by just three nurses along with a team of retired health professionals including nurses, midwives, doctors, paramedics and pharmacists. Mr Cullen and Pauline McClintock head up the team. They are supported by the defence forces who take responsibility for transporting the vaccines, managing queues and medication management. He said the team is phenomenal and has a good rapport.

"Nurses are used to adapting and going

that extra mile. We've watched people die from this. We've seen our colleagues get sick. We see the difference a vaccine can make. All we have to do is look at measles, polio and other awful sicknesses which have almost been eradicated due to vaccines.

"We really are making a difference and saving lives. In years to come we will talk about this pandemic the way our grandparents talked about World War 2. It's such a privilege to be on the frontlines during this pandemic and to be part of the solution to this crisis," he added.

Experiencing difficulties paying?

For cyber security reasons, in the interests of protecting the integrity of individual banking credentials, new restrictions have been imposed on payment systems. The INMO will no longer be able to accept payments over the phone. Payments can be made by:

- Monthly salary deduction, using the deduction at source form available from INMO (Not all work locations offer this facility so an alternative would be by monthly standing bankers order through your bank)
- Monthly standing bankers order, using form available from the INMO
- Cheque payable to INMO
- Postal order payable to INMO
- Bank draft payable to INMO
- Online via our website (using your unique quick payment code available from the INMO).

If paying online, your bank security will require that the billing details on the card you are using are the same as those used to register membership with INMO.

We apologise for any inconvenience, but heightened awareness of cyber security is in all of our interests. We must implement the highest standard of protection for our members.

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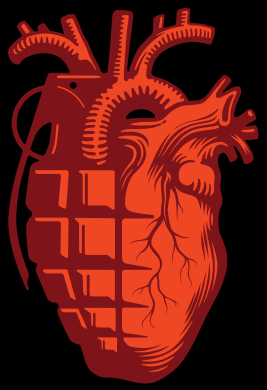

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H FpEF — heart failure with preserved ejection fraction in patients typically over 60 years old[5-7]

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

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

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

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

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

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

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References

1. Sipe JD, Benson MD, Buxbaum JN, et al. Amyloid fibril proteins and amyloidosis: chemical identification and clinical classification International Society of Amyloidosis 2016 Nomenclature Guidelines. *Amyloid*. 2016;23(4):209-213. **2.** Maurer MS, Elliott P, Comenzo R, Semigran M, Rapezzi C. Addressing common questions encountered in the diagnosis and management of cardiac amyloidosis. *Circulation*. 2017;135(14):1357-1377. **3.** Connors LH, Sam F, Skinner M, et al. Heart failure due to age-related cardiac amyloid disease associated with wild-type transthyretin: a prospective, observational cohort study. *Circulation*. 2016;133(3):282-290. **4.** Pinney JH, Whelan CJ, Petrie A, et al. Senile systemic amyloidosis: clinical features at presentation and outcome. *J Am Heart Assoc*. 2013;2(2):e000098. **5.** Mohammed SF, Mirzoyev SA, Edwards WD, et al. Left ventricular amyloid deposition in patients with heart failure and preserved ejection fraction. *JACC Heart Fail*. 2014;2(2):113-122. **6.** Maurer MS, Hanna M, Grogan M, et al. Genotype and phenotype of transthyretin cardiac amyloidosis: THAOS (Transthyretin Amyloid Outcome Survey). *J Am Coll Cardiol*. 2016;68(2):161-172. **7.** González-López E, Gallego-Delgado M, Guzzo-Merello G, et al. Wild-type transthyretin amyloidosis as a cause of heart failure with preserved ejection fraction. *Eur Heart J*. 2015;36(38):2585-2594. **8.** Narotsky DL, Castano A, Weinsaft JW, Bokhari S, Maurer MS. Wild-type transthyretin cardiac amyloidosis: novel insights from advanced imaging. *Can J Cardiol*. 2016;32(9):1166.e1-1166.e10. **9.** Brunjes DL, Castano A, Clemons A, Rubin J, Maurer MS. Transthyretin cardiac amyloidosis in older Americans. *J Card Fail*. 2016;22(12):996-1003. **10.** Castaño A, Drach BM, Judge D, Maurer MS. Natural history and therapy of TTR-cardiac amyloidosis: emerging disease-modifying therapies from organ transplantation to stabilizer and silencer drugs. *Heart Fail Rev*. 2015;20(2):163-178. **11.** Carroll JD, Gaasch WH, McAdam KP. Amyloid cardiomyopathy: characterization by a distinctive voltage/mass relation. *Am J Cardiol*. 1982;49:9-13. **12.** Cyrille NB, Goldsmith J, Alvarez J, Maurer MS. Prevalence and prognostic significance of low QRS voltage among the three main types of cardiac amyloidosis. *Am J Cardiol*. 2014;114(7):1089-1093. **13.** Quarta CC, Solomon D, Uraizee I, et al. Left ventricular structure and function in transthyretin-related versus light-chain cardiac amyloidosis. *Circulation*. 2014;129(18):1840-1849. **14.** Connors LH, Prokaeva T, Lim A, et al. Cardiac amyloidosis in African Americans: Comparison of clinical and laboratory features of transthyretin V122I amyloidosis and immunoglobulin light chain amyloidosis. *Am Heart J*. 2009;158(4):607-614. **15.** Nakagawa M, Sekijima Y, Yazaki M, et al. Carpal tunnel syndrome: a common initial symptom of systemic wild-type ATTR (ATTRwt) amyloidosis. *Amyloid*. 2016;23(1):58-63. **16.** Rapezzi C, Merlini G, Quarta CC, et al. Systemic cardiac amyloidoses: disease profiles and clinical courses of the 3 main types. *Circulation*. 2009;120(13):1203-1212. **17.** Sperry BW, Reyes BA, Ikram A, et al. Tenosynovial and cardiac amyloidosis in patients undergoing carpal tunnel release. *J Am Coll Cardiol*. 2018;72(17): 2040-2050. **18.** Westermark P, Westermark GT, Suhr OB, Berg S. Transthyretin-derived amyloidosis: probably a common cause of lumbar spinal stenosis. *Ups J Med Sci*. 2014;119(3):223-228. **19.** Yanagisawa A, Ueda M, Sueyoshi T, et al. Amyloid deposits derived from transthyretin in the ligamentum flavum as related to lumbar spinal canal stenosis. *Mod Pathol*. 2015;28(2):201-207. **20.** Sueyoshi T, Ueda M, Jono H, et al. Wild-type transthyretin-derived amyloidosis in various ligaments and tendons. *Hum Pathol*. 2011;42(9):1259-1264. **21.** Phelan D, Collier P, Thavendiranathan P, et al. Relative apical sparing of longitudinal strain using two-dimensional speckle-tracking echocardiography is both sensitive and specific for the diagnosis of cardiac amyloidosis. *Heart*. 2012;98(19):1442-1448. **22.** Ternacle J, Bodez D, Guellich A, et al. Causes and consequences of longitudinal LV dysfunction assessed by 2D strain echocardiography in cardiac amyloidosis. *JACC Cardiovasc Imaging*. 2016;9(2):126-138. **23.** Coelho T, Maurer MS, Suhr OB. THAOS - The Transthyretin Amyloidosis Outcomes Survey: initial report on clinical manifestations in patients with hereditary and wild-type transthyretin amyloidosis. *Curr Med Res Opin*. 2013;29(1):63-76. **24.** Swiecicki PL, Zhen DB, Mauermann ML, et al. Hereditary ATTR amyloidosis: a single-institution experience with 266 patients. *Amyloid*. 2015;22(2):123-131.

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Pfizer Rare Disease

Navigating the effects of Covid

Edward Mathews discusses how the INMO is working to mitigate the ongoing effects of the pandemic, which are affecting the lives of nurses and midwives both personally and professionally

DURING the Covid-19 pandemic issues surrounding professional ethics, judgement and practice, including the practice environment, have been to the fore of our members' minds and our work. From the earliest stages of the crisis to the current day we have been acutely aware of the pressures faced by our members in the clinical environment and the potential for significant ethical and practical difficulties.

Early in 2020 we secured guidance from the Nursing and Midwifery Board of Ireland (NMBI) to the effect that in the event that any concern was raised in relation to a nurse or midwife that the context and circumstances that prevailed at the time would always be taken into consideration.

Context

This would apply in the current context of the pandemic. The Board also emphasised that the Scope of Practice guidance supports a nurse or midwife taking appropriate action in emergency and/or life-threatening situations. At all times, the overall benefit to the patient must be served in these situations.

The INMO further secured guidance from NMBI in relation to circumstances in which PPE might be difficult to source and we used that guidance and the precautionary principle to support our members in accessing necessary PPE throughout the country.

Decision making

In January 2021 we secured further guidance from NMBI in relation to maintaining professional ethics in the context of decision making in relation to care provision. The Board articulated that it appreciated that nurses and midwives continue to demonstrate the values of compassion, care and commitment in providing services during the Covid-19 pandemic and that at all times the overall benefit of the patient was being served though our members' practice. Additionally, the Board acknowledged that the pandemic has challenged the lens through which some decisions have to be made and that if concerns are raised about the practice of a nurse or midwife, the context and circumstances that prevailed at the time would always be taken into consideration.

The statements secured from NMBI both serve to ensure that our members are bolstered to rely on their Code and the Scope of Practice in guiding their practice and in insisting with our support on the appropriate supports in the practice environment. These are not mere sentiments, on many occasions members have been supported to rely on their professional ethical principles and guidance in safeguarding their patients and themselves.

Redeployment

Redeployment has posed a significant burden on many nurses and midwives in terms of both personal and professional demands. The INMO has worked to support members industrially by agreeing protocols around redeployment, including the unwinding of these as emergency circumstances abated. Abuse of redeployment agreed in the context of Covid-19 and utilised for other purposes has also been called out and resisted.

Additionally, in terms of redeployment we have advised and supported members in relation to their Code and Scope of Practice in the context of redeployment.

In doing so we reflected that, mindful that these are unprecedented times, we should also remember that while we may not be competent in respect of a given task in a given area, nursing and midwifery are not task-oriented professions.

While there are spheres of activity in a given area where we cannot safely contribute, and thus must not stray, there may well in the very same areas be other nursing and midwifery services which we can provide safely. Therefore, when asked to work in a different, new or unfamiliar area we need to consider our knowledge, skills and associated competencies. However, we need to do so in a holistic way – acknowledging that which we can do and refrain from that which we cannot do safely.

We must communicate constantly with colleagues and managers to maximise our ability to make a safe and impactful contribution. We must also bear delegation in mind, as well as our obligation in this area to only delegate where we can do so safely in the context of Scope of Practice and the Code of Conduct.

As well as providing a checklist of support and considerations in redeployment, the INMO re-emphasised that organisations and individual managers must support nurses and midwives to maintain professional principles at all times and must respect a professional's decision in relation to the limitations of their Scope of Practice.

INMO support

We continued to support our members in professional practice through the publication of guidance in relation to safety going to and coming from work. We also facilitated a wide range of professional webinars in diverse areas of practice to provide a space for conversation and information sharing in what were extremely

difficult circumstances. We published online guidance, and transitioned all of our professional events, materials and education to online forums to support and maintain contact with our members throughout this difficult time.

The INMO is particularly conscious of the toll that working during Covid-19 has taken, and continues to take, on our members' physical, psychological and emotional wellbeing. As well as providing the INMO counselling telephone helpline, we commissioned online resources and services in area of wellness and wellbeing to support all of our members.

Appreciating that the toll was severe, and in many respects only partially visible, if at all, we needed to bring to the fore the true effects of the pandemic on members to ensure that they receive the recognition and support that they deserve.

Survey

Our survey of members provided key data on the well-being of respondents, including the impact of workplace and organisational stressors, Covid-19 stressors, physical health impacts, mental health impacts and knowledge of available services.

The vast majority (91%) of nurses and midwives who responded to the survey said they have experienced mental exhaustion while off duty.

More than four out of every five respondents (83%) said their experience of Covid-19 had a negative impact on them as an individual, while 95% said it had a negative impact on their colleagues.

More than half of respondents said a patient they cared for died as a result of Covid-19 and 61% said they considered leaving the profession due to the impact of the pandemic on their wellbeing.

The survey also highlighted work-related concerns that arose during the pandemic:

- 83% agreed with the statement "I feel my personal health has been put at risk"
- 90% experienced stress about the risk of spreading the infection to family or housemates
- 40% said they did not have confidence in their employer's ability to keep them safe
- 25% disagreed with the statement "PPE was always available in my workplace"
- 90% believed that routine Covid-19 testing of staff should take place
- 33% reported stress in relation to difficulty accessing childcare.

These were and continue to be important indicators about the experience of our members. This data continues to facilitate the INMO's advocacy on the safety of our members, support of our members and the recognition of our members.

An analysis of the repeat survey carried out in 2021 continues to demonstrate that more than 90% of the respondents report negative effects on members of the profession and mental exhaustion while off duty.

The continuing evidence of the effects of the pandemic emphasise the importance of tangible recognition for the role played by nurses and midwives and the need for consistent personal, professional and trade union support in the workplace.

Edward Mathews is INMO director of professional and regulatory services

Long Covid – FAQs

As research on long Covid evolves, **Margaret Kirby** answers frequently asked questions about the condition based on existing data

What is long Covid? Also known as post-Covid-19 condition, long Covid currently affects up to one in 10 people. These people still have symptoms for up to 12 weeks beyond the course of their infection, and in some cases up to a year after. The majority of people improve in time but some may experience differences in their rate of improvement.[1]

Who does it affect? Any person who has had Covid-19 or suspected Covid-19 is at risk of developing this condition. It affects people of any age. In some cases it does not correlate with the severity of the acute infection,[2] although some research indicates that those who were exposed to a high viral load during their initial infection are at a higher risk of developing it later, eg. those working with infected Covid-19 cases.

What are the symptoms? The most common symptoms reported include physical and cognitive fatigue, shortness of breath, headaches and chest pain. Less common symptoms include joint pain, dizziness and a cough. Other symptoms may involve serious organ disease, including cardiovascular symptoms, neurocognitive (memory and speech), neurological (stroke and migraines) and respiratory issues (lung disease and asthma). For some individuals, symptoms may overlap with post-infectious chronic fatigue syndrome, also called myalgic encephalomyelitis (ME).

Which work sectors are most at risk? Healthcare workers, social care workers and those who are in contact with infected individuals or waste may be exposed to a greater viral dose than other workers and therefore may be at greater risk.

How is it diagnosed? To date, there is no single test for diagnosing this condition. Obtaining a full history from the individual is important, including age, occupation, general medical history and Covid-19 infection history. Guidelines produced by the National Institute for Health and Care Excellence (NICE) in the UK advises the following two criteria for diagnosing persistent symptoms of Covid-19:

- Ongoing symptomatic Covid-19 – if people present with symptoms four to 12 weeks after the start of acute Covid-19 infection that are not explained by an alternative diagnosis
- Post-Covid-19 syndrome/condition – if the person's symptoms have not resolved 12 weeks after the start of acute Covid-19.

What should employees do if they suspect they have long Covid? According to the HSE, people with symptoms should initially attend their GP for a general assessment, followed by referral onto specialist pathways for people who require specialist services. Examples of assessments may include clinical tests focusing on lung function impairment, reduced muscle strength, nerve damage, automic dysregulation and organ damage. Employees are also encouraged to engage with their employer if they are diagnosed with the condition to enable the employer to offer any supports and provide any work accommodations that may be needed. A consultation with an occupational health provider is also recommended to ensure the best possible advice is given to the individual regarding the condition, the return-to-work options and any work adjustments needed to facilitate the individual in the work environment. According to the Society of Occupational Medicine, patients with specific conditions, including myocarditis (inflammation of the heart muscle), problems with the autonomic nervous system (heart, bladder, intestines etc.) and lung issues may require specialist cardio-respiratory clearance before returning to strenuous work.

What treatments are available? Treatment options vary depending on the symptoms being experienced. The model of treatment proposed by the HSE is based around supporting people to manage their own symptoms and setting up a limited number of specialist pathways for those who require specialist services. For those with improved symptoms, research suggests that treatments may include speech therapy, antihistamines, dietary alterations and heart rate and angina control. Physiotherapy may be useful for those with postural tachycardia syndrome (PoTS), which is an abnormal increase in heart rate that occurs after sitting up or standing.[3]

What are the implications for employers? Employers who have sickness absence policies may need to review these with regard to long Covid. An international survey on behalf of the Society of Occupational Medicine found that more than 20% of employees remained off work for up to seven months following infection, and 45% were working at a reduced capacity. According to a recent report in *The Economist*, one in five people with long Covid say they are unable to fulfil even a part-time, desk-based job. Employers should consider flexible working policies, the provision of home-working where possible and reduced hours. They should also be patient with those who have the condition. A phased return to work may be needed as the person may appear well one day and not well the next.

What are the work implications for employees returning to work after long Covid? Long Covid can have serious consequences on what an employee can and cannot do in the course of their job and each person's symptoms should be assessed individually. Research shows there may be issues with prolonged standing due to autonomic dysfunction. Ongoing fatigue can limit the length of time workers can stay at a task and also impact on work intensity. The use of certain meeting technologies, eg. Zoom, can aggravate hoarseness due to over stimulation of the voicebox. Short-term memory, reading, naming objects, concentration and attention can all be impacted.

What are the implications for occupational health professionals? The role of occupational health is to advise on fitness to work and make recommendations on any adjustments that are needed to facilitate a person remaining in work or returning to the workplace after a period of illness or absence. Post Covid-19 condition should be treated the same as any medical condition impacting on work and employees returning to work may require support or advice, including the offer of any Employee Assistance Programme (EAP), such as counselling services. Consideration should be given to a phased return to the workplace or altered duties if necessary. This should be done in consultation with the employer, occupational health and the employee.

What are the implications for health and safety professionals? The health and safety professional, in conjunction with line management, should ensure that any person returning to work has had a fitness to work assessment completed by occupational health and the workplace risk assessment is updated. The risk assessment should reflect any changes/ modifications required to facilitate the employee at work and ensure no other employees are placed at additional risk due to those changes. Further information on the HSA's fitness to work guidance following Covid-19 absence is available at **https://tinyurl.com/3yspde5v**

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Q and A Bulletin Board

With INMO director of industrial relations Tony Fitzpatrick

Being a close contact of Covid-19

Q. What arrangements apply if I must restrict my movements following close contact with a confirmed case of Covid-19?

If you are vaccinated or have had Covid-19 you do not need to restrict your movements or be tested for Covid-19 if it is more than:

- Seven days after your second Pfizer-BioNTech dose
- 14 days after your second Moderna dose
- 14 days after the Janssen vaccine
- 15 days after your second AstraZeneca dose.

If you are a close contact of a person who tests positive for a Covid-19 variant of concern you will need to:

- Get tested for Covid-19
- Self-isolate for 14 days.

You will need to do both even if you are fully vaccinated.

Special leave with pay does not apply to employees who are required to restrict their movements or self-isolate as a close contact of a variant of concern as they are not sick. Where an employee is required to restrict their movements, or self-isolate as a close contact of a variant of concern, the employer must facilitate working from home. If working from home is not possible then the employee may be assigned work that could be outside of their usual duties. Employees must co-operate with all such flexibilities while they are restricting their movements. While working from home the employee is deemed available for work and paid as normal.

Returning to work after Covid

I am due to return to work after being on long-term sick leave as a result of Covid-19. I am contracted for 30 hours per week, but occupational health has advised that I return on a phased basis on 20 hours per week. My employer has advised me that in order to be paid my contracted hours I need to record the outstanding 10 hours as annual leave. Is this correct?

If you were in receipt of the special leave with pay (SLWP) during your absence then you retain access to special leave with pay during your phased return to work subject to the following conditions:

- The occupational health physician (OHP) carries out a medical assessment and recommends a phased return to work, on a temporary basis, in line with the employer's rehabilitation policy
- SLWP may apply, subject to defined time limits, to the portion of contracted hours that the employee is deemed temporarily unfit to work due to the medically certified Covid-related illness. The 10 hours that you are temporarily unable to work will be recorded as special leave with pay
- During the phased return, the OHP confirms that the employee is accessing appropriate medical care and rehabilitation supports
- The employee will be required at all times to comply with their employer's HR policies and procedures governing sickness absence.

Overtime entitlements

Q. I am currently working in the public health service as a staff nurse. My employer requested that I work overtime, and I was advised that this will be paid at time and a quarter. I had read in an INMO update that overtime rates had increased.

Yes, overtime rates have increased. Overtime rates were cut in 2013. However, under the Building Momentum Agreement the rates were put back to the level they were previously at. As of July 1, 2021, overtime rates have increased. Below are the new rates which you should bring to the attention of your employer.

Monday to Friday	
Flat rate x 1½	For additional hours worked between start of normal day duty and midnight
Flat rate x 2	For additional hours worked between midnight and start of normal day duty
Saturday	
Flat rate x 1½	For additional hours worked overtime will be paid at 1½ for the first four hours
Flat rate x 2	For additional hours worked in excess of the first four hours
Sunday	
Flat rate x 2	For all additional hours worked

Staff Nurses/Midwives and Enhanced Nurses/Midwives

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

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

If you have any queries in relation to the above, please get in touch with the INMO Information Officers:

Catherine Hopkins or Karen McCann at Tel: 01 664 0610 or 01 664 0619 or by email to: catherine.hopkins@inmo.ie or karen.mccann@inmo.ie

Spotlight on: Leadership

The first article in a new series on nursing and midwifery leadership

INSPIRED by the Nursing Now Challenge and Nurses Together, this new series of articles in *WIN* will seek to explore the concept of leadership, its varying styles, theories and approaches and provide views and insights from leaders in the field.

Nursing leadership is central to the delivery of an efficient, high-quality and effective healthcare service that keeps patient safety and care excellence at its core. Leadership is crucial for achieving United Nations sustainable development goal 3 and achieving universal healthcare on a global scale. International organisations such as the International Council of Nurses and the International Confederation of Midwives provide leadership representation on a global scale, working closely with the World Health Organization (WHO) and the UN to achieve these essential goals.

Nationally and regionally, nurses and midwives hold critically important senior positions providing strategic leadership and decision-making. They deliver innovative, cost-effective and compassionate healthcare services and offer the highest level of care to patients and service users.

From the boardroom to the bedside, leadership is increasingly an essential skill for nurses and midwives working at the point of care and is not solely associated with formal positions of seniority or management. Clinical leadership is a crucial component for practising nurses and midwives and is central to delivering on a change agenda and providing responsive quality improvement initiatives.

Increasingly, leaders are challenged by the complex nature of modern, dynamic healthcare systems. Ireland is no exception, and nurse and midwife leaders have made real and important advancements in healthcare provision over the years. The establishment of the chief nursing officer position marked a significant milestone for the country.

The literature on leadership is extensive and can be somewhat overwhelming. Even the definition of leadership itself is complex and can mean different things in different settings. According to The Kings Fund,[1] "leadership is the most influential factor in shaping organisational culture and so ensuring the necessary leadership behaviours, strategies and qualities are developed is fundamental".

There is no one fixed or correct approach, and certain situations may call for a specific type of leadership style. More recently, the ability to lead across professional boundaries and in teams has become central to leadership.

Healthcare leadership is constantly under scrutiny; therefore providing ongoing education and training in this area is vital. Of particular importance is leadership education training and support early in a nurse's or midwife's career. This is a central motivation for the Nursing Now Challenge.

The pandemic is a testament to the leadership that exists within the professions. Throughout the past 18 months, nurses and midwives have demonstrated their ability to lead while under immense pressure due to a lack of staff and increasingly heavy workloads while facing severe risks to their health and wellbeing.

Leadership does not stand still; rather it changes over time and although significant advancements have been achieved, more changes are required. The State of the World's Nursing Report[2] identifies the importance of leadership, specifically transformational leadership, to ensure that the gender issues that exist are overcome: "Women only comprise 25% of health system leadership roles. Addressing the gender-related barriers to leadership that exist within the nursing profession and outside of it is critical to ensuring sustainable delivery of essential health services and primary health care to all communities."

The report also identifies the need for investment in leadership, for the creation of leadership pathways and for having nurses and midwives at the decision-making table. The WHO has described the need for "bold" investments in leadership and education. Only when these are achieved will further progress be made for the nursing and midwifery professions.

Get in touch

If you are interested contributing to this series of leadership articles, email Steve Pitman, INMO head of professional development at: steve.pitman@inmo.ie

INMO Professional runs a continuing professional development programme entitled 'Introduction to Management and Leadership Skills for Nurses and Midwives'. For upcoming dates, check the INMO Professional Website – **inmoprofessional.ie** – for further information.

The Royal College of Midwives provides a series of leadership online modules, which are accessible to registered midwives. For further information, contact the library at: library@inmo.ie

Niamh Adams is head of library services and Steve Pitman is head of professional development, both with the INMO

Inspired by the 2021 Nursing Now Challenge and Nurses Together, this article is the first in a series on the topic of leadership. Launched in 2021, the Nursing Now Challenge brings forward the Nightingale Challenge mandate, which focuses on developing leadership opportunities for nurses and midwives globally. Visit ***www.nursingnowireland.ie***

Cornmarket

Invest in your future and watch it grow with an AVC

Adrian Travers, Manager for Life and Pensions, discusses how investing in an Additional Voluntary Contribution (AVC) is one of the best decisions you can make while you're working.

Right now, almost everything in your life depends on your salary. When you retire it's your pension, not your salary, that will fund your lifestyle and provide you with financial security. When you retire you may still have dependents, want to go traveling, want to do up your house or upgrade your car... to name but a few!

What are the benefits of investing in an AVC?

✔ **You get tax relief now**
Investing in an AVC allows you to save money for your future and get tax relief right now!
For example, if you pay income tax at 40%, for every €100 you invest in an AVC the actual cost to you is only €60!
This is because you will get €40 of your €100 investment back in tax relief.

✔ **You have the option to retire early**
An AVC can help you bridge the gap in your pension benefits enabling you to retire early.
Wouldn't it be great to be able to start this exciting next chapter in your life earlier, if you want to?

Did you know?

Of a sample of 250 nurses who settled their AVCs in 2020*:

- **25 years** was the average years of service
- **Only 23 nurses** had the full 40 years' service.

If you're closer to 25 years' service than 40 years, don't worry... that's what an AVC is for!

✔ **You decide how much you invest**
It's your AVC so you can increase, decrease, stop or restart your AVC contributions at any time**.
This means that your investment can adapt in line with your life and priorities.

✔ **You choose what option suits best**
When the time comes to retire, you choose what options suit you best, for example:

- Tax-free lump sum
- Approved Retirement Fund
- Taxable cash
- Annuity

Note: Options are subject to Revenue requirements and, therefore, may not all be available to everybody.

How much would I get at retirement?

In 2020, over 1,000 Cornmarket clients settled their AVC at retirement and below are their average values***. The figures speak for themselves:

What they invested	What they got at retirement
€27,000 Net amount	**€61,000** Total AVC value
€45,000 Gross amount	**€19,000** Taken as a tax-free lump sum
€18,000 Tax relief invested (assuming they received tax relief at 40%)	**€42,000** Taxable balance (majority invested in an Approved Retirement Fund (ARF))

How can I start an AVC?

Start yours today by speaking with one of our experts call **(01) 420 0967** or visit **cornmarket.ie/avc**

The sooner you start, the more your investment will grow!

Warning: The value of your investment may go down as well as up.
Warning: This product may be affected by changes in currency exchange rates.
Warning: If you invest in this product you may lose some or all of the money you invest.
Warning: If you invest in this product you will not have any access to your money until you receive your Superannuation Benefits.

*Source: Cornmarket, July 2021.
**Subject to minimum contribution of €75 per month and maximum age-related revenue tax relief limits.
***Source: Irish Life, January 2021. Figures have been rounded to the nearest thousand and are based on 1,090 Cornmarket clients from four AVC Schemes.

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'Loyal, fun loving and a great confidante': Regina Durcan remembered

A much-loved member of the INMO, Regina Durcan served three terms on the Executive Council and spent eight years as an IRO

REGINA DURCAN passed away in June following a short illness. She was the INMO's industrial relations officer (IRO) for the Western Region for eight years, prior to which she sat on the INMO Executive Council for three terms from 2000 to 2008. She was active with the union throughout her career.

Regina's first love was her family – husband Tom and daughters Catherine and Gina. She looked forward to her retirement and spending more time with Tom once the girls were finished their education. In retirement, Regina delighted in being at home in the countryside enjoying her garden and her polytunnels for fresh vegetables and home grown potatoes.

Regina was a proud nurse and midwife and always had a real sense of fair play. She had a great practical approach and exercised a high level of common sense during her career in the health service. The delivery of high standards of care was always to the forefront of Regina's professional life.

Regina was never afraid to speak out on behalf of members if something was wrong. She tackled many challenging workplace issues on behalf of INMO members and addressed each one professionally and with integrity. Nothing would distract her pursuance of members' issues in her inimitable forthright and practical manner.

There are many nurses and midwives within the INMO membership who have benefited from Regina's intervention. Throughout her time working as an IRO in the Western Region, management and colleagues from other unions always held her in high regard.

As a friend and colleague, Regina was loyal, fun loving and a great confidante. While she retired in 2016, she maintained strong ties with her friends in the INMO.

Above left: Mary Power and Regina Durcan. Above right: Regina Durcan. Below: Regina Durcan (third from right) pictured with her fellow INMO IROs in 2016

The bravery she demonstrated during her short illness has left a deep imprint on those who knew her. Knowing that she had a life-limiting illness really tested her strength and she bravely used that time to prepare her family and friends for her passing.

It is difficult to put into words what the loss of our dear friend means. It was a privilege to have known Regina. She will be very sadly missed by us all.

Protecting your mental health

THE mental health and wellbeing of nurses and midwives has never been more important. However, mental health stigma and a 'just get on with it' culture in the profession can often create barriers to seeking support when members need it.

To start the conversation on this, we invited former nurse and TV personality Norah Casey to host the *Let's talk About It* Podcast series for INMO members. This series is a real, honest and important conversation with nurses and midwives as well as leading mental health experts, support services and more. Tune in to hear truths, the highs and lows of the profession and get some practical advice along the way.

Let's Talk About It, a mental health collective for INMO members, is brought to you by INMO and Cornmarket.

The complete *Let's Talk About It* Podcast series is now live and available for INMO members at: **https://www.cornmarket.ie/lets-talk-about-it/podcast**

Episode 1: The wellbeing situation/Covid-19: Norah talks to applied psychologist and researcher Dr Sharon Lambert, senior staff nurse and INMO Executive Council member Ann Noonan, and clinical nurse researcher Toyosi Atoyebi to help us understand the situation and uncover the stresses experienced by those in the profession both before and during the pandemic

Episode 2: Myths and stigma around seeking support Norah is joined by nurse and mental health expert Bríd O'Meara and national lead for the HSE's Employee Assistance Programme, Morgan Lucey, to discuss the stigma around seeking mental health support in the nursing and midwifery profession

Episode 3: Self-compassion – Is it okay to 'just get on with it'? Nurses and midwives as professionals are great at looking after others, but not necessarily themselves. Karen McGowan, nurse and INMO president, Davina Ramkissoon, wellness director of Zevo Health, and Ann Marie O'Reilly, RNID talk about self care and self compassion in nursing and midwifery and if it is okay to 'just get on with it'

Episode 4: Starting the conversation on mental health: Norah is joined by disabilities nurse, Johnny Hunt and director of 50808 Text About It, Nicole Forster to discuss how nurses and midwives can start the conversation about mental health with friends, family or with a support service

Episode 5: Menopause, mental health and nursing: Norah talks to former nurse Kathleen Kinsella of Kinsella Management Solutions and founder of the Menopause Hub, Loretta Dignam about the impact menopause has on the wellbeing and mental health of nurses and midwives

Episode 6: The signs of trauma: Norah is joined by Johnny Moran from the Trauma Response Network Ireland and Davina Ramkissoon, wellness director of Zevo Health, to help us understand differences between trauma, PTSD and burnout. Throughout the pandemic, many front-line workers have been in survival mode. Now, as we adjust to our lives working with Covid-19, it's time to acknowledge our own traumatic responses, listen to our bodies and seek support

Warm welcome to first-year students

Catherine O'Connor welcomes incoming nursing and midwifery students and shares some advice from class reps

I WOULD like to extend a very warm welcome to all of the incoming first year nursing and midwifery students joining the INMO. You are entering a challenging yet hugely rewarding and valued profession and the INMO is here to support you during your training and career. The role of the union is to promote the interests of nurses and midwives.

As a student member you can contact the union for free advice, information, support and representation if you experience any issues while on clinical placement. You can also access a variety of services, such as our library, continuing professional development courses, a legal advice helpline, and a counselling helpline.

As your student and new graduate officer, I am here to answer questions that you may have in relation to your clinical placements and I can advise you on your rights and entitlements. I will update you on issues that may affect you through a Student Link e-zine, which will be emailed to you regularly. If you would like to learn more about how the union works and how you can get involved as a rep for your group, please contact me. Please read the advice below from some of your fellow students based on their experience.

Catherine O'Connor is the INMO's student and new graduate officer. If you have a question for her, please email catherine.oconnor@inmo.ie

Ciarán Freeman, third-year general nursing student, INMO student rep and chair of the INMO Student Section

"Remember to slow things down and take things in. Everything can (and will) absolutely fly by and it's only afterwards you'll realise the chances you've missed. Slow down and take the time to really talk and engage with your patients – they're the real teachers. Slow down and watch out for yourself and your classmates. It's not always easy but a group mentality overcomes most challenges."

Sarah Joyce, second-year general nursing student and INMO student rep

"Starting out college in an online environment for nursing – knowing that in a few months I'd be fighting the pandemic as a frontline healthcare worker with no in-person learning – was hard, but it made me realise that being a nurse is not about having everything perfect all of the time. Of course, getting good grades and achieving competency in clinical skills is very important, but the compassionate care you give to your patients, being there for them when their family can't be and the dedicated commitment to help make their recovery a reality, makes the 12-hour shifts and continuous assignments more than worth it.

Don't be scared to ask questions and reach out for support if you're struggling because, as cliché as it sounds, you can't care for others if you don't care for yourself first. Be organised and make notes so you're not stressing out right before deadlines (it's not like school so the teachers don't hand them out). The advice I wish I'd been given is that nursing isn't just a college degree, rather it is a privileged role you're stepping into because you get to help people to get their lives back on track. The reward that comes along with that is worth so much more than a 4.0 GPA."

Laura Henry, internship midwifery student, INMO student rep, and secretary of the INMO Student Section

"Dear first years,

First of all, a huge congratulations! It takes fierce hard work to get to this starting point. Take a moment to reflect on your journey and celebrate this achievement. The start of your training is as big and important a milestone as the end of training.

It's beyond cliché at this stage but I'll say it anyway - what a time to be beginning your career! I certainly never imagined finishing my training in these conditions and I'm sure that for many of you when you first felt the pull to the caring profession, you didn't envision it all starting for you during a pandemic. It speaks to your strength, determination and passion that you are stepping into this career, particularly at this moment.

My advice to you is to guard those qualities. Find people and routines to keep you strong. Focus on your goal and reach out for help when you need it. This will help you to sustain your passion and keep the joy in your working life. While we have heard stories over the last year and a half that might make us unsteady in starting on this path, it is so important that you find joy in what you do each day."

Quality & Safety

A column by Maureen Flynn

Planning your quality improvement learning journey

THIS month we explore ways in which nurses and midwives can develop their quality improvement knowledge and skills. The HSE Quality Improvement (QI) team has recently produced several quality improvement resources to support you on your QI learning journey and in this column we will showcase the opportunities currently on offer as well as coming soon.

QI learning

QI is an important part of everyone's job and we all have a role to play in improving the quality of the service we provide. Creating and sustaining improvement is not always easy but it can be greatly supported by taking a systematic approach. Learning about the QI methodologies and tools can greatly enhance the chances of your improvement idea getting implemented and most importantly being sustained.

e-learning module

If you are new to QI, a good place to start is the 30-minute e-learning module entitled 'Introduction to Quality Improvement', which is hosted on HSeLanD under the Quality, Leadership & Management Catalogue. This e-learning module has been accredited by NMBI and is awarded one continuing education unit (CEU). A full description of the programme can be found in the Q&S column in the February 2021 issue of *WIN*.

Identifying your QI knowledge and skills learning needs

A key step in any learning journey is to identify what you already know and what you can learn. The newly published *Quality Improvement Knowledge and Skill Guide* will assist you in assessing your knowledge and skills across three levels and will help you to identify your areas for development. This is a great resource to use when preparing for professional development planning meetings with your line manager. The guide can be found at: **www.hse.ie/eng/about/who/qid/improvement-knowledge-and-skillsguide/**

Level 1 – Foundation in Quality Improvement programme

This programme is aimed at those who wish to learn about the basic QI methodologies and tools to support quality improvement. The Level 1–Foundation in Quality Improvement is a three-hour e-learning programme hosted on HSeLanD under the Quality, Leadership and Management Catalogue.

This e-learning programme is underpinned by the six drivers of the HSE' Framework for Improving Quality and includes interactive videos, presentations as well as reflective practice and extended learning opportunities. This programme will be available in autumn 2021 and has been submitted to NMBI for CEU approval.

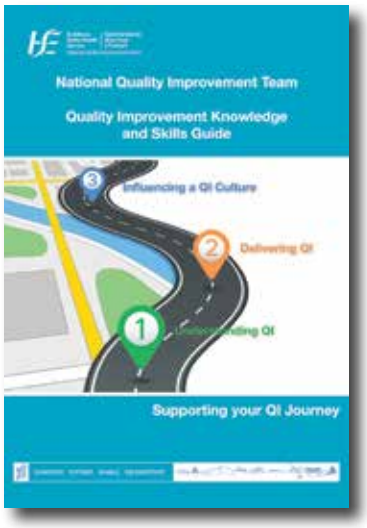
Level 2 – Quality Improvement in Practice Programme

This level of learning is aimed at those who are working as part of a team who wish to implement a quality improvement initiative in their area. The Level 2 – QI in Practice programme uses a blended learning approach consisting of self-directed study, live virtual webinars, project clinics and extended learning activities. Participants consist of teams of two to three members who will work on an improvement project as part of their study. This programme, which is currently under development, will run over a period of 20 weeks commencing in winter 2021. NMBI accreditation for this programme is pending.

Level 3 – Quality Improvement Leadership Programme

This programme is aimed at those in positions with responsibility for influencing a culture of QI in their areas, who support, facilitate, mentor and enable others to implement and sustain improvements.

The level 3 learning programme has been co-designed and co-delivered in conjunction with the Royal College of Physicians of Ireland. This programme is delivered over 42 weeks using blended learning that combines online educational materials and opportunities for interaction online with traditional classroom methods and virtual classroom sessions. The programme is accredited by the RCPI and is awarded 72 CPD credits.



For more information see: **https://courses.rcpi.ie/product?catalog=Quality-Improvement-Leadership-Programme**

Contact the team

For further advice and support about QI education and learning contact the School of QI Programme:

- Email: national.schoolofqi@hse.ie
- Web: **www.qualityimprovement.ie**
- Twitter: @nationalqi

Useful links

The HSE's *Quality Improvement Knowledge and Skills Guide* is accessible at: **www.hse.ie/eng/about/who/qid/improvement-knowledge-and-skillsguide/**

The National QI Toolkit is accessible at: **www.hse.ie/eng/about/who/qid/nationalsafetyprogrammes/national-quality-improvement-toolkit.html**

The *Framework for Improving Quality in our Health Services* is accessible at: **www.hse.ie/eng/about/who/qid/framework-for-quality-improvement/**

Maureen Flynn is the director of nursing ONMSD, QI Connections lead, HSE Quality and Patient Safety Directorate

Acknowledgement: A special thank you to my colleagues Caroline Connelly and Veronica Hanlon for sharing this information and collaborating in writing this column

Quality Improvement (QI) forms a central focus of the newly formed HSE Chief Clinical Officers' Quality and Patient Safety (QPS) Directorate led by Dr Orla Healy. The QI team supports services to lead sustainable improvements for safer better healthcare. We partner with people who provide and people who access our health and social care services to champion, enable and demonstrate improvements – achieving measurably better and safer care. Read more at www.qualityimprovment.ie or link with us on Twitter: @nationalQI

Office of the Nursing & Midwifery Services Director

Section focus

INMO Professional

Jean Carroll, Section Development Officer

A masterclass for nurse/midwife leaders not to be missed

MENOPAUSE in the workplace, toxic leadership and the psychological impact of Covid-19 on nurses and midwives are among the issues on the packed agenda for the upcoming masterclass for directors and assistant directors sections.

There will also be an update on international issues by Margrieta Langins, recently appointed nursing/midwifery policy adviser to the WHO.

Loretta Dignam, founder and CEO of the Menopause Hub, will present on what can be done to best support women at work during the menopausal years. The HSE estimates that eight out of 10 women experience symptoms leading up to the menopause. Of these, 45% find their symptoms difficult to deal with. The INMO position paper on *Menopause at Work* can be found on **www.inmo.ie**

The INMO's follow-up survey on the psychological impact of Covid-19 on nurses and midwives will be used to inform the union's strategy for supporting and representing members.

There will also be a session on toxic leadership – how it develops and how to deal with levels of toxicity within your working environment. Minding your mental health and a short session on mindfulness are also on the agenda.

The Director of Nursing Midwifery & Public Health Nursing, with the Assistant Directors of Nursing, Midwifery, Public Health & Night Superintendent National Sections fourth annual masterclass will be held on Thursday September 30, from 2-4.30pm. This is a free online event, with bookings available on **www.inmoprofessional.ie**

ODNs hear of Covid's traumatic effect

THE Operating Department Nurses Section held its first webinar in June, which proved to be a very engaging event.

Topics covered at this online event ranged from the effects of Covid-19 on healthcare staff to dealing with traumatic death, burnout and disengagement. It also covered workplace health and wellbeing and heartfulness meditation. The webinar generated a lot of engagement, questions and discussion.

As with all INMO events, this webinar is available to watch back on **inmoprofessional.ie**

Pictured participating in the ODN Section's first webinar were: INMO president Karen McGowan; Liz Waters, section education officer; Bruce Pierce, director of education, St Luke's Home, Cork; Steve Pitman, INMO head of education & professional development; Dr Tara Feeley, consultant anaesthetist , Auckland, New Zealand; Sandra Morton, section secretary; Karen Eccles, section chairperson; Sibeal Carolan, Workplace Health & Wellbeing Unit, HSE; and Hester O'Connor, principal psychology manager, HSE

Children's Nurses Section conference

THE line-up for the first conference being held by the INMO National Children's Nurses Section is almost complete.

There will be a detailed presentation on the recent publication of *Leading the way: A national strategy for the future of Children's nursing in Ireland 2021-2031*. The meeting will also hear from nurse specialists from a variety of fields, including speakers on: autism in children; paediatric sepsis; eating disorders; self harm in adolescents; and the psychological impact of Covid-19.

This free event will take place on Saturday, November 20, 2021, to mark World Children's Day. Booking is essential, and can be made through **inmoprofessional.ie**

In brief...

Retired Section

The INMO Retired Nurses and Midwives Section is delighted to announce that the long-awaited trip to Bundoran, Co Donegal is back on the agenda.

It will run for four nights from Sunday, October 3, 2021 to Thursday, October 7, staying in the Great Northern Hotel, Bundoran.

The all inclusive cost is €340pps with a €15 single supplement available. Full details are available directly from McGinley Travel agents on 074-9135201 or email Annette at **jmgtravel@eircom.net**

PHN Section's conference

PLANS are underway for the second Public Health Nurses Section conference, which will take place online on Saturday, October 16, 2021.

The wide-ranging agenda will focus on topics such as: postnatal depression; the menopause and positive ageing; paediatric skin conditions in the community; ANP pathway and the virtual ward; and health safety and wellbeing.

This event, organised by the PHN Section will be of interest to colleagues in all aspects of nursing and midwifery, including CRGNs, GP practice nurses and midwives.

For further information and to book your free place, log on to **inmoprofessional.ie**

Get in touch

Contact: Jean Carroll
Section Development Officer
at HQ at Tel: 01 6640 600
or email: jean.carroll@inmo.ie

INMO Professional

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Tools for Safe Practice for Nurses and Midwives

3 CEUs

Tuesday, 2 November 2021

(Tuesday, 21 September 2021 is now full)

Practical advice on:

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

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Retirement Planning WEBINAR

Thursday, 28 October 2021

Online from 2pm - 3.30pm

Places must be booked in advance to join this webinar.

- Superannuation and your entitlements.
- Drawing down your AVC at retirement.
- Consider a lump sum AVC before retirement?
- Protecting your lump sum against inflation.
- Key steps to long term investing.
- Top tax tips for retirement.
- Covid-19 Q & A:
  Retirement planning in uncertain times.

FREE LIVE ONLINE WORKSHOP FOR INMO MEMBERS; €20 FOR NON MEMBERS

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INMO EDUCATION PROGRAMMES

INMO Professional

Continuing professional development for nurses and midwives

Keep up to date with new online courses from INMO Professional

Training Delivery and Evaluation *(September/October 2021)*

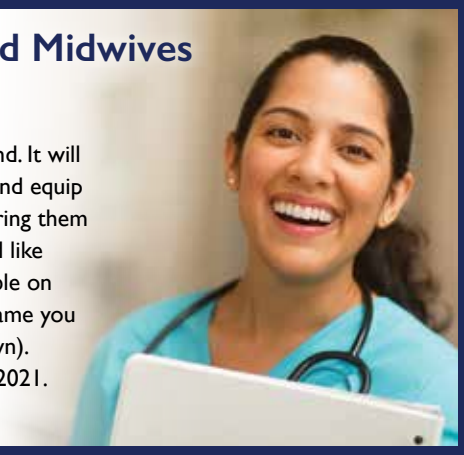
QQI Level 6, category 1 approved by the NMBI (30 CEUs) – €550 for INMO members

This five-day programme provides nurses and midwives with the knowledge, skills and competence to deliver, assess and evaluate a training provision. It is scheduled to take place online on the following dates: September 28, 29 and 30 and October 12 and 13, 2021. A limited number of places have just become available on this popular programme. To book a place, please contact Marian Godley, course co-ordinator at Tel: 01 6640641 or email: marian.godley@inmo.ie

Orientation Programme for International Nurses and Midwives

Friday, October 8, 2021

This programme is for nurses and midwives who have recently arrived or are coming to Ireland. It will cover information to support the transition to life in Ireland and the Irish healthcare system and equip participants with a broad understanding of Ireland's work ethics and culture, further empowering them to integrate with their professional colleagues and the system. If you know anyone who would like information and support in transitioning to life in Ireland, details of this programme are available on **www.inmoprofessional.ie** To book, email: education@inmo.ie with the following: name (the name you will use to register as a nurse/midwife here), email, mobile number and work location (if known). For INMO members it is essential that you use your INMO number. Date: Friday, October 8, 2021. Time: 10am-1pm.



New Programmes

INMO Professional continues to develop new online programmes covering a range of clinical topics, including 'Infection Control: Link/Champion Guide to Standards' (October 11); 'Telephone Assessment and Advice Skills for Nurses and Midwives' (October 15); 'An Introduction to the Management of Chronic Disease in Primary Healthcare' (October 18); 'Diabetes CBT and General Wellbeing (October 28) and 'Safer Better Care Standards 8 themes: Public Health/Community RGN perspective' (November 16). All programmes are category 1 approved and can be viewed on **www.inmoprofessional.ie** Don't forget to avail of our special offer – book three and get your fourth course free.

INMO Professional

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LIVE ONLINE EVENTS

Online Education Programmes Autumn 2021

All courses are Category 1 approved by NMBI

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- **Highly skilled, expert facilitators and lectures**
- **Category 1 approved by NMBI**
- **Digital certificate provided with CEUs**

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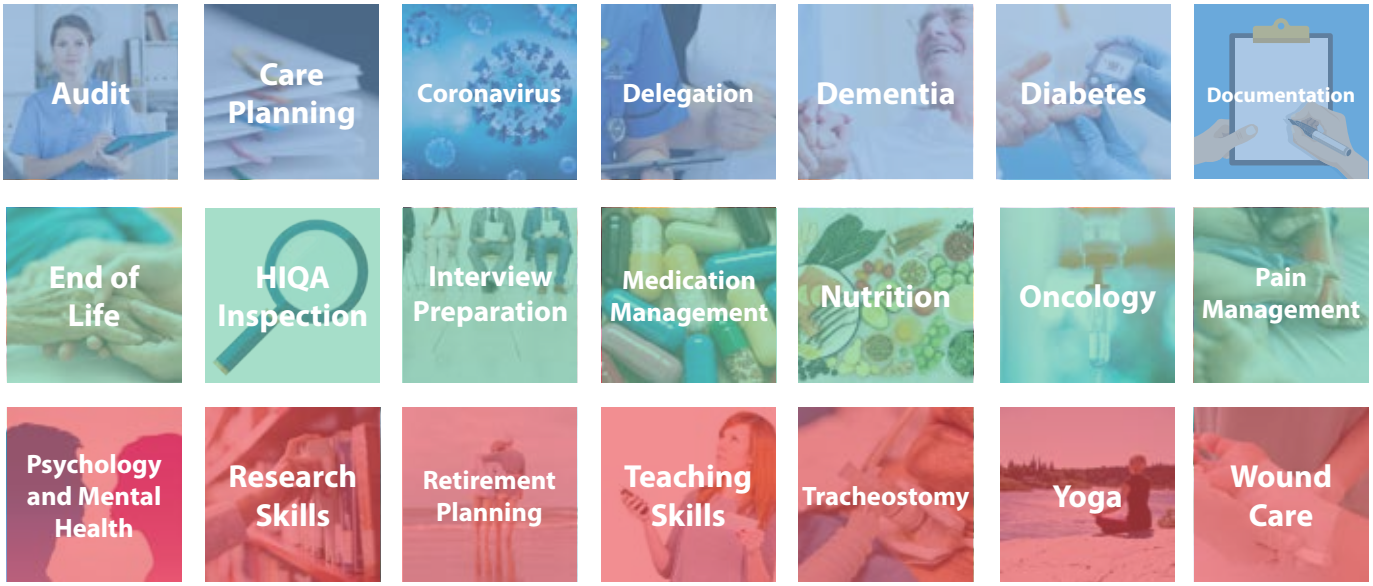

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Keep your CPD up to date • Extensive range of programmes • NMBI category 1 approved • Digital certification provided

Sep 8 **Introduction to Wound Management for Nurses and Midwives**

Topics covered in this programme will include wound healing, wound bed preparation, treatment options and dressing selections. Participants will learn about the anatomy and physiology of wound management, the factors influencing wound healing, the differences between acute and chronic wounds, implementation of a holistic assessment of individuals with wounds and different types of dressing and their application.

Sep 9 **Navigating Your Way Through Conflict**

This course will help participants develop the insight and skills necessary to navigate conflict situations and reach satisfactory solutions. Workplaces can be the perfect breeding ground for conflict. As well as our skills, we bring our individual needs, ambitions, personalities, perspectives, backgrounds and vulnerabilities with us to work. It is hardly surprising, therefore, that conflict can arise as we interact with others. While some conflict can be healthy, unresolved conflict can lead to negative outcomes for our wellbeing.

Sep 9 **The Sociology of Health**

This online programme is an introduction to the sociology of health and illness. It examines the meaning of health, disease, illness and sickness. The impact of social inequality will also be explored, along with other topics such as the sick role and the role of healthcare professionals.

Sep 14 **Owning Your Future – Taking Control**

The key learning outcome of this short session will be to support each participant to become aware of their competencies as an employee and to explore how they can increase their ability to take control of their careers in these uncertain times. The physical and mental strain of working in a pandemic has left little time for nurses and midwives to think about their careers. New skills and competencies have been acquired, common sense or tacit knowledge has played a key role in coping. Yet, little value may be put on these skills unless nurses and midwives recognise and articulate their value.

Sep 14 **Risk Management and Incident Reporting**

This programme outlines the principles of best practice in managing risk. It will enable participants to understand terms related to risk management in healthcare, outline the stages of the risk management process based on the international standard and framework for risk management, outline the five steps of risk assessment, understand the purpose of a risk register and complete accurate records of incidents.

Sep 15 **Introduction to Treating and Preventing Pressure Ulcers**

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

Sep 15 **Restrictive Practices in Residential Care Settings for Older People**

This short online course encourages participants to reflect on interventions that could be seen as restraining residents if viewed from a resident's perspective. Many interventions within healthcare environments can restrict movement of older people. They are unintentional and can be argued as in the best interest or for the protection of residents, for example, a nursing home locked at night to protect residents and staff from intruders.

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

Sep 16 **Nursing Patients with Disorders of the Renal System – An Introduction**

This programme focuses on developing the nurses' competency in the assessment and management of patients with both acute and chronic disorders of the renal system. It will assist in implementing evidence based practice while caring for this cohort of patients

Sep 21 **Change Management – Valuable Tools for Nurses and Midwives**

The aim of this course is to enhance your understanding of change management and strategies to improve the potential for successful change initiatives in helping them lead, develop and manage change in their workplace. Participants will gain valuable tools in how to understand the nature and process of change within the healthcare setting; appreciate the importance of managing stakeholders as part of the change process; apply change concepts within their clinical and managerial practice and reflect on their previous experience of change. They will leave with knowledge of how to best support their work colleagues on how to approach change positively.

Sep 21 **Tools for Safe Practice for Nurses and Midwives** *(course full)*

This programme provides safe practice tools to protect the nurse, midwife and patient within current healthcare settings. This programme is now fully booked, next available date is Tuesday, 2 November 2021. Early booking is advisable.

Sep 22 **Introduction to Leg Ulcer Management**

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

Sep 23 **Chronic Obstructive Pulmonary Disease (COPD) – Getting the Basics Right**

This programme is aimed at nurses working in clinical practice who require basic knowledge and skills to care for people with COPD. It will help participants to understand the clinical evidence underpinning the diagnosis and ongoing care of patients with COPD.

Sep 28 **Training Delivery and Evaluation**

A limited number of places have come available on this five-day programme. Please contact Marian Godley, course co-ordinator at Tel: 01 6640642 or email marian.godley@inmo.ie if you wish to book a place.

Sep 28 **Understanding and Developing Care Plans for Nurses and Midwives**

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

Sep 29 **Introduction to Management and Leadership Skills for Nurses and Midwives**

The aim of this course is to identify managerial and leadership competencies for frontline managers and to explore how these are applied in practice. The course will include management theory, effective leadership and teamwork, as well as delegation and clinical supervision.

Oct 5 **The Importance of Documentation – Getting it Right**

This short programme will assist nurses and midwives in understanding their duty of care and responsibility in the area of best practice in documentation, keeping good records and their ethical and legal responsibility of getting it right. Introduction to legal and professional requirements: NMBI Code and Guidance for Recording Clinical Practice; relevant HIQA regulations and standards; adhering to consent and data protection legislation in record-keeping; purpose of healthcare records; the 'dos' of documentation.

Oct 6 **Nutrition and Cancer Care: Nursing Roles and Interventions (hospital, residential and community settings)**

This online programme is aimed at nurses who work in hospital, residential and community settings. It addresses the challenges of managing cancer patients' nutrition and will promote best practice in the provision of nutrition and cancer care in both the home and in hospital. The programme will provide guidance on assessment, care planning and monitoring of cancer patients' nutritional needs. It will identify current nutrition guidelines, the importance of nutrition in cancer care and the implementation of nursing strategies to tackle malnutrition.

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

Oct 6 **End of Life Care and Covid-19**

This short online programme outlines the legal and professional requirements for end of life care in designated centres and identifies how to apply this practice to Covid-19. Participants will learn how to recognise signs and symptoms of deterioration through the programme, which will assess, monitor and review physical, psychological, social and spiritual areas of care at end of life for a person with Covid-19. It will cover the *Guidance for Registered Nurses and Midwives on Medication Administration* and national guidance. Participants will be able to identify and apply effective interpersonal communication with families of a loved one at the end of their life during this challenging period.

Oct 7 **Adult Asthma – Getting the Basics Right**

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

Oct 11 **Infection Control: Link/Champion Guide to Standards**

This short online programme is aimed at nursing staff that are identified as infection control champions/link within an organisation or staff interested in infection prevention and control standards. The course utilises infection control eight themes as a guide: identifying key areas in infection prevention, control and infection control resources in line with standards and use and review of equipment will be reviewed. This course will support key staff in identifying their strengths and providing support with short, medium and long-term goals within the role of infection control champions in their clinical area.

Oct 11 **Introduction to Effective Library Search Skills**

This short online course is aimed at nurses and midwives who would like to develop valuable lifelong information-seeking skills to get the most up-to-date information for clinical practice, reflection or policy development. This course will assist participants who are undertaking academic programmes.

Oct 12 **Become More Assertive**

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

Oct 13 **Improve Your Academic Writing and Research Skills**

This short online course is designed for nurses and midwives who are undertaking third-level academic programmes. It will assist participants in completing their written assignments. The objective of the course is to help prepare the student for academic study, which requires efficient literature searching, research critique and accurate referencing skills. On the day there will also be a question and answer session to help you with any of your queries.

Oct 14 **Delegation Principles and Practice**

This programme will explore the issues surrounding delegation and decision-making. Participants will learn the difference between clinical and managerial delegation and how delegation differs from assignment of a task. Guidance will be provided on the assessment of a delegate's experience and role and how best to match appropriate clinical supervision to a specific delegated function. The professional, legal and quality of care issues involved when deciding to delegate a function will also be explored.

Oct 14 **Best practice for Clinical Audit for Nurses and Midwives**

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

Oct 15 **Telephone Assessment and Advice Skills for Nurses and Midwives**

This short new online programme is for nurses and midwives involved in providing telephone assessment and advice, in A&E, general practice and other community settings. Such calls assess patients' needs and may provide advice for self-care, prompt the caller to seek immediate medical attention or refer the patient to another healthcare professional or agency. This programme will provide strategies and guidance on how best to communicate with each caller in a professional and tactful manner.

Oct 15 **Overview of Nursing Assessment and Management of Stroke**

This short online programme will give participants an overview of nursing assessment and management of stroke during the Covid-19 pandemic. At the end of the training participants will be able to: identify and discuss the two types of strokes; identify and ascertain the various treatment options; understand best practice for the nursing care of people who have suffered an acute stroke, including secondary prevention; be aware of aetiology of stroke and rationale for specific diagnostic tests.

Oct 18 **An Introduction to the Management of Chronic Disease in Primary Healthcare**

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

Oct 19 **Falls Reduction, Assessment and Review**

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

Oct 19 **Fundamentals of Pain Management**

This short online pain management programme for nurses and midwives will promote critical thinking and a safe and systematic approach in the assessment and management of pain. It will demonstrate how to recognise and differentiate patient's pain more confidently, through understanding the concepts, meaning and classification of pain. Participants will learn skills in the early recognition and treatment of pain to help enhance patient comfort, well-being and recovery from illness, injury and surgery. At the end participants should be able to: describe the pathophysiology of nociceptive and neuropathic pain; select and describe the use of appropriate pain assessment tools for use with varying patient populations; discuss the main components of a pain-focused physical assessment; articulate a clear rationale for the safe use of specific pharmacologic interventions for acute and chronic pain; describe the effective use of the analgesic ladder to treat acute and chronic pain.

Oct 20 **Understanding and Managing Burnout for Nurses and Midwives**

This programme is designed to explore the nature of burnout and work engagement. Burnout is an important issue for nurses and midwives and is related to a decrease in occupational wellbeing and an increase in absenteeism, turnover and illness. The prevention of burnout can be achieved by focusing on engagement, organisational assessment and the early detection of burnout. The key focus of this programme will be on the causes, definitions, measurement and interventions that can help create a more positive, fulfilling and engaging workplace.

Oct 21 **Paediatric Asthma – Understanding the Basics**

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

Oct 21 **Type 1 Diabetes Management for Nurses and Midwives**

This programme will provide nurses and midwives with knowledge and skills regarding type 1 diabetes. The literature would suggest that diabetes, chronic disease management and the self-care that is associated with it brings high incidence rates of depression, anxiety and negative thoughts. The use of different strategies, self-management, treatment options, insulin pump therapy and CGM will be looked at to improve patient self-management. The exploration of these strategies and management of type 1 diabetes is a necessary component to help nurses and midwives to formulate plans to combat issues that clients face.

Oct 27 **Competency-based Interview Preparation for Nurses and Midwives**

This online programme will help participants to prepare for a competency-based interview that enables candidates to show how they would demonstrate certain behaviours and skills in the workplace by answering questions about how they have reacted to, dealt with and handled previous workplace situations. It will explore preparation, presentation and performance during the interview and will briefly focus on CV preparation.

Oct 28 **Retirement Planning Webinar**

Planning for retirement is even more important today than it has ever been. There are many factors to consider as you approach retirement. It is good to start by reviewing your finances to ensure your future income will allow you to enjoy the lifestyle you want. This webinar will cover: superannuation, AVCs, lump sum and investments. This event is free to members. Prior booking is essential. Time: 2pm-3.30pm.

Oct 28 **The 'Know How' of Inhaler Technique**

This short, two-hour online programme for nurses and midwives will address issues around inhaler technique. The programme will introduce the participant to current best practice in relation to inhaler technique and assist in the understanding of the role of inhaled medication with the correct use of inhalation devices (fee for members: €20).

Oct 28 **Diabetes CBT and General Wellbeing**

The literature would suggest that diabetes, chronic disease management and the self-care that is associated with it brings high incidence rates of depression, anxiety and negative thoughts. The use of different strategies, Cognitive Behaviour Therapy (CBT) and clinical trials look at the area of wellbeing and theories and models to help clients and healthcare providers try and formulate plans to look at these issues. This programme will explore techniques and interventions that can be used to help clients acknowledge issues that arise from having diabetes.

Nov 1 **Introduction to Management and Leadership for Nurses and Midwives**

The aim of this short course is to identify managerial and leadership competencies for frontline managers and to explore how these are applied in practice. The course will include management theory, effective leadership and teamwork, as well as delegation and clinical supervision. Topic/content: management theory; effective leadership and team working; delegation and clinical supervision; understanding the nature and approaches to leadership; leading nursing and midwifery in your workplace; understanding yourself; leading others; professionalism, regulation and fitness to practice.

Nov 2 **Tools for Safe Practice for Nurses and Midwives**

This programme provides safe practice tools to protect the nurse, midwife and patient within current healthcare settings. The programme is free to INMO members. Places must be booked online in advance of your attendance.

Nov 3 **Infection Prevention and Control During Covid-19 Pandemic in residential care settings**

Infection prevention and control is essential in order to prevent the spread of Covid-19. This short online course for nurses working in residential care settings will outline evidence-based and national guidance on infection prevention and control in residential care settings during the Covid-19 pandemic. Understanding infection control will provide the participant with the tools to prevent Covid-19 from spreading.

Nov 4 **Introduction to Oncology: Terminology and Patient Pathways**

This short three-hour session will give participants an increased understanding of the language of oncology in order to improve fluency with patients and colleagues, increased insight into the oncology journey and stages the patient is at which will improve overall patient care and outcomes. There will also be an opportunity to ask questions.

Nov 8 **Understanding Epilepsy for Nurses and Midwives**

This short course will provide a good foundation and increase participants' knowledge when caring for patients with epilepsy. Nurses who are not specialists in epilepsy can play a central role in providing optimal care, education, and support to their patients with epilepsy given the proper tools. This course will provide a foundation on which to build increasing knowledge of epilepsy and care of the patient.

Nov 9 **Medication Management Best Practice 2021 – Guidance for Nurses and Midwives**

This short online programme supports nurses and midwives in providing safe, evidence-based practice in the area of medication management thus preventing medication errors and near misses. The programme will cover key topics such as: the key principles of medication management, the medication management cycle, management of controlled drugs and medication safety. Participants will have the opportunity to update their knowledge in line with the most up-to-date Nursing and Midwifery Board of Ireland Guidance for Registered Nurses and Midwives Administration (2020) and Health Information and Quality Authority requirements for medication management.

Nov 11 **Introduction to Chemotherapy**

Chemotherapy simplified: this introductory session will equip you with the main principles of chemotherapy, its side effects and how to feel safe and confident handling these drugs. In return you will feel empowered to deliver improved care to your patients. This session will cover pharmacology of chemotherapy; chemotherapy side-effects and chemotherapy regimes and safe handling of cytotoxics. As good communication skills with patients and families are crucial in chemotherapy, this programme will keep your skills up to date.

Roundup of recent Irish literature

This month we look at recent Irish articles covering such topics as older people, midwifery, children's nursing and Covid-19

Mental health nursing

- Kirwan S, Keogh B, Donohue G. Nurse leadership in implementing digital change in an Irish mental health service. Mental Health Practice 2021; pp. 18–23
- Smyth S et al. Stuck between a Rock and a Hard Place: How Mental Health Nurses' Experience Psychosocial interventions in Irish Mental Health Care Settings', Journal of Psychiatric & Mental Health Nursing 2021; 28(4), pp. 590–600
- Frain S et al. Not Left in Limbo: Service User Experiences of Mental Health Nurse Prescribing in Home Care Settings. Issues in Mental Health Nursing 2021; 42(7), pp. 660–666

Children's nursing

- McDonnell T et al. Policy of free GP care for children under 6 years: The impact on emergency department attendance. Social Science & Medicine 2021; 279
- Hurley F, Kiernan G, Price J. Starting Out in Haziness: Parental Experiences Surrounding the Diagnosis of their Child's Non-Malignant Life-Limiting Condition in Ireland. Journal of Pediatric Nursing 2021. 59, pp. 25–31
- Kenny M et al 2021. It can be difficult to find the right words: Parents' needs when breaking news and communicating to children with cancer and their siblings. Journal of Psychosocial Oncology 2021; 39(4), pp. 571–585

Covid-19

- O'Connor K et al. Mental health impacts of Covid-19 in Ireland and the need for a secondary care mental health service response', Irish Journal of Psychological Medicine 2021; 38(2) pp. 99–107
- Hyland P et al. Resistance to Covid-19 vaccination has increased in Ireland and the United Kingdom during the pandemic. Public Health (Elsevier 2021); 195, pp. 54–56
- Quinn BG et al. Exploring the role of effective nurse leadership during Covid-19. Nursing Management 2021
- McIntyre A et al. Covid-19 and its effect on emergency presentations to a tertiary hospital with self-harm in Ireland. Irish Journal of Psychological Medicine 2021; 38(2), pp. 116–122
- Plunkett R et al. Impact of the Covid-19 pandemic on patients with pre-existing anxiety disorders attending secondary care., Irish Journal of Psychological Medicine 2021; 38(2), pp. 123–131

Older people

- Tuohy D et al. Towards the development of a national patient transfer document between residential and acute care – a pilot study. International Journal of Older People Nursing 2021; 16(4), pp. 1–12
- Ward M et al. Mortality risk associated with combinations of loneliness and social isolation. Findings from The Irish Longitudinal Study on Ageing (TILDA). Age & Ageing, 2021; 50(4), pp. 1329–1335
- Meagher E et al. The decline of hip fracture incidence rates over a 10-year period: A single centre experience. Injury 2021
- Donegan D et al. Calling time on the 'dance of the blind reflex': how collaborative working reduced older persons' length of stay in acute care and increased home discharge. International Practice Development Journal 2021; 11(1), pp. 1–14

Intellectual disability

- McCausland D et al. The nature and quality of friendship for older adults with an intellectual disability in Ireland. Journal of Applied Research in Intellectual Disabilities 2021. 34(3), pp. 763–776
- O'Brien F et al. The prevalence, awareness, treatment, and control of hypertension in older adults with an intellectual disability in Ireland: a cross sectional study. European Journal of Cardiovascular Nursing, 2021; 20(4), pp. 315–323
- Manduchi B et al. Prevalence and risk factors of choking in older adults with intellectual disability: Results from a national cross-sectional study. Journal of Intellectual and Developmental Disability, 2021; 46(2), pp. 126–137
- Murphy K, Bantry-White E. Behind closed doors: human rights in residential care for people with an intellectual disability in Ireland. Disability & Society 2021; 36(5), pp. 750–771
- Doyle A et al. People with intellectual disability in Ireland are still dying young. Journal of Applied Research in Intellectual Disabilities 2021; 34(4), pp. 1057–1065

Midwifery

- Beecher C et al. Development of a survey instrument to evaluate women's experiences of their maternity care. Women & Birth 2021;, 34(4), pp. e396–e405
- O'Brien D, Butler MM, Casey, M. The importance of nurturing trusting relationships to embed shared decision-making during pregnancy and childbirth, Midwifery 2021
- Power S, O'Donoghue K, Meaney S. Experiences of Volunteers Supporting Parents Following a Fatal Foetal Anomaly Diagnosis, Qualitative Health Research 2021; 31(5), pp. 835–84
- O'Shaughnessy E, O'Donoghue K, Leitao S. Termination of pregnancy: Staff knowledge and training. Sexual and Reproductive Healthcare 2021

Library services

The library has a number of services to support your practice and educational requirements, including literature searching, document supply, reference desk assistance and searching consultations. To find out more, call 01664061 4 or email: library@inmo.ie

Online – Introduction to Effective Library Search Skills

Next course date: Monday, October 11

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

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

INMO Professional

RCM i-learn

THE ROYAL COLLEGE OF MIDWIVES

Developing coping and study skills as a student

This month we feature two RCM i-learn modules designed to help students to settle into and get the most out of their college course

STARTING university is exciting and probably a bit daunting. Juggling study and clinical practice needs some forward thinking. Your course tutors and the university will provide you with lots of information, however, these modules have been designed by students and tutors providing some extra tips and guidance to help you settle and get the most from your course.

Student survival skills

This i-learn module, a student survival guide, provides information and support for student midwives at the beginning of their course and in the first year. The module has been developed using feedback from student midwives and provides advice on settling into life as a student midwife, academic requirements, and starting out with clinical practice. This module will take approximately 40 minutes.

This module includes sections on Getting Started, dealing with stress, academic work, surviving clinical practice, learning midwifery language, and staying safe on social media.

Learning outcomes

Having completed this module, you will have:

- Considered strategies to help you settle into life as a student midwife
- Developed insight into how your day-to-day life may change now that you are a student midwife
- Had an opportunity to review your financial situation as a student midwife
- Considered strategies to minimise your stress levels now that you are a student midwife
- More insight into the academic requirements of midwifery courses
- Considered how clinical placements are organised
- Considered strategies that will help you to get the most out of your clinical experience in year one placements.

Developing your study skills

This course is designed for anyone who is either studying or who wants to improve their active reading, reflective and critical thinking skills. The course will support you in looking critically at your range of study, reading and time management skills and in developing a personal action plan. This module will take approximately one hour to complete.

There are various chapters included in this module including sections on learning styles, time management, reflection, assessments and examinations, plagiarism and writing a personal development plan. The module includes a link to the Vark questionnaire which will allow you to identify your own learning style. Some academics consider that there is no real evidence to support the notion of different learning styles but for some learners they provide a useful tool.

RCM iLearn has another short 10-minute module on developing reflective skills, if you wish to learn more about reflection and reflective practice.

At the end of this i-learn module you will have had the opportunity to:

- Explore contemporary research and evidence in learning and study skills
- Consider your own strengths and weaknesses in approaching study skills
- Understand the importance of planning and time management
- Think about how best to organise yourself in terms of resources
- Be introduced to techniques around reading, note taking and referencing your work.

RCM i-learn access for INMO midwife members

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

INMO Professional

INMO
Irish Nurses and Midwives Organisation
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Nursing now Ireland

Webinars and Conferences 2021

ONLINE INTERACTIVE CONFERENCES

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Coronavirus COVID-19 Public Health Advice

Whilst these events are currently planned as follows, the most current Public Health Advice will be fully adhered to and should the dates or the format in which the national conference is delivered change, we appreciate your understanding.

• Telephone Triage Nurses Section	Monday, 20 September
• Directors and Assistant Directors Masterclass	Thursday, 30 September
• Public Health Nurses Section	Saturday, 16 October
• All Ireland Midwives Annual Conference	Thursday, 11 November
• Occupational Health Nurses Section	To be confirmed
• National Children's Nurses Section	Saturday, 20 November

2021

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Leading the way

The advancement of excellence in leadership, scholarship and clinical practice in children's nursing is critical to the health and wellbeing of children and communities in Ireland, writes **Rosemarie Sheehan**

IN EARLY July 2021 children's nurses throughout Ireland celebrated the launch of their new nursing strategy *Leading the Way – A National Strategy for the Future of Children's Nursing in Ireland 2021-2031*.

This represents the first formal examination of children's nursing in Ireland and the project was jointly sponsored by:

- Children's Health Ireland
- Office of the Nursing and Midwifery Services Director (ONMSD), HSE
- Office of the Chief Clinical Officer, HSE.

The project represents an extensive examination of children's nursing in Ireland. The purpose of this examination was to develop a vision for children's nursing that is responsive to the needs of children and their families and a strategic framework to support implementation of this vision.

Due to the large number of stakeholders in children's healthcare provision in Ireland, the scope and breadth of this project was very broad which added to its complexity. The primary focus was on the role of registered children's nurses (RCN) while taking cognisance of the other nursing/midwifery disciplines including general, public health, mental health, intellectual disability nurses and midwives who provide a substantial amount of care to children in a variety of healthcare settings, including the home.

Context

This project was undertaken during a positive transformation of health service policy and provision of care to children in Ireland with the implementation of the National Model of Care for Paediatric Healthcare Services developed by the HSE and the Royal College of Physicians in Ireland,[1] Sláintecare,[2] the development of a new children's hospital and Overarching Standards of Care for Health and Social Care Provision for Children using the Health and Social Care Services.[3]

The implications of these key policy and service developments informed the project by presenting an opportunity for children's nurses to deliberate on the future of the profession, and how to ensure its contribution for a transformed children's health service.

The Senior Children's Nursing Network identified the untapped resource children's nurses are and their potential to contribute to children's healthcare and wellbeing service development, which was the catalyst for this report.

During the 2019-2021 timeframe of this project, nursing has been in a global spotlight with 2020 being designated the International Year of the Nurse and Midwife by the World Health Organization (WHO) as well as recognition of nursing's contribution during the Covid-19 pandemic.

The WHO, along with the International Council of Nurses and Nursing Now, published the first ever report on, the *State of the World's Nursing 2020: investing in education, jobs and leadership*.[4] The key message is that harnessing the full potential of nurses offers the best possibility of transforming health systems globally. This will require policy interventions that enable all nurses to have maximum impact and effectiveness by optimising their scope and leadership, together with investment in education, skills and jobs.

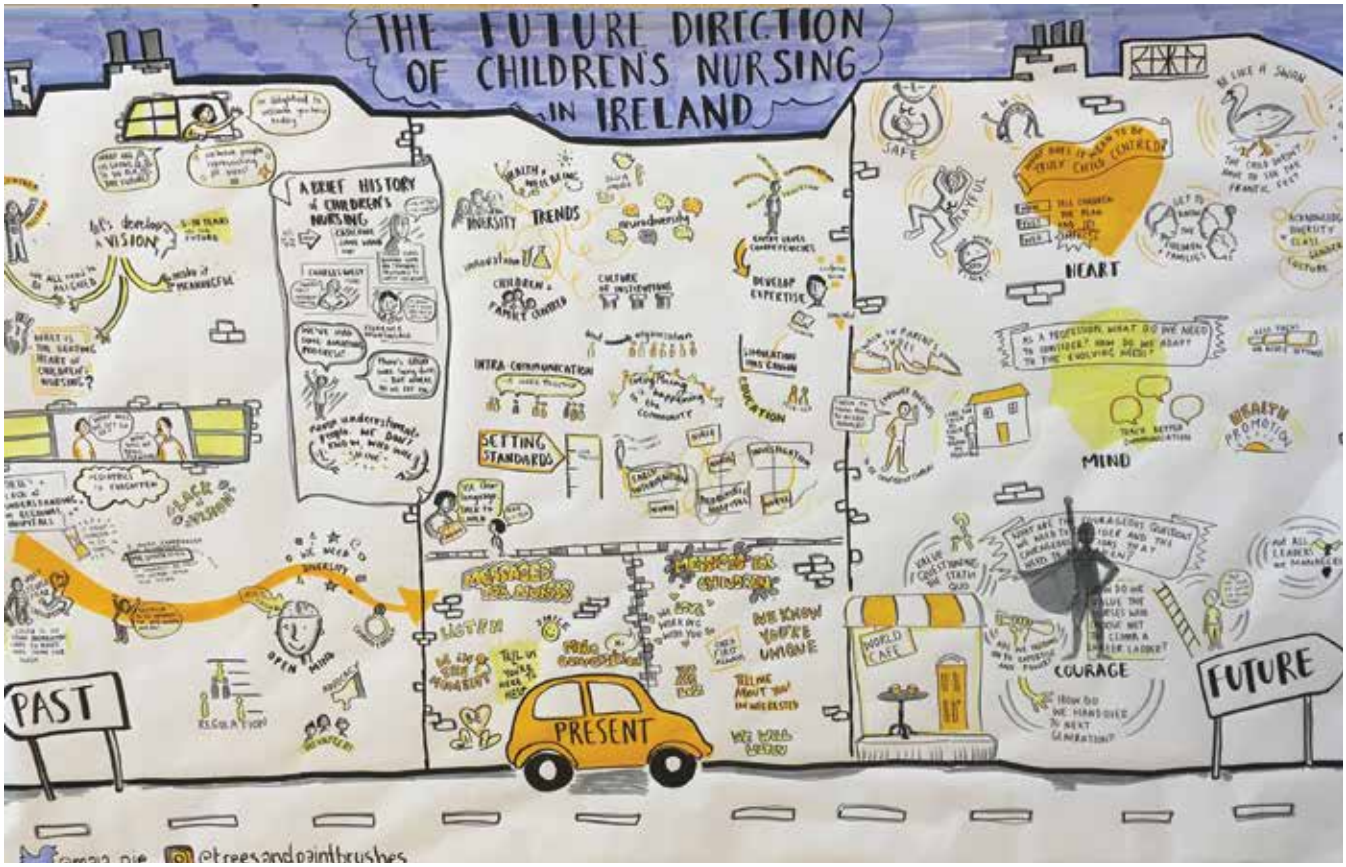
The pandemic has had significant implications for children and their families that have yet to be realised and many of the new ways of working developed over the pandemic will require further development and enhancement by the children's nurse of the future.

Design and sample

This project was underway when the pandemic began, which had significant implications on the methodology, data gathering and overall progress of this project. It was designed collaboratively with members of the project team from the National Steering Committee and the Expert Advisory Panel. A mixed-method consultative design was adopted incorporating two data gathering phases in parallel with the scoping review of the literature[5] due to the onset of the pandemic.

Throughout this project, there was positive collaboration with a variety of professionals, including a large vision workshop in March 2020 (see *Figure 1*).

Figure 1: Future direction of children's nursing in Ireland



Therefore, a wide variety of stakeholders offered a multifaceted view of the future needs of children and their families across the services incorporating what children and their families need in the future from nurses in the home, community and hospital and the supports and capabilities required to meet these needs. In all over 1,000 nurses participated at different stages as well as many other key stakeholders including the INMO and ten members of the Youth Advisory Council (YAC).

Qualitative data was gathered from group workshops, a survey of children's nurses across acute and community settings, invited written submissions and expert informant interviews. The data was analysed based on the principles of thematic analysis.[6]

Integration of data was then undertaken to identify overall themes from the data. This involved the development of a matrix of the findings of all the data sets to cross check data, through which congruence and dissonance of the findings were explored. Due to the large volume of data that had been gathered and the overall progress of the project this matrix was then mapped against key recommendations from the scoping literature review to create an integrated matrix which was used to develop the final recommendations of this project.

As this was a consultative process ethical approval was not sought. All participants in the project were bound by their professional standards, codes of good practice and code of conducts within their disciplines. The consultation with YAC was planned to ensure the protection of the children's identity at all times. The guidelines on children's participation described by the Ombudsman for Children's Office and the Lundy model described in this document supported the planning and participation of the children.[7]

Findings

The overall findings reflect the immense changes taking place in the delivery of healthcare to children in Ireland, the changing demographics and epidemiology of childhood illness and increasing complexity in children's healthcare. They mirror many reported contemporary international issues in child healthcare.

The need for the advancement of the role of the RCN is demonstrated in the findings of this project and the crucial requirement for them to lead in the enhancement and innovation of children's nursing services, ensuring excellence in care. This will ensure that children's nursing meets the needs of children and their families, and positively influences the health and wellbeing of children and their families living in Ireland.

An important observation of this report is that children's nurses are one core group with a unique knowledge and skill set that provide care to children. However, children's health and wellbeing is the responsibility of many nursing and midwifery professionals as well other many other professions.

This presents a national challenge to eliminate variance. The significance of ensuring all children receive a similar standard and core philosophy of child and family-centred care by appropriately educated and skilled nursing professionals was highlighted. The importance and willingness of the RCN to engage in interdisciplinary working and learning, partnerships and networks was identified as key to the future of integrated care.

Other significant findings in this report include the need for more inclusive education and professional development pathways for nurses who care for children including those in the wider community.

While a strong focus of service and policy reform is a 'care closer to home' model, this report found evidence of the need to also focus on education and workforce planning for nurses working in specialist areas. This includes developing

skills in high dependency nursing early in the career of the children's nurse reflecting the complexity and acuity of children presenting to hospital today.

The role of the expert nurse as mentor and role model was identified as a key component in supporting and developing early career nurses, and the necessity to support and allow protected time to enable them to fulfil this role was evident. Robust workforce planning, and development of the role of the registered advanced nurse practitioner across all services was found to be critical to ensure the availability of a sustainable workforce with the capacity and capability to meet the current and future needs of children and their families. Another key theme of the outcomes was the requirement to extend the evidence-based Taskforce model to determine safe staffing levels and skills mix to these services.

A key enabler identified to support the advancement of the discipline of children's nursing was the very positive professional identity that emerged in the findings, and the value RCNs place on their profession and their role in supporting and meeting the needs of children and their families. (See *Figure 2*)

To advance children's nursing, this project has identified a vision for the future of children's nursing in Ireland, *Leading the way in the nursing care of children and their families*, and a number of aims to support implementation of this vision:

- Promoting child and family-centred care
- Supporting and nurturing child health and wellbeing practices, initiatives and services nationally
- Extending our reach and sharing our knowledge
- Building partnerships and developing networks
- Creating seamless journeys through the healthcare system for the child and family
- Embodying equality, diversity and inclusion
- Exemplifying care, compassion and commitment
- Discovering new ways of working and learning
- The pursuit of excellence in clinical practice, professional leadership and scholarship.

Areas to progress the profession have been identified and reflect the interrelated healthcare issues for children's nurses across healthcare services, research and education. These include:

- Fostering innovative and adaptive leadership and workforce planning
- Advocating as a voice of influence in the care of children and their families
- Creating innovative clinical, research and education pathways for nurses caring for children and their families.

This report reflects many voices, especially the voice of the child and family by identifying their unique needs and perspectives. It is also highlights the voice of the large number of contributions from children's nurses delivering direct care across wards and the community in Ireland.

Significantly, this project has established that the advancement of excellence in professional leadership, scholarship, clinical practice and innovation in children's nursing is critical to making a difference in the health and wellbeing of children, their families and communities in Ireland.

The full report and scoping review of the literature can be accessed on the ONMSD website or through HSE libraries.

Figure 2: Values in action in children's nursing

Rosemarie Sheehan is a project officer and assistant director of nursing at Children's Health Ireland. For further information email: rosemarie.sheehan@nchg.ie

References

1. Health Service Executive and Royal College of Physicians in Ireland 2016. A National Model of Care for Paediatric Healthcare Services in Ireland [online]. Available from: https://www.hse.ie/eng/services/publications/clinical-strategy-and-programmes/model-of-care-for-paediatric-healthcare-executive-summary.pdf

2. Government of Ireland 2017. Committee on the Future of Healthcare Sláintecare Report. Houses of the Oireachtas. Dublin: The Stationery Office

3. Health Information and Quality Authority. The Mental Health Commission 2021. Evidence review to inform the development of Overarching National Standards for the Care and Support of Children using Health and Social Care Services. www.hiqa.ie/reports-and-publications/standard/evidence-review-inform-development-overarching-national-standards

4. World Health Organization 2020). State of the world's nursing 2020: investing in education, jobs and leadership [online]. Available from : https://apps.who.int/iris/handle/10665/331677.

5. Lambert V, Savage E, Corcoran Y, Smith H et al, 2020. A scoping literature review to support the development of a vision and strategic framework for the future direction of children's nursing in Ireland. Dublin, Ireland. Commissioned Report

6. Braun V, Clarke V. 2006. Using thematic analysis in psychology. Qualitative Research in Psychology 3 (2), pp. 77-101

7. Ombudsman for Children's Office 2018). Children's Participation in Decision-making Good Practice Guidance from the Ombudsman's for Children's Office. Dublin: Ombudsman for Children's Office

Enhancing the care of children and young people

Catherine Sheridan reports on the recent Paediatric Nursing Associations of Europe annual meeting and congress

ESTABLISHED in 2003, the Paediatric Nursing Associations of Europe (PNAE) provides a collaborative professional platform for nurses working with children and young people in Europe. There are currently 19 European countries affiliated as members of the association, which meets twice annually and holds a congress every two years. Up to four representatives from each country can attend meetings.

Annual meeting

The PNAE held its 37th annual meeting via Zoom on May 20 this year. Affiliated countries were represented by registered children's nurses or nurses working with sick neonates, infants, children and young people. An overview of children's nursing is usually presented by the host country; this year the Estonian Nurses Union Society of Paediatric Nurses delivered an excellent presentation in respect of children's nursing services in their country.

Each representative was given an opportunity to present an update on the impact of the Covid-19 pandemic on children and related issues in their own country, followed by group discussions regarding the progress of current projects.

Congress

The fifth PNAE congress was held online on May 21 and 22, 2021. Congress was hosted by our paediatric nursing colleagues in Estonia and was attended by paediatric nursing representatives from many countries across Europe. I have represented the INMO as an affiliated member of the PNAE since 2015. I was proud to represent the National Children's Nurses Section at both events this year, providing an Irish perspective on matters of mutual importance in the world of children's nursing.

The agenda for congress was packed with presentations from various children's nurses on interesting and diverse topics. I had the pleasure of moderating one of the parallel sessions entitled 'Child support and nursing development'. During this session, three research projects were presented on the following topics: 'Digital nursing for care and first discharge in paediatric oncohematology: development of an APP'; 'Sexual and gender diversity in adolescence: The development of a conceptual model to support secondary school nursing' and 'Tripartite hermeneutic education? An empirical response to paediatric medication errors'.

Many excellent posters were entered into the poster competition, with the winner entitled 'Nursing simulations: a learning strategy between fiction and reality'.

The congress allowed me to access interesting information that was relevant to my profession. The role of the children's nurse is constantly evolving, and attending the PNAE meetings and congress highlighted that we all share similar challenges across Europe and indeed across the globe. We have so much to learn from each other as we continue to provide care for sick neonates, infants, children and young people.

Goals of the PNAE

The PNAE aims to enhance the care of children and young people, to promote and advocate for their health, wellbeing and development aligned with the United Nations Convention of the Rights of the Child (UNCRC) 1989 and to encourage communication and collaboration. It forms a united voice for nurses working with children and young people across Europe.

At the meeting hosted by the Croatian Nurses Association of Paediatric Nurses Society in October 2019, PNAE members agreed to elect a new co-ordination team and set a goal to update the group's terms of reference and modernise its website. This goal has been achieved and now all position statements, surveys and meeting updates can be viewed at **www.pnae.eu**

These projects allows for active collaboration between countries and helps to form strong professional relationships.

Further information

The next PNAE meeting is scheduled to take place in October 2021 with the exact date to be confirmed. I encourage everyone to visit the PNAE website for further information on the work carried out to date by the PNAE: **www.pnae.eu**

Catherine Sheridan is a registered children's nurse at University Hospital Galway and is secretary of the INMO's National Children's Nurses Section

WIN Vol 29 No 7 September 2021

Living with neurodegeneration

Freda Hughes spoke to nurse Trish Donnelly about her mother and former Executive Council member Ann Redmond's battle with PSP

BEFORE developing progressive supranuclear palsy (PSP) in 2016, Ann Redmond was always a strong character and an innovative nurse. She grew up among her seven siblings in Westmeath later going to Liverpool to train as a nurse at the age of just 17. Having worked in the NHS for a few years, she returned to Dublin to train as a midwife in the Rotunda before moving to New York where she worked at the Montefiore Medical Centre in the Bronx.

It was in New York that she met her husband Phil. They fell in love during a fundraising outing for the hurling club Phil had helped to establish. Their first three children – Mary, Breda and Trish – were born in New York and their son Seán was born when the family returned to Ireland. After a short break from nursing, Ann started working in St Colman's in Rathdrum, Co Wicklow where she was night sister for 26 years.

She was passionate about care of the older person and advocated hard for her patients' rights. She paid particular attention to the issue of financial abuse of older people and educated those in her care on how to safeguard against it. In 1993, along with her colleagues Eileen Galvin and Breda Fitzgerald, she published a booklet to mark the European Year of the Elderly, highlighting the research they carried out in St Colman's on incontinence care, the high tech equipment sourced through fundraising and the close knit family atmosphere created by staff and residents there.

Ms Redmond's daughters Mary and Trish both followed her into nursing. Mary was a PHN in Bray for 15 years and Trish worked in palliative care in California before returning to Ireland. Breda and Seán did not go into nursing but all four siblings assist in the care of their mother. Breda manages the home-care package, co-ordinating the day-to-day schedule of care. This challenging role is essential to keep Ann in her own home, which has always been her main wish.

PSP is a rare and progressive neurodegenerative condition characterised pathologically by neural cell loss due to abnormal tau protein deposits. Clinically, the condition manifests as Parkinsonism with the addition of progressive balance, speech, swallowing difficulty, eye movement and cognitive impairment, ultimately leading to death within seven years of diagnosis.

"Mum was diagnosed in 2016 after many investigations and doctors' appointments. Even though she was not having any typical Parkinson's symptoms she knew something wasn't right and kept insisting that is was Parkinson's but the medical teams she went to were not convinced.

"PSP is notoriously difficult to diagnose. Mum had some falls but we put it down to her glasses. She went to an ophthalmologist but still she was falling mostly, rather bizarrely, backwards. She also insisted she just didn't feel right in her head, but couldn't define it," explained Trish Donnelly.

It is important for health professionals to remember that patients with PSP still retain most of their cognitive function. Unlike dementia they can understand what is going on although they may not be able to communicate. Ms Donnelly explained that it is very important to keep PSP patients informed about their care and to treat them with the dignity they deserve.

She said that there are tell-tale signs worth watching out for with this difficult-to-diagnose illness. Depression is one of these symptoms as is impulsiveness and this is due to the impact PSP has on the frontal lobe of the brain. Loss of balance, difficulty with eye movements and persistent neck pain can also be indicators of the disease.

There is no cure for the disease but a multidisciplinary approach along with medication to treat the symptoms such as pain and depression can help a little. Parkinson's medication has been trialled with PSP patients but has only been successful in about 10% of those who tried it.

Early on in her diagnosis Ann Redmond attended every conference she could get to about the disease. She wanted to fully understand the condition she had been diagnosed with and was delighted when she discovered that she could donate her brain to PSP research when she dies.

She and her family want to progress understanding of the condition within the health service. They are all involved with Progressive Supranuclear Palsy Association Ireland where they can link with other sufferers and their families, and avail of talks and discussions with experts in the field such as consultant neurologist Tim Lynch in the Mater Hospital.

Former INMO Executive Council member Ann Redmond pictured in her early career and later on the front page of ***The Irish Times*** *during the 1999 strike*

"It's been a long, slow road and now she is mostly bed bound and cannot feed herself. The last few weeks has seen her speech deteriorate badly, it can take up to an hour to find out what she wants to say. She has a terrific sense of humour and that has not been taken from her," said Ms Donnelly.

Ann Redmond sat on the INMO Executive Council for two years from 1989. She was active during the 1999 strikes during which she was featured on the front page of a number of newspapers internationally campaigning for better pay and conditions for her peers. She continued to be active with the Retired Section of the Organisation for many years until her illness prevented her. Her advocacy in the workplace and through the union have been inspiring. Her resilience and strength while facing this awful illness is inspirational. Resigned to her fate and surrounded by her loving family, she often quotes these lines: *I wait in the lounge of departure, I know not the time of my flight. I hope it's some way in the future, but it could be I'm flying tonight …*

Nursing voices

Freda Hughes spoke to former nurse turned radio producer Gráinne McPolin about her career and most recent documentary

GRÁINNE McPolin originally trained as a nurse but now works as a freelance radio producer, documentary maker and broadcast journalist. She files regional reports for RTÉ Radio and teaches radio production at Kerry ETB. She also mentors students at Radio Kerry and the National Digital Skills Centre.

Her nursing career has inspired some of her radio work and in 2016 she won the Clarion International Women in Media Award for a documentary she co-produced with Ronan Kelly about her time as a nurse in the Middle East.

Her most recent documentary, broadcast on Newstalk in March 2021 entitled *Angels of Mercy,* is the story of the women who left Ireland to train and work as nurses in the UK's NHS across the second half of the 20th century and how they were an often overlooked but important element in the development of the service. The narrative plays out through the stories of five women who made that choice to leave Ireland behind and move to the UK.

Bringing her own experience to the narrative, Ms McPolin herself left Ireland to work in the UK in the 1980s, following in the footsteps of her mother who had done the same in the 1950s.

In the documentary nurses spoke about the sense of adventure in moving abroad to train and the notion of escaping the nuns and the drudgery of Ireland. They also discussed the high standard of education offered by the NHS and the fact that accommodation was provided and the education was free as compared to the situation at home in Ireland.

Making the option to make the move to the UK yet more attractive, in those days there was no need for a Leaving Cert qualification in the UK and there was a sense that the NHS recruitment process was more streamlined. The NHS also ran active recruitment campaigns throughout these decades targeting young Irish women.

Conditions of employment in Ireland were poor for women at the time, while women working in NHS were able to send money home, helping the Irish economy.

Gráinne McPolin, nurse turned radio documentary maker, pictured here in studio. Her most recent documentary 'Angels of Mercy' can be heard on the Newstalk website

The women she interviewed also discussed the racism and discrimination they sometimes faced in the UK. They came from a former colony but were white and looked similar to English people so that put them in a strange bracket where they were sometimes not treated as equals but rather seen as a soft target.

They also spoke about finding great empathy among other nurses who had travelled from all over the world to work in the NHS who were also missing home. The documentary portrays a great sense of camaraderie and adventure across the decades.

Ms McPolin grew up in Kerry and trained in what was then Cork Regional Hospital. Her mother was a nurse and her father was a doctor. Her sister also went on to train as a nurse in St Vincent's Hospital in Dublin.

There were 60 in Ms McPolin's class when she started her training, which was more like an apprenticeship than it is now. She lived in the nurses home on site at first and then went on to share a house with other trainee nurses in the city.

At the end of her training she and her colleagues were told that there were no jobs for them in Ireland. It was common at this time for newly qualified nurses to go abroad in search of work. She took a bus and ferry to London and stayed with friends while applying for jobs. She was lucky to get work in the London Clinic because they provided accommodation and transport to work on top of your wages. Ms McPolin described it as a "gentle landing" into London life and after about a year she decided she was ready for the NHS.

"I told myself I'm ready now for the NHS, because that really was my goal in life. It was very attractive at the time. And I have no regrets."

She started off in Northwick Park Hospital in Harrow where she worked in the post-anaesthesia care unit and the intensive care unit. She explained that she built up her confidence there.

"I loved ENT and head and neck care because we used to look after a lot of children postoperatively with airway difficulties which was a great challenge for me," Ms McPolin said.

She went on to train in the Royal National Throat, Nose and Ear Hospital which was attached to the Royal Free Hospital and built up her experience in that area over the next two and half years. She moved on to Queen Mary's in Roehampton where she worked for five years in acute care and anaesthetics.

Her colleagues pushed her to go for a senior post and so she moved to the Hammersmith Hospital and trained in anaesthetics. She says this really opened doors for her.

"That's what I loved about my colleagues, they really pushed me to move forward with my career. A lightbulb went on and I thought this is for me. I loved it. I went on to run my department in St Mary's. I discovered the five of us in my anaesthetics training group in Hammersmith ended up running the five central London departments at that time. I took the lead in St Mary's in the recovery unit and got the opportunity to introduce a bay booking service in the recovery unit and commissioned a fast track cardiac unit while I was there."

After 14 years in England Ms McPolin decided it was time to return home and initially took a job in Tallaght Hospital. The Adelaide and Meath Hospitals were moving on to the Tallaght site at the time initially to run the progressive care unit, but the budget was small so she ended up working as a staff nurse in anaesthetics before returning to Cork where she worked in the Mercy Hospital for eight years, later taking a job as nurse manager in Galway University Hospital where she stayed for a further seven years.

During the recession she suffered pay cuts like the rest of the workforce so decided to try working in the Middle East for a few years. Then in her 50s, Ms McPolin went to Riyadh in Saudi Arabia to work as a nurse and this is where the door opened to a career in radio. She had always had a passion for radio and her grandfather was a ham radio operator during the 1916 Rising.

While working in Saudi Arabia she contacted RTÉ *Documentary on One* and its producer Ronan Kelly became her mentor. He taught her how to carry out interviews and record voices so when she returned to Ireland she decided to train with Radio Kerry and the National Digital Skills Centre at Kerry ETB while she worked as a nurse with South Doc by night.

She began producing short features for RTÉ during her training with her background in nursing often inspiring her output and approach.

"You have to put your whole heart into a career change otherwise it won't work. I said yes to everything. I wanted to give nurses a voice because nurses are wonderful people. The caring and the kindness and compassion that they give every single day to patients comes naturally but its draining and they need a voice. They need to be heard.

"As a nurse, we see life, we see death, and we see everything in between," said Ms McPolin.

In the context of Ms McPolin's own research, we discussed the ongoing emigration of Irish nurses and midwives and how this could be addressed. She feels that more accessible education and mentorship in the workplace would greatly benefit patient care and nursing education and said that she would love to see more nurses and midwives progress to leadership roles while remaining in the clinical setting.

"Advanced practice and specialist roles are great as they allow experienced and qualified expert nurses to stay on the frontline. Pay needs to improve too if we are to make our health service sustainable. Nurses deserve a proper standard of living," she said.

We must take action now

Being among the world's most trusted professions, **Sara Kramer** calls for nurses and midwives to lead in taking action on climate change

AS NURSES and midwives we are continuing to face challenges we could not have expected as we entered 2020 – the Year of the Nurse and Midwife. We are still in a global pandemic, feeling the weight of how interconnected our world truly is. We witnessed this interconnection with the racial unrest after the death of George Floyd and saw how the world responded. We see how events in one part of the world affect another part of the world. This interconnection will be a common theme with climate change into the future.

"Every child born today will be profoundly affected by climate change, with populations around the world increasingly facing extremes of weather, food and water insecurity, changing patterns of infectious disease, and a less certain future. Without intervention, this new era will come to define the health of people at every stage of their lives."[1] We are sitting on the brink of whether we will address and act with the science and knowledge we already know regarding climate change or just sit idly by, and we have a choice.

The Nurses Drawdown project attempts to build a global community to make it easier for nurses and midwives to fight climate change and to take part in evidence-based learning and inspire – and take inspiration from - their peers worldwide. It is an online project of the Alliance of Nurses for Healthy Environments in partnership with the INMO and 20 other global nursing organisations and counting.

Nurses Drawdown is like a gathering of a global community, a source to make it easier for nurses to get started in the fight against climate change and to learn with evidence-based information and get inspired by work of other nurses and midwives. Actions highlighted on **nursesdrawdown.org** include five key areas: food, mobility, gender equity, energy and nature-based solutions. These five areas were chosen as they are pertinent to nurses and midwives and highlight the importance of human health and the health of the planet.

If you feel hopeless, especially during the pandemic, Nurses Drawdown can give you a reason for hope by helping you come up with your own action plan. Choose one of the five key areas that you feel passionate about.

Food

Climate change will affect the quality, supply and security of food around the world. With our industrialised food system, we are all contributing to climate change. Three billion people around the world are forced to use unsafe cooking conditions which causes air pollution and brings harm to health and the climate.[2]

Plant-rich diets are important as they tend to be healthier and lower the risk of chronic diseases. Nurses Drawdown estimates that if 50-75% of the population restricted their diet to 2,250 calories per day and reduced meat consumption overall, at least 43-68 gigatons of emissions could be avoided from dietary changes alone.[3]

You can get started by trying to send less food waste to landfill. Start slow, plan your meals and label leftovers with the date they were made. Another action is to check what you already have in your fridge and cupboards before you head to the shops.

Mobility

We are living in a mobile world. Transportation is responsible for 14% of the global greenhouse gas emissions.[4] We need to change our infrastructure in our cities to be more bike-friendly and make them more walkable as well as making improvements to public transport.[4] As individuals we can be creative – a carpool to work is a way to help your wallet and the planet.

Energy

With the pandemic, there has been research showing that areas with high air pollution are getting hit harder by Covid-19.[6] Greenhouse gases contribute to respiratory diseases directly in areas with high levels of pollution.

If you want to take action around energy you could become an advocate in your workplace and push for a switch to greener energy sources. Additionally, many private sector hospitals hold stock in fossil fuel-based companies, which supports the continuation of these climate unfriendly industries. Organisations such as Health Care Without Harm can teach us about divestment strategies and how to become an advocate for greener energy solutions in our workplaces.

Gender equity

Gender equity matters. Educating girls about sexual and reproductive health leads to women and girls having more control over their lives and their bodies. Nurses and midwives are in positions to help educate patients on sexual and reproductive health and support access to it. When communities obtain good-quality education, they have healthier and smaller families and can actively manage their reproductive health.[2]

Nature

The fifth area of focus is nature. Healthy humans and healthy forests are interlinked. Protecting forests, especially in the tropics, can reduce greenhouse gases which benefits human health. Trees also help support pollinators, provide habitat, filter water and sequester carbon.[2] We can plant trees

which will act as 'carbon sinks', protecting tropical forests and forest protection. Reducing the use of paper products and compost at home also protects our natural resources.

Spreading the word

Nurses Drawdown is spreading the word of nurses and midwives' individual voices, such as that of renowned cardiology nurse Tucker Annis, who is now cycling to work. Mr Annis sees the benefit not only to his health and wallet but to the environment in his inspirational video on Nurses Drawdown website where he comments: "If you commute 20 miles to work in a car that gets 25 miles per gallon, your personal carbon emissions a year would be 8,000lb. That's the weight of seven grand pianos of CO_2 floating into the air and warming the planet."[2]

However, not everyone may be able to cycle to work. We need to be realistic that everyone's way of taking action on climate change may be different. That doesn't mean we shouldn't try to figure out little ways we can make changes toward a cleaner environment. Maybe it's starting a carpool to work or using public transport if cycling is not an option. Maybe it's finding healthier cleaning products that are more environmentally friendly for your home, or maybe it's changing your diet to become more plant-based. All of these small steps add up to make big changes to the health of our planet.

As nurses and midwives across the globe, let us work together and get started by taking action in one of these five focus areas. We hope that taking the first step will lead you to wanting to do more and advocate for climate positive policies in your communities. With about 30 million nurses and midwives worldwide, when we come together as an interconnected global community, progress will be made.

When children are protesting and making statements to political leaders for change, we can too. As Xiye Bastida, a Mexican-Chilean climate activist, said: "We don't call water a resource; we call it a sacred element. The relationship we have with everything that Earth offers is about reciprocity. That is the only way we are going to learn how to shift our culture from an extraction culture to a balanced and harmonious culture with the land." [7]

Action is key, and we know what we need to do. Let us come together as nurses and midwives to become climate change leaders and show how climate action can lead to a healthier future for generations to come.

Sara Kramer is a registered nurse who recently graduated with a master of science in Massachusetts in the US. Her practicum advisor was Katie Huffling a registered nurse and executive director of the Alliance of Nurses for Healthy Environments

References

1. Watts N, Amann M, Arnell N, Ayeb-Karlsson S, Belesova K, Boykoff M, et al. The 2019 report of The Lancet Countdown on health and climate change: ensuring that the health of a child born today is not defined by a changing climate. The Lancet 2019 Nov 16;394(10211):1836-1878

2. Nurses Drawdown. A project of the Alliance of Nurses for a Healthy Environment and Project Drawdown. Available from: https://www.nursesdrawdown.org

3. Project Drawdown. Plant-Rich Diets. Available from: https://www.drawdown.org/solutions/plant-rich-diets

4. Project Drawdown. Transportation. Available from: https://drawdown.org/sectors/transportation

5. Brenan M, Nurses Again Outpace Other Professions for Honesty, Ethics. Available from: https://news.gallup.com/poll/245597/nurses-again-outpace-professions-honesty-ethics.aspx

6. Wu X, Nethery RC, Sabath MB, Braun D and Dominici F, 2020. Air pollution and Covid-19 mortality in the United States: Strengths and limitations of an ecological regression analysis. Science advances, 6(45). Available from: https://projects.iq.harvard.edu/covid-pm

7. Climate Change Resources. Xiye Bastida. Available From: https://climatechangeresources.org/dt_testimonials/xiye-bastida/ Accessed April 2021

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Ehlers Danlos syndrome

There is a shocking lack of awareness of this complex syndrome among healthcare professionals in Ireland, writes **Rebecca O'Shea**

EHLERS Danlos is a chronic illness that casts a shadow over my daily life. Both my son and I suffer from it. I know I had a lucky childhood with my health compared to some with the same diagnosis.

When I was about 10 and getting ready for school I realised that I didn't feel well. I wasn't sick but it was a definite awareness that my energy levels had dropped. I think from that point it took me longer than others to bounce back from being unwell. When I started secondary school I was hit with regular kidney infections and at times was deathly pale despite eating well and getting plenty of sleep. My GP referred me to see consultants but no reason for the unexplained symptoms could be found. At this stage my gastric symptoms had become a real problem and I would have the typical boom/bust cycles where I would burn out every three months and need to take time off school, college or work.

Throughout my childhood I entertained friends with my many unusual party tricks. My favourite was touching my nose with my tongue but I could also bend my limbs into unnatural positions. I would find out much later that these were all red flags for a syndrome that I never knew existed.

I trained as a nurse, I gave 100% of myself to it and it defined who I was for a very long time. I loved my job but at times felt as unwell as those I cared for.

In 2011 when pregnant with my first child, I collapsed in work and was brought to the ED. Shortly after, my cardiac problems were diagnosed. I struggled throughout the pregnancy and nearly lost my first baby who arrived early but healthy. I suffered a complication with my bladder and still see this time as the most traumatic experience of my life. My health declined but to the outside world I looked fine. I underwent a cardiac procedure when my son was nine months old and did somewhat bounce back.

My son too was a worry, with a low birth weight and severe reflux that became so problematic he was hospitalised. He grew stronger and we both reached a level of normality that allowed me to go back to work. When he was 12 months old I had my first miscarriage – an awful experience for any couple but little did we know it would be the first of many. My second baby was born early weighing just over 4lb but was well. In total I endured six miscarriages.

My son spent a lot of time with our GP for recurrent ear and chest infections. He was diagnosed with asthma which became all consuming. I continued to suffer with unusual ailments and to miscarry. All the while no one could find any reason for any of it so I assumed it was normal and learned to endure the exhaustion that I assumed everybody lived with.

As time went on I struggled especially in work where we were so busy you could hardly draw breath at times. Each step became harder and more painful but no one really knew. I had an amazing manager who knew that I wasn't well. She saw it in my face and gave me support that I will always be so grateful for. I left work early one day after injuring my neck by simply turning too quickly to talk to someone. For me it was the final straw. This injury still plagues me and I never returned to work.

This marked the end of my nursing career but it's also what saved me. During this time my cardiac issues had become unbearable and my cardiologist and my occupational health doctor connected the dots. After reading through notes my occupational health doctor asked if anyone had ever mentioned a connective tissue disorder. Shortly afterwards I was referred to rheumatology and diagnosed with Ehlers Danlos syndrome.

My GP was fantastic. I never felt dismissed and am grateful for his care and compassion. He had referred me to many consultants down through the years and I think my diagnosis hit him hard. To me it highlights how little is known about it. As a nurse I don't ever remember learning about connective tissue disorders and will admit to being totally in the dark after being diagnosed.

While I was initially delighted to have finally been diagnosed, that was short lived as I had more questions than answers. It's at this point that I will explain that I trained as a tissue viability nurse. I'm trained in dermatology and skin issues like wounds and burns. I never saw my velvet skin as a symptom, even the scars and the overly stretchy skin didn't ring alarm bells. I have skin that feels like a newborn's and joked with friends down through the years about it. It remains a constant learning curve with endless waiting lists and appointments.

I think the worst part about it is the lack of awareness not just in the public but sadly among healthcare professionals. I feel compelled to tell my story for this reason. Some doctors are amazing, others very dismissive and defensive out of lack of knowledge. Compared to the UK we are failing miserably at both diagnosing and treating people with it.

This time last year my son had a spontaneous bleed in his neck. It took three trips to the ED before they acknowledged there had been no trauma and admitted him for surgery. A year on and he has now started his own Ehlers Danlos journey. It seems that he has weaker blood vessels and unfortunately has a dilated aortic root in his heart. The day that I got that news I was alone with him and I felt like I had lost my little boy. I felt as though all the hopes and dreams I had for his future were taken away.

I watched him so closely over the coming weeks with a pain in my heart. I was afraid that he might disappear suddenly in a catastrophic medical emergency. Thankfully I got my head out of that place and like lots of parents with children in similar situations I began to realise life hasn't changed that much because you simply can't let it. He is still the same happy boy who wants to be a doctor and loves reading. He has accepted that he will require careful monitoring and regular hospital visits.

The reason I wanted to share our story was to raise awareness. I believe that Ehlers Danlos is not as rare as first thought but totally underdiagnosed in our health service, which I was once part of. The fault however does not lie with any individual and I am the proof of this. No nurse or doctor can see what they have not been trained to. I feel compelled to speak as many people have lost the strength to fight for themselves while battling this illness. I am so fortunate in this life to now find myself in the care of those I once worked with. It brings me comfort to know that my son and I are in good hands.

Rebecca O'Shea is a nurse and INMO member

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Posology: One 6 mg dose (a single pre-filled injector) of Pelgraz is recommended for each chemotherapy cycle, given at least 24 hours after cytotoxic chemotherapy. Safety and efficacy of Pelgraz in children and adolescents has not yet been established and no recommendation on a posology can be made. No dose change is recommended in patients with renal impairment, including those with end-stage renal disease. **Method of administration:** Pelgraz is for subcutaneous use. The injections should be given subcutaneously into the thigh, abdomen or upper arm. See SmPC for instructions on handling of the medicinal product before administration. **Contraindications:** Hypersensitivity to pegfilgrastim or any of the excipients in Pelgraz. **Warnings and precautions:** To improve the traceability of biological medicinal products, the trade name of the administered product should be clearly recorded. The long-term effects of pegfilgrastim have not been established in acute myeloid leukaemia (AML); therefore, it should be used with caution in this patient population. Granulocyte-colony stimulating factor (G-CSF) can promote growth of myeloid cells *in vitro* and similar effects may be seen on some non-myeloid cells *in vitro*. The safety and efficacy of pegfilgrastim have not been investigated in patients with myelodysplastic syndrome, chronic myelogenous leukaemia, and in patients with secondary AML; therefore, it should not be used in such patients. Particular care should be taken to distinguish the diagnosis of blast transformation of chronic myeloid leukaemia from AML. The safety and efficacy of pegfilgrastim administration in *de novo* AML patients aged < 55 years with cytogenetics t(15;17) have not been established. The safety and efficacy of pegfilgrastim have not been investigated in patients receiving high dose chemotherapy. This medicinal product should not be used to increase the dose of cytotoxic chemotherapy beyond established dose regimens. Pulmonary adverse reactions, in particular interstitial pneumonia, have been reported after G-CSF administration. Patients with a recent history of pulmonary infiltrates or pneumonia may be at higher risk. The onset of pulmonary signs such as cough, fever, and dyspnoea in association with radiological signs of pulmonary infiltrates, and deterioration in pulmonary function along with increased neutrophil count may be preliminary signs of Adult Respiratory Distress Syndrome (ARDS). In such circumstances pegfilgrastim should be discontinued at the discretion of the physician and the appropriate treatment given. Glomerulonephritis has been reported in patients receiving filgrastim and pegfilgrastim. Generally, glomerulonephritis resolved after dose reduction or withdrawal of filgrastim and pegfilgrastim. Urinalysis monitoring is recommended. Capillary leak syndrome has been reported after G-CSF administration and is characterised by hypotension, hypoalbuminaemia, oedema and haemoconcentration. Patients who develop symptoms of capillary leak syndrome should be closely monitored and receive standard symptomatic treatment, which may include a need for intensive care. Generally asymptomatic cases of splenomegaly and cases of splenic rupture, including some fatal cases, have been reported following administration of pegfilgrastim. Spleen size should be carefully monitored (e.g. clinical examination, ultrasound). A diagnosis of splenic rupture should be considered in patients reporting left upper abdominal pain or shoulder tip pain. Treatment with pegfilgrastim alone does not preclude thrombocytopenia and anaemia because full dose myelosuppressive chemotherapy is maintained on the prescribed schedule. Regular monitoring of platelet count and haematocrit is recommended. Special care should be taken when administering single or combination chemotherapeutic medicinal products which are known to cause severe thrombocytopenia. Sickle cell crises have been associated with the use of pegfilgrastim in patients with sickle cell trait or sickle cell disease. Therefore, use caution when prescribing pegfilgrastim in patients with sickle cell trait or sickle cell disease, monitor appropriate clinical parameters and laboratory status and be attentive to the possible association of this medicinal product with splenic enlargement and vasoocclusive crisis. White blood cell (WBC) counts of 100 x 10^9 /L or greater have been observed in less than 1% of patients receiving pegfilgrastim. No adverse reactions directly attributable to this degree of leukocytosis have been reported. Such elevation in WBCs is transient, typically seen 24 to 48 hours after administration and is consistent with the pharmacodynamic effects of this medicinal product. Consistent with the clinical effects and the potential for leukocytosis, a WBC count should be performed at regular intervals during therapy. If leukocyte counts exceed 50 x 10^9 /L after the expected nadir, this medicinal product should be discontinued immediately. Hypersensitivity, including anaphylactic reactions, have been reported with pegfilgrastim. Permanently discontinue pegfilgrastim in patients with clinically significant hypersensitivity. Do not administer pegfilgrastim to patients with a history of hypersensitivity to pegfilgrastim or filgrastim. If a serious allergic reaction occurs, appropriate therapy should be administered, with close patient follow-up over several days. Stevens-Johnson syndrome (SJS), which can be life-threatening or fatal, has been reported rarely in association with pegfilgrastim treatment. If the patient has developed SJS with the use of pegfilgrastim, treatment must not be restarted at any time. As with all therapeutic proteins, there is a potential for immunogenicity. Rates of generation of antibodies against pegfilgrastim is generally low. Binding antibodies do occur as expected with all biologics; however, they have not been associated with neutralising activity at present. Aortitis has been reported after filgrastim or pegfilgrastim administration in healthy subjects and in cancer patients. The symptoms experienced included fever, abdominal pain, malaise, back pain and increased inflammatory markers (e.g. C-reactive protein and WBC count). In most cases aortitis was diagnosed by CT scan and generally resolved after withdrawal of filgrastim or pegfilgrastim. The safety and efficacy of Pelgraz for the mobilisation of blood progenitor cells in patients or healthy donors has not been adequately evaluated. Increased haematopoietic activity of the bone marrow in response to growth factor therapy has been associated with transient positive bone-imaging findings. This should be considered when interpreting bone- imaging results. This medicinal product contains 50 mg sorbitol in each unit volume, which is equivalent to 30 mg per 6 mg dose. Pelgraz contains less than 1 mmol (23 mg) sodium per 6 mg dose, that is to say essentially 'sodium-free'. The needle cover contains dry natural rubber (a derivative of latex), which may cause allergic reactions. **Pregnancy and Lactation:** Pegfilgrastim is not recommended during pregnancy and in women of childbearing potential not using contraception. A decision must be made whether to discontinue breastfeeding or to discontinue/abstain from pegfilgrastim therapy taking into account the benefit of breastfeeding for the child and the benefit of therapy for the woman. **Adverse Events include: Adverse events which could be considered serious include: Common:** Thrombocytopenia. **Uncommon:** Sickle cell crisis, capillary leak syndrome, glomerulonephritis, hypersensitivity reactions (including angioedema, dyspnoea, anaphylaxis), splenic rupture (including some fatal cases), Sweet's syndrome (acute febrile dermatosis), pulmonary adverse reactions including interstitial pneumonia, pulmonary oedema and pulmonary fibrosis have been reported. Uncommonly cases have resulted in respiratory failure or ARDS which may be fatal. **Rare:** Aortitis, pulmonary haemorrhage, Stevens-Johnson syndrome. **Other Very Common adverse events:** Headache, nausea, bone pain. **Other Common adverse events:** Leukocytosis, musculoskeletal pain (myalgia, arthralgia, pain in extremity, back pain, musculoskeletal pain, neck pain), injection site pain, non-cardiac chest pain. See SmPC for details of other adverse events. **Shelf Life:** 3 years. Store in a refrigerator (2°C – 8°C). Pelgraz may be exposed to room temperature (not above 25°C ± 2°C) for a maximum single period of up to 72 hours. Pelgraz left at room temperature for more than 72 hours should be discarded. Do not freeze. Accidental exposure to freezing temperatures for a single period of less than 24 hours does not adversely affect the stability of Pelgraz. Keep the container in the outer carton in order to protect from light. **Pack Size:** One prefilled injector with one alcohol swab, in a blistered packaging. **Marketing Authorisation Number:** EU/1/18/1313/002. **Marketing Authorisation Holder (MAH):** Accord Healthcare S.L.U, World Trade Center, Moll de Barcelona, s/n, Edifici Est, 6a planta, Barcelona, 08039 Spain. **Legal Category:** POM. Full prescribing information including the SmPC is available on request from Accord Healthcare Ireland Ltd, Euro House, Little Island, Co. Cork, Tel: 021-4619040 or www.accord-healthcare.ie/products. **Adverse reactions can be reported to Medical Information at Accord-UK Ltd. via E-mail:** medinfo@accord-healthcare.com **or Tel:** +44(0)1271385257.
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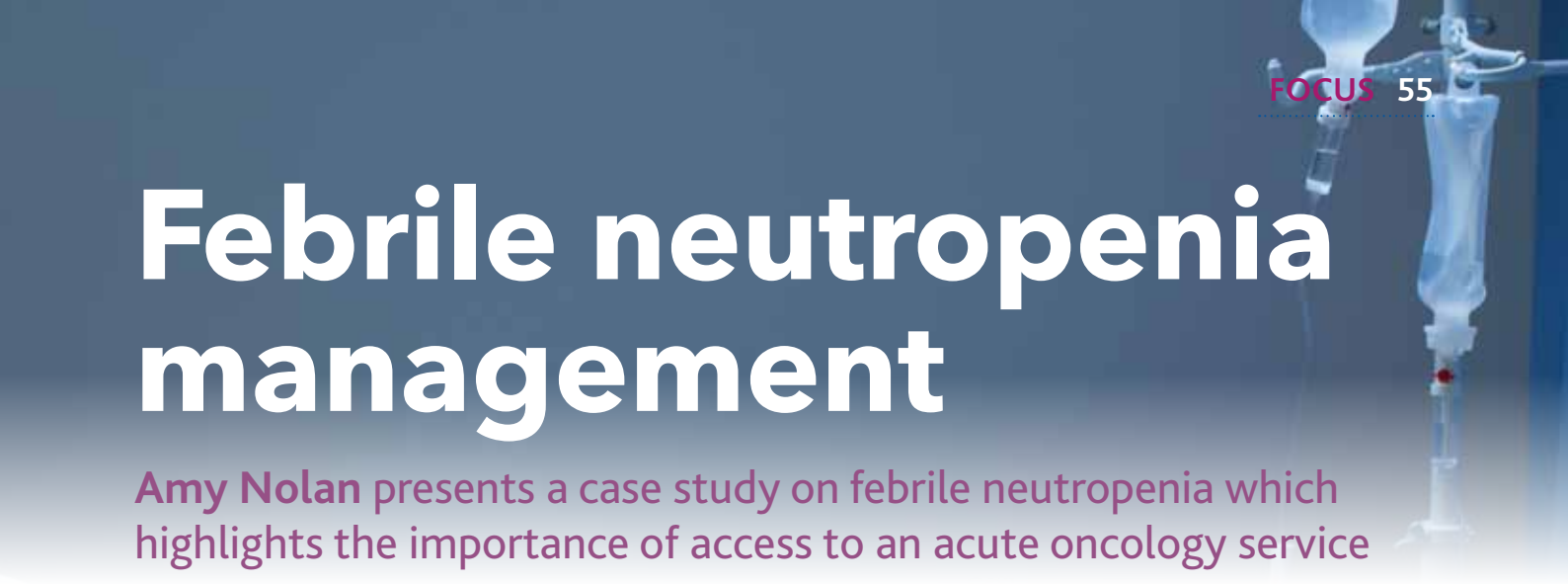
May 2020. IE-01429



Febrile neutropenia management

Amy Nolan presents a case study on febrile neutropenia which highlights the importance of access to an acute oncology service

A 70-YEAR-OLD woman presented with altered bowel habit, including constipation and bleeding. She was diagnosed with Stage 4 colorectal cancer, including liver metastases in May 2020. She had no known allergies or sensitivities, and initial treatment was six cycles of FOLFOX (oxaliplatin, 5-fluorouracil [5FU] and leucovorin) chemotherapy regimen during which she experienced an episode of neutropenic sepsis with neutrophil count of 0.3 x 10^9/L and was prescribed G-CSF (granulocyte colony stimulating factors) for subsequent cycles of chemotherapy.

A CT scan noted progressive disease in March 2021 and the patient's treatment regimen was subsequently altered. She is currently receiving the FOLFIRI chemotherapy regimen (leucovorin, 5-fluorouracil and irinotecan). The regimen is administered every two weeks and requires a PICC line (peripheral intrathecal central catheter), as the treatment is typically administered in a day ward setting. The patient was discharged with a 5FU pump attached to her PICC line, which infuses over a 48-hour period. The pump is then disconnected from the PICC line by a member of the community nursing team.

Prior to commencing chemotherapeutic regimens, education regarding chemotherapeutic agents, potential side effects including neutropenic sepsis and ancillary medications (including steroids and antiemetics) and emergency 24-hour contact telephone numbers were provided. The patient's husband also has cancer and she is his primary carer; he attends another hospital for his cancer treatment. They do not have children and live in a two-storey house within 5km of the hospital.

The patient commenced cycle four, day one of FOLFIRI at the beginning of July 2021. Five days following her chemotherapy, she contacted the haematology oncology telephone triage service to report mucositis, which was assessed as Grade 3. She was advised to attend the oncology day ward to receive IV fluids and opiate analgesia. The patient declined to attend the day ward as she had to care for her husband and as a result she was provided with a prescription for valaciclovir (500mg) and Difflam oral rinse.

On cycle four, day six post-chemotherapy, she attended the oncology day ward for review and ongoing mucositis with weight loss, and poor oral intake was noted. A swab (for culture/sensitivity) was taken, and her full blood count result highlighted neutrophils 0.7 x 10^9/L.

As the patient was feeling well and hydrated and had an 'early warning score (EWS)' = 0, she was discharged with oramorph and BMX (Benylin, Maalox and lidocaine), to be taken prior to meals. She was advised that should she feel unwell, and/or have a temperature of > 37.5°C, to contact the haematology/oncology service without hesitation, for urgent review and assessment.

During cycle four, day 10 post-chemotherapy, a further telephone call was received by the acute oncology service, whereby the patient reported that her mucositis was much improved. However, her fluid intake was poor as she was experiencing nausea/vomiting as a result of the opiates, and she was advised to desist from taking further opiates.

On cycle four, day 11 post-chemotherapy, the patient was admitted to the oncology day ward reporting nausea, vomiting, fatigue and unsteadiness. On examination, it was deemed that she had both Grade 3 diarrhoea and mucositis (which were side-effects of 5FU and irinotecan). Her complexion was pale, her mucosa dry and her chest was clear, with good bilateral air entry, and normal heart sounds. Her abdomen was soft, lax and non-tender and bowel sounds were present, and her central nervous system (CNS) was also grossly intact.

A full septic screen was undertaken, which entailed:

- Blood cultures – peripheral and central line (PICC)
- Sputum sample
- Mid-stream urine sample
- Stool sample
- Chest x-ray
- Full blood count (FBC)
- Renal, liver, bone profile
- CRP
- Lactate
- Vital signs.

Her vital signs revealed her temperature was 38.3°C and analysis of her FBC showed her white cell count was 1.2 and her neutrophil count was 0.5 x 10^9/L. Thus, the deferential diagnosis of neutropenic sepsis was confirmed.

The patient was admitted to hospital to continue IV antibiotics (commenced on arrival to the oncology day ward), IV fluids and antiemetics.

On cycle four, Day 12 post-chemotherapy, her neutrophil count was 1.0 x 109/L, and therefore she was no longer neutropenic, and plans were made to discharge her with oral antibiotics.

Neutropenic sepsis

Neutropenic sepsis is defined as a neutrophil count of < 0.5 x 109/L with pyrexia of 38°C and/or signs and symptoms suggestive of sepsis.[1]

It is a predictable, common and potentially life-threatening condition for patients receiving systemic anti-cancer therapies. The estimated mortality of patients with neutropenic sepsis following systemic anticancer therapies is 2-12%.[1] Neutropenic patients are vulnerable to invasive infection.

Importance of optimal neutropenic sepsis management

There exists an overall awareness within health services that sepsis is a medical emergency and much work has been done since the HIQA 2013 Patient Safety Investigation report into services at University Hospital Galway (UHG) and as reflected in the care provided to Savita Halappanavar[2]

to utilise the early-warning score (EWS) and the 'sepsis six' pathway,[3] to ensure adherence with a 'one-hour from door-to-needle' policy for septic patients.

Successful implementation of 'sepsis six' has proven to be beneficial towards patient outcomes.[3]

The Irish Department of Health sepsis guidelines[4] determined that launching international sepsis awareness campaigns to ensure early recognition and intervention for septic patients, typically result in a 20-30% reduction in mortality from sepsis/septic shock.[4]

Management

Presenting features of sepsis at initial assessment are two or more of the following:

- Fever (≥ 38°C)
- Hypothermia (< 36°C)
- Tachycardia (> 90/min-1)
- Tachypnoea (> 20).

However, in many neutropenic patients, their systemic anti-inflammatory response can be hampered. This may be due to steroids administered as part of their treatment, antiemetic regimens or patients taking paracetamol (despite guidance not to as it masks any signs of infection). A clear focus of infection may not be identified and the usual diagnostic criteria for infection may not be attained.[5] In fact, Clarke et al[6] noted that patients' symptoms can be subtle and ill-defined as in this case, as she was apyrexial but had symptoms of diarrhoea and mucositis and had been prescribed steroids as part of her antiemetic regimen on days one to four post chemotherapy.

A low threshold for contacting the oncology day ward is applied should a patient feel unwell – if in doubt, reach out. This was reflected in this patient's scenario, as she had an absence of fever but her general condition had deteriorated and she contacted the haematology oncology telephone triage service.

Typically, the neutrophil count reaches its nadir between days 10-14 following chemotherapy.[7] We cannot determine the exact day on which this patient reached her nadir, but we do know that on day 11 post chemotherapy, her neutrophil count was 0.5 x 10^9/L. On admission, an immediate physical assessment/examination is required of the airway, breathing and circulation plus history (ABC and history) – in order to attempt to identify any sources of infection.

It is recommended that vital signs and monitoring of bloods such as a FBC, kidney and liver function test, C-reactive protein (CRP), lactate and blood cultures be taken. Patients with a central access device such as a portacath, Hickman line or PICC line (as in this case) should have combined cultures on admission from the line and peripheral samples also. In addition, diarrhoea and urine samples and any other potential sources of infection should be taken for culture and sensitivity purposes.

The immediate administration of broad-spectrum IV antibiotics and IV fluids are required as per the Sepsis Management National Clinical Guideline.[4] It is imperative to commence antibiotics without delay, and not wait for the identification of neutropenia (prior to the administration of antibiotics), as any delay will increase the risk of death due to sepsis.

The global sepsis campaign of 'one hour door-to-needle' is recognised and frequently-referenced within Irish healthcare and our applicable hospital policies. It advocates for broad-spectrum antibiotics such as piperacillin/tazobactim (Tazocin) and amikacin. It is also important to note that the removal of a patient's central venous access device (where present) is not recommended as part of the initial empiric management of suspected neutropenic sepsis[1] unless there is clear evidence of line infection.

Patients who have an 'uncomplicated' neutropenic sepsis (as in this case) are managed as inpatients, reviewed daily, reassessed for risk by their medical oncology team and assessed at four-hourly intervals by their nursing team.

Recovery

If the patient is afebrile after 48-hours, with an EWS = 0 and considered to be at a low-risk of septic complications, they should be prescribed oral antibiotics and discharged home (clinical/domestic circumstances permitting). In this patient's case, she was anxious to return home in order to care for her husband and following medical, social work and clinical assessments, she was discharged home.

In alternate circumstances, if the patient is still pyrexial at 48 hours or their EWS deteriorates, a full reassessment and additional consideration of fungal or atypical infection should be considered. The antibiotics initially prescribed should be continued unless there is a clinical deterioration, or a report from the hospital microbiology team to indicate the presence of another type of infection and alternative antibiotics or antifungal therapies are recommended.

Risk assessment

It is advisable to consider additional therapies such as the use of granulocyte colony stimulating factors (G-CSF) for some patients who pose a higher-risk of developing neutropenic sepsis. This is the clinical guideline recommendation of the European Society for Medical Oncology (ESMO), where in circumstances of a confirmed case of neutropenic sepsis with confirmed bacteraemia, hypotension and a fever for over seven consecutive days.[8]

Additional febrile neutropenia risk-factors post-chemotherapy are outlined within the ESMO guidelines for the management of neutropenic sepsis.[8] Older people pose a considerably greater risk of developing febrile neutropenia and associated risk factors include:

- Advanced disease
- A history of prior febrile neutropenia
- No antibiotic prophylaxis (rarely prescribed in the Irish context) or G-CSF use
- Mucositis
- Poor performance status
- Cardiovascular disease.

Such risk factors increase the potential for adversely affecting mortality rates in the presence of febrile neutropenia.

Within a Dublin hospital, a febrile neutropenia assessment tool was developed and introduced with great effect. The tool was utilised over a one-year period, and identified patients most at-risk of neutropenic sepsis in advance of commencing their chemotherapy regimen, and G-CSF was prescribed based on the associated risk. As a result, a 52% reduction in episodes of neutropenic sepsis was noted.[9]

A reduction in patients with neutropenic sepsis has a consequential impact on hospital bed stays, and subsequent dose reduction and dose delays of chemotherapeutic agents, and mortality.[10] An Irish study[11] identified resource-use and the cost of hospitalisation for an episode of neutropenic sepsis, including length of stay in a hospital bed, antibacterial treatment laboratory investigations and blood bank products was on average €8,915.11

Patient education

The education of patients and their relatives on the severity and potential life-threatening aspects of neutropenic sepsis is essential. Patients require clear and concise literature, ideally in-line with Plain English guidelines.[12] The literacy level of the patient should be considered and verbal information offered also on how to manage should they become unwell and/or become pyrexial.

Interestingly, according to Clarke et al,[6] patients were aware of the importance of checking their temperature and becoming febrile, however many patients did not appreciate the significance of feeling unwell (in the absence of a febrile temperature).[6]

Patients within this Dublin site were educated through group sessions, prior to the outbreak of the Covid-19 pandemic, and are subsequently educated via virtual interactive meetings by supportive cancer services in Ireland prior to commencing chemotherapy. Education concerning specific chemotherapy regimen side-effects including neutropenic sepsis is provided by the oncology medical team, oncology clinical nurse specialists and members of the nursing team within the oncology day ward, as they administer chemotherapy to patients.

Despite multiple and varied education avenues, patients may experience psychological, physical and/or emotional effects due to neutropenic sepsis.[13] Barriers to hospital attendance often include fear, denial and, as in the present case, other considerations such as that she was her husband's sole carer (which hampered her attendance at the day ward).

The delivery of a 24-hour, dedicated haematology oncology telephone triage which applies the UKONS (United Kingdom Oncology Nurse Society) telephone triage toolkit,[14] provides timely, effective intervention in managing potential side effects and can be lifesaving for patients. The equivalent UKONS telephone triage capability utilises query 'prompts', to determine gradings such as side-effects or other challenges, and also applies a 'traffic light system' (red/amber/green) to identify a recommended plan for patients. 'Red' indicates an immediate attendance to hospital is required for clinical assessment/treatment. The additional benefit of telephone triage services is that they ensure accessibility and equity of access for patients requiring expert standardised assessment and care and advice (through the utilisation of the UKONS telephone triage toolkit).[14]

Oncology patients are often referred to their local hospital's emergency department for assessment, review and resuscitation. However; due to an overall lack of comprehension of the complexities of neutropenic sepsis and clinical expertise, delays may invariably result, with subsequent increases in mortality.[15]

An acute oncology service is defined as the management of cancer patients presenting with complications of their cancer treatment or of their cancer disease itself.[16] The adoption of the acute oncology pathway can increase the speed at which a patient can be treated and as a result mortality rates are reduced. The benefits are therefore self-evident of having an acute oncology service, through increased compliance with the aforementioned 'one-hour door-to-needle' policy.

Acute oncology services have also been pivotal in achieving a reduction in hospital stay durations following admission. Additionally, such services reduce the number of patients requiring admission, due to timely and expert clinical advice and urgent care, which can facilitate same-day discharge.[17] In our patient's case, having access to expert clinical advice and prompt care resulted in a better patient experience and very likely reduced the length of her inpatient stay.

Conclusion

Neutropenic sepsis is a life-threatening oncological emergency. The implementation of a 'one-hour door-to-needle' policy, septic screen and the rapid administration of IV antibiotics and fluids, all impact patient mortality and hospital stay and recovery durations. Consideration should be given to the application of a febrile neutropenia assessment tool to indicate G-CSF prescription recommendations. In this case, the patient had many of the increased risk factors outlined in the ESMO guidelines for the management of febrile neutropenia:[8]

- The patient was 70 years old, with liver metastases
- Had a previous episode of neutropenic sepsis during an earlier chemotherapy regimen
- Had received chemotherapeutic agents previously
- Her primary complaint when she had contacted the telephone triage service was mucositis
- Her ECOG status was '0', and subsequently deteriorated to ECOG status '2' in the lead-up to her episode of febrile neutropenia.

On reflection, in this patient's case it is likely that the initial prescribing of G-CSF at the outset of her new chemotherapy regimen (FOLFIRI) may have prevented her episode of febrile neutropenia and subsequent hospital admission. The patient's prompt recognition of symptoms and her ability to access emergency oncological services for unwell patients, were paramount towards her immediate medical care and recovery from her neutropenic sepsis episode.

Patient education, telephone triage systems and acute oncology services are an essential 'trinity' towards ensuring that patients are facilitated with immediate, safe and standardised care that is both equitable and accessible should they develop neutropenic sepsis.

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References

1. Bate J, Gibson F, Johnson E et al [National Institute for Clinical Excellence – NICE]. Neutropenic sepsis: prevention and management of neutropenic sepsis in cancer patients (NICE Clinical Guideline CG151). Arch Dis Child Educ Pract Ed 2013 Apr; 98(2):73-5

2. Health Information and Quality Authority (HIQA). Patient Safety Investigation report into services at University Hospital Galway (UHG) and as reflected in the care provided to Savita Halappanavar. 2013, Oct 9

3. Daniels R, Nutbeam T, McNamara G, Galvin C. The sepsis six and the severe sepsis resuscitation bundle: a prospective observational cohort study. Emerg Med J 2011; (28):507-12

4. The Department of Health – National Clinical Effectiveness Committee. Sepsis Management: National Clinical Guideline no 6. November 2014. ISSN 2009-6259

5. Dunkley S, McLeod A. Neutropenic sepsis: assessment, pathophysiology and nursing care. Br J Neurosc 2015; 11(2):79-87

6. Clarke R, Warnick J, Stretton K, Littlewood TJ. Improving the immediate management of neutropenic sepsis in the UK: lessons from a national audit' Br J Haematol 2011; 153(6):773-9

7. Ford A, Marshall E. Neutropenic sepsis: a potentially life-threatening complication of chemotherapy. Clin Med 2014; 14(5):538-42

8. Klastersky J, De Naurois J, Rolston K, Rapoport B, Maschmeyer G, Aspro M, Herrstedt J [on behalf of the ESMO Guidelines Committee]. Management of febrile neutropenia: ESMO Clinical Practice Guideline. Supportive and palliative care (supplement guidelines) clinical practice guidelines. Ann Oncol 2016; 27 (suppl 5): v111-v118

9. O'Brien C, Dempsey O, Kennedy MJ. Febrile neutropenia risk assessment tool: improving clinical outcomes for oncology patients. Eur J Oncol Nursing 2014; 18(2):167-74

10. Krell D, Jones AL. Impact of effective prevention and management of febrile neutropenia. Br J Cancer 2009; (101), Suppl 1 S23-S26

11. O'Brien C, Fogarty E, Walsh C et al. The cost of the inpatient management of febrile neutropenia in cancer patients – a micro-costing study in the Irish healthcare setting. Eur J Cancer Care 2014; 24(1):125-32

12. National Adult Literacy Agency. https://www.nala.ie/health-literacy/health-sector-services/ and https://www.nala.ie/plain-english/

13. Warnock C. Neutropenic sepsis: prevention, identification and treatment. Nursing Standard 2015; 30(35):51-60

14. UK Oncology Nursing Society. Oncology/Haematology 24 Hour Triage Rapid Assessment and Access Toolkit. https://www.ukons.org/site/assets/files/1134/oncology_haematology_24_hour_triage.pdf

15. Wilde T. Improving door to needle times for patients with suspected neutropenic sepsis. Emergency Nurse 2017; (7):24-29

16. Bruce CM, Smith J, Price A. A study of the incidence and management of admissions for cancer related symptoms in a district general hospital: The potential role of an Acute Oncology Service. Clinical Oncology 2017; 29(9):148-55

17. King J, Ingham-Clarke C, Parker C, Jennings, R, Leonard P. Towards saving a million beds reducing length of stay through an acute oncology model for inpatients diagnosed as having cancer'. BMJ Quality & Safety 2011; 20(8):718-72

Prescribing Information: Please read the Summary of Product Characteristics (SPC) before prescribing. **Presentation:** Prolonged-release tablet, containing mirabegron 25mg/50mg. **Indication:** Symptomatic treatment of urgency, increased micturition frequency and/or urgency incontinence as may occur in adult patients with overactive bladder (OAB) syndrome. **Posology and method of administration:** The recommended dose is 50 mg once daily. A lower dose of 25mg is recommended for specific patient populations (renal and hepatic impairment) as well as in specific patient populations in combination with strong CYP3A inhibitors such as itraconazole, ketoconazole, ritonavir and clarithromycin. Renal impairment: *End stage renal disease* (GFR < 15 mL/min/1.73 m2 or patients requiring haemodialysis): Not recommended. *Severe renal impairment* (GFR 15 to 29 mL/min/1.73 m2): Reduce dose to 25 mg. *Severe renal impairment and concomitant strong CYP3A inhibitors:* Not recommended. *Moderate renal impairment* (GFR 30 to 59 mL/min/1.73 m2): 50 mg. *Moderate renal impairment and concomitant strong CYP3A inhibitors:* Reduce dose to 25 mg. *Mild renal impairment* (GFR 60 to 89 mL/min/1.73 m2): 50 mg. *Mild renal impairment and concomitant strong CYP3A inhibitors:* Reduce dose to 25 mg. Hepatic impairment: *Severe hepatic impairment* (Child-Pugh Class C): Not recommended. *Moderate hepatic impairment* (Child-Pugh B): Reduce dose to 25 mg. *Moderate hepatic impairment and concomitant strong CYP3A inhibitors:* Not recommended. *Mild hepatic impairment* (Child-Pugh A): 50 mg. *Mild hepatic impairment and concomitant strong CYP3A inhibitors:* Reduce dose to 25 mg. The tablet is to be taken once daily, with liquids, swallowed whole and is not to be chewed, divided, or crushed. It may be taken with or without food **Contraindications:** Hypersensitivity to the active substance or to any of the excipients (see the SPC for a list of excipients). Severe uncontrolled hypertension defined as systolic blood pressure ≥180 mm Hg and/or diastolic blood pressure ≥110 mm Hg. **Special warnings and precautions for use:** Renal impairment: Betmiga has not been studied in patients with end stage renal disease (GFR < 15 mL/min/1.73 m2 or patients requiring haemodialysis) and, therefore, it is not recommended for use in this patient population. Data are limited in patients with severe renal impairment (GFR 15 to 29 mL/min/1.73 m2); based on a pharmacokinetic study a dose reduction to 25 mg is recommended in this population. This medicinal product is not recommended for use in patients with severe renal impairment (GFR 15 to 29 mL/min/1.73 m2) concomitantly receiving strong CYP3A inhibitors. Hepatic impairment: Betmiga has not been studied in patients with severe hepatic impairment (Child-Pugh Class C) and, therefore, it is not recommended for use in this patient population. This medicinal product is not recommended for use in patients with moderate hepatic impairment (Child-Pugh B) concomitantly receiving strong CYP3A inhibitors. Hypertension: Mirabegron can increase blood pressure. Blood pressure should be measured at baseline and periodically during treatment with mirabegron, especially in hypertensive patients. Data are limited in patients with stage 2 hypertension (systolic blood pressure ≥ 160 mm Hg or diastolic blood pressure ≥ 100 mm Hg). Patients with congenital or acquired QT prolongation: Betmiga, at therapeutic doses, has not demonstrated clinically relevant QT prolongation in clinical studies. However, since patients with a known history of QT prolongation or patients who are taking medicinal products known to prolong the QT interval were not included in these studies, the effects of mirabegron in these patients is unknown. Caution should be exercised when administering mirabegron in these patients. Patients with bladder outlet obstruction and patients taking antimuscarinic medicinal products for OAB: Urinary retention in patients with bladder outlet obstruction (BOO) and in patients taking antimuscarinic medicinal products for the treatment of OAB has been reported in postmarketing experience in patients taking mirabegron. A controlled clinical safety study in patients with BOO did not demonstrate increased urinary retention in patients treated with Betmiga; however, Betmiga should be administered with caution to patients with clinically significant BOO. Betmiga should also be administered with caution to patients taking antimuscarinic medicinal products for the treatment of OAB. **Interactions:** *Pharmacokinetic interactions:* Mirabegron is a substrate for CYP3A4, CYP2D6, butyrylcholinesterase, uridine diphospho-glucuronosyltransferases (UGT), the efflux transporter P-glycoprotein (P-gp) and the influx organic cation transporters (OCT) OCT1, OCT2, and OCT3. *Pharmacokinetic interactions involving the potential for other medicinal products to affect mirabegron exposures:* Increases in mirabegron exposure due to drug-drug interactions may be associated with increases in pulse rate. *Strong CYP3A inhibitors* See Posology and administration above for dose adjustments recommended during concomitant use of strong CYP3A inhibitors in patients with renal or hepatic impairment. Mirabegron exposure (AUC) was increased 1.8-fold in the presence of the strong inhibitor of CYP3A/P-gp ketoconazole. *CYP2D6 inhibitors:* No dose adjustment is needed for mirabegron when administered with CYP2D6 inhibitors (or in patients who are CYP2D6 poor metabolisers). Inducers: Inducers of CYP3A (such as rifampicin) or P-gp may decrease the plasma concentrations of mirabegron. No dose adjustment of mirabegron is required as this effect is not expected to be clinically relevant. *Pharmacokinetic interactions involving the potential for mirabegron to affect exposures to other medicinal products: Inhibition of CYP2D6:* Moderate and time dependent inhibition of CYP2D6 by mirabegron may result in clinically relevant drug interactions. CYP2D6 activity recovers within 15 days after discontinuation of mirabegron. Caution is advised if mirabegron is co-administered with medicinal products metabolized by CYP2D6 with a narrow therapeutic index such as thioridazine, Type 1C antiarrhythmics (e.g.flecainide, propafenone) and tricyclic antidepressants (e.g., imipramine, desipramine). Caution is also advised if mirabegron is co-administered with CYP2D6 substrates that are individually dose titrated. *Inhibition of P-gp:* Mirabegron is a weak inhibitor of P-gp. For patients who are initiating a combination of Betmiga and digoxin, the lowest dose for digoxin should be prescribed initially. Serum digoxin concentrations should be monitored and used for titration of the digoxin dose to obtain the desired clinical effect. The potential for inhibition of P-gp by mirabegron should be considered when Betmiga is combined with sensitive P-gp substrates e.g. dabigatran. **Fertility, pregnancy and lactation:** The effect of mirabegron on human fertility has not been established. Betmiga is not recommended during pregnancy and in women of child-bearing potential not using contraception. Mirabegron should not be administered during breast feeding. Refer to SPC for full guidance. **Driving and use of machines:** Betmiga has no or negligible influence on the ability to drive and use machines. **Undesirable effects:** Summary of the Safety Profile: the safety of Betmiga was evaluated in 8433 patients with OAB, of which 5648 received at least one dose of mirabegron in the phase 2/3 clinical program, and 622 patients received Betmiga for at least 1 year (365 days). In the three 12-week phase 3 double blind, placebo controlled studies, 88% of the patients completed treatment with this medicinal product, and 4% of the patients discontinued due to adverse events. Most adverse reactions were mild to moderate in severity. The most common adverse reactions reported for patients treated with Betmiga 50 mg during the three 12-week phase 3 double blind, placebo controlled studies are tachycardia and urinary tract infections. The frequency of tachycardia was 1.2% in patients receiving Betmiga 50 mg. Tachycardia led to discontinuation in 0.1% patients receiving Betmiga 50 mg. The frequency of urinary tract infections was 2.9% in patients receiving Betmiga 50 mg. Urinary tract infections led to discontinuation in none of the patients receiving Betmiga 50 mg. Serious adverse reactions included atrial fibrillation (0.2%). Adverse reactions observed during the 1-year (long term) active controlled (muscarinic antagonist) study were similar in type and severity to those observed in the three 12-week phase 3 double blind, placebo controlled studies. The following adverse reactions were observed with mirabegron in the three 12-week phase 3 double blind, placebo controlled studies. The frequency of adverse reactions is defined as follows: very common (≥1/10); common (≥1/100 to <1/10); uncommon (≥1/1,000 to <1/100); rare (≥1/10,000 to <1/1,000); very rare (<1/10,000); not known (cannot be established from the available data) Within each frequency grouping, adverse reactions are presented in order of decreasing seriousness. The adverse events are grouped by MedDRA system organ class. Infections and infestations: *Common:* urinary tract infection *Uncommon:* vaginal infection, cystitis Psychiatric disorders: *Not known:* Insomnia*, confusional state* Nervous system disorders: *Common:* headache* dizziness* Eye disorders: *Rare:* eyelid oedema Cardiac disorders: *Common:* tachycardia *Uncommon:* palpitation, atrial fibrillation Vascular disorders: *Very rare:* Hypertensive crisis* Gastrointestinal disorders: *Common:* nausea*, constipation*, diarrhoea* *Uncommon:* dyspepsia, gastritis *Rare:* lip oedema Skin and subcutaneous tissue disorders: *Uncommon:* urticaria, rash, rash macular, rash papular, pruritus *Rare:* leukocytoclastic vasculitis, purpura, angioedema* Musculoskeletal and connective tissue disorders: *Uncommon:* joint swelling Renal and urinary disorders: *Rare:* urinary retention* Reproductive system and breast disorders: *Uncommon:* vulvovaginal pruritus Investigations *Uncommon:* blood pressure increased, GGT increased, AST increased, ALT increased *(*observed during post-marketing experience).* **Reporting of suspected adverse reactions:** see below. **Legal category:** POM (S1B) **Marketing Authorisation number: EU/1/12/809/003** - 25mg **EU/1/12/809/010** - 50mg. **Marketing Authorisation holder:** Astellas Pharma Europe B.V. Sylviusweg 62, 2333 BE Leiden, The Netherlands. **Further information is available from:** Astellas Pharma Co., Ltd, 5 Waterside, Citywest Business Campus, Dublin 24. Phone: +3531 467 1555. Summary of Product Characteristics with full prescribing information available upon request. **Job number:** BET_2019_0002_IE **Date of preparation of API:** 27 May 2019.

Reporting of suspected adverse reactions:
Reporting suspected adverse reactions after authorisation of the medicinal product is important. It allows continued monitoring of the benefit/risk balance of the medicinal product. Healthcare professionals are asked to report any suspected adverse reactions via:

HPRA Pharmacovigilance
Earlsfort Terrace, IRL - Dublin 2
Tel: +353 1 6764971
Fax: +353 1 6762517
Website: www.hpra.ie
E-mail: medsafety@hpra.ie.

Astellas Pharma Co. Ltd
Tel: + 353 1 467 1555
E-mail: Irishdrugsafety@astellas.com

Date of preparation: June 2019

References: 1. Freeman R, et al. Current Medical Research and Opinion 2017. https://doi.org/10.1080/03007995.2017.1419170.

Approval code: BET_2019_0004_IE

Urinary incontinence

In the second of a two-part series, **Susmita Sarma** discusses the wide variety of treatment options available for overactive bladder

TREATMENT for urinary incontinence includes conservative/lifestyle changes, physical therapy, pharmacotherapy and surgical interventions. For many women, exercise, weight loss and smoking cessation can be recommended but there is a lack of evidence for these interventions with minimal randomised trials published. There is an association between obesity and both stress and urgency incontinence with evidence for weight loss and improvement in stress incontinence symptoms in morbidly obese women but less so in moderately obese patients.

Medication

The detrusor pressure in the normal bladder does not increase during the storage phase. The stretching urothelium activates the sympathetic nerves, which reduces the parasympathetic input and inhibits detrusor contractions. The sympathetic nerves also control continence by maintaining a tonic contraction of the urethral sphincter. When it is socially convenient, the urethral sphincter relaxes and the detrusor muscle contracts.

Medication for overactive bladder is based on inhibiting the action of acetylcholine which stimulates detrusor contractions via muscarinic receptors. There are five subtypes of muscarinic receptors with M2 and M3 mainly in the bladder and M1 in the cerebral cortex and hippocampus. Inhibition of these receptors in the brain disrupts cognitive functions such as learning and memory. Non-selective anticholinergics also interfere with muscarinic function in other organ systems such as the eye and salivary glands. Most anticholinergics have similar efficacy with adverse effects depending on receptor selectivity, peak serum levels and route of delivery.

Before starting medication, it is important to explain to women that 60% of users will see an improvement (40% with placebo), to outline the common side-effects and warn that it is likely to take over four weeks to see an improvement in symptoms.[1]

Table 2 provides a list of OAB medications. Regarding which drug to use first, there are a few RCTs recommending one over another.[2] The NICE guidelines recommend using the medication with the lowest acquisition cost.[1] The HSE guidelines recommend tolterodine ER as the first-line choice for this reason, not because of better success rates.[3] Typical antimuscarinic side-effects include dry mouth, constipation, blurred vision and drowsiness.

Long-term adherence to medications (> six months) is generally poor, dropping from 39.4% at 12 months to 12% at 24 months.[4] Adverse effects, lack of effect and 'learning to get by' are the most common reasons for stopping. Prolonged QT interval was seen in studies using antimuscarinics but the clinical implications of these are not known. Because mirabegron is a selective M3 receptor agonist, it lacks some of the common side-effects seen with other medications.

OAB and older people

OAB and urgency incontinence increase as we age but there is concern with the use of OAB medication in patients with conflicting reports of adverse cognitive effects from antimuscarinics that have anticholinergic properties. The ageing brain is deficient in cholinergic neurotransmission and muscarinic receptors, in particular M2 receptors are involved in cognitive processes. The older less selective antimuscarinics were shown to decrease cognitive function in women.

Immediate-release oxybutynin has been shown to adversely affect cognition in older people. There is no data on the use of medication in those who are already cognitively impaired such as those with mild cognitive impairment, dementia, Parkinson's disease etc.[5] The risk of delirium is often cited as a reason not to give these medications. Delirium appears to be an idiosyncratic reaction and uncommon. In a randomised controlled study of extended-release oxybutynin in nursing home residents with mild to severe dementia, there was no incidence of delirium over the duration of the study.[6]

The relatively newer antimuscarinics with their more selective affinity for muscarinic receptors have been shown to be safe in older people. These include solifenacin, fesoterodine, tolterodine and trospium chloride (which does not cross the blood-brain barrier). The PILLAR study looked at mirabegron in over 65s, looking specifically at cognitive safety and found no statistically significant change in the Montreal Cognitive Assessment Score during use.[7] Studies on the use of mirabegron in combination with solifenacin in older people also show good safety data.[8]

Transdermal oxybutynin can be especially useful for women who do not tolerate oral medication and as it bypasses hepatic metabolism, it has a favourable side-effect profile.

Desmopressin can be used for troublesome nocturia. It is a synthetic analogue of anti-diuretic hormone and reduces urine production. Clinically significant hyponatraemia is reported in 5% of patients and sodium levels should be monitored.[9] There

is reasonable data for its use in over 65s short-term, but no long-term data. Caution is also needed in those with cystic fibrosis and in over 65s with cardiovascular disease or hypertension.[1]

There have also been several studies which looked at the combination of anticholinergic medication where monotherapy has not sufficiently controlled symptoms, and these have shown dual therapy to be safe and effective.[10]

Vaginal oestrogen is safe and effective in treating vaginal atrophy and can be useful in treating women with OAB. Oestrogen treatment results in increased thickness of the epithelium and bladder and can help reduce OAB symptoms.

Medication for stress incontinence

Duloxetine is the only medication licensed for use for stress incontinence. Duloxetine is a balanced dual serotonin and norepinephrine reuptake inhibitor and acts on Onuf's nucleus of the sacral spinal cord. It results in a stronger urethral contraction and persistent sphincter tone during the storage phase. Nausea is the most common side-effect and the main reason for discontinuation. It is not recommended for first-line treatment for stress incontinence but does have use for women who have failed conservative treatment and where further treatment such as surgery is not available.[1]

Surgery for OAB wet/urge incontinence

Botox

Patients who fail conservative measures and have trialled two or more anticholinergic medications can be offered botulinum toxin. Botulinum toxin is administered via a cystoscope and injected into the detrusor from within, usually at 20-30 sites across the dome of the bladder, and usually sparing the trigone. Botox blocks the presynaptic release of acetylcholine and causes full or partial paralysis and weakening of an overactive muscle. It can be administered under local or general anaesthesia via rigid or flexible cystoscopy.

The median duration of effect of botox is six months. Adverse effects include 16% risk of urinary tract infection and voiding dysfunction in 10%, which is usually managed by self-catheterisation. Botox can be used for the treatment of OAB symptoms in the absence of confirmed urodynamic-proven detrusor overactivity.[11,12]

The majority of patients who commence treatment with botox will require long-term repeat treatments.

Sacral neuromodulation

Sacral neuromodulation (SN) was introduced for OAB wet patients in 1997 and multiple studies have shown its safety and efficacy. The exact mechanism of action is still poorly understood but it is known that sacral nerve stimulation can lead to excitatory or inhibitory reflexes on the bladder, depending on the force and rate.

Table: List of OAB medications

- Fesoterodine 4mg and 8mg
- Mirabegron 25mg and 50 mg
- Oxybutynin 5mg and transdermal patch 3.9mg/24 hour
- Propiverine 15mg BD or 30mg extended release
- Solifenacin 5mg and 10 mg
- Tolterodine 2mg and 4mg extended release
- Trospium 20mg

Sacral neuromodulation moderates the normal micturition reflex by stimulating the somatic afferent inhibition of sensory processing of the bladder within the spinal cord. Although SN has been shown to have short-term and long-term efficacy, 30-40% of patients experience complications within the first five years. One in three (33%) needed surgical correction by year one due to pain and infections. Device malfunction, postoperative haematoma and lead migration are other complications associated with this procedure.[12]

Augmentation cytoplasty and urinary diversion

Finally, augmentation cystoplasty and urinary diversion are rare surgical procedures for intractable urge incontinence. Augmentation cystoplasty usually uses a piece of ileum to expand the bladder volume and is used in paediatric urology and refractory OAB. It can be carried out laparoscopically and more recently by robotic assisted techniques. Long-term problems include metabolic disturbance, bacteriuria, urinary tract stones, incontinence, perforation, the need for intermittent self-catheterisation and carcinoma.

For some patients, the creation of an ileal conduit urinary diversion remains another viable option, particularly for those who might be deemed unsuitable for reconstructive bladder surgery. The procedure, however, is not without complications including the risks of recurrent urinary sepsis, and upper tract dilatation, and the possibility of renal function deterioration in the longer-term.[1]

Surgery for stress incontinence

The past three years has seen a seismic shift in the surgical treatment for stress urinary incontinence. The mid-urethral sling or tension free vaginal tape (TVT) was the gold standard procedure for stress incontinence until it was paused in Ireland by the HSE in June 2018. This was done in order to put in place new recommendations to ensure that procedures are being done in line with international best practice. This was expected to last a few months but has continued pending several issues raised including the creation and maintenance of a national database for mesh registration, a national consent form, the assurance that only appropriately trained surgeons should carry out such surgery, and the creation of mesh removal centres. It is not known when this procedure will resume.

The procedure was introduced in 1999 and rapidly became the main surgical correction option for stress incontinence. Initial and long-term studies have recommended the type 1 macroporous monofilament polypropylene mesh for treatment and it remains the most extensively studied surgery for stress incontinence. It is associated with comparable success to the previous procedures of colposuspension (both open and laparoscopic) and pubofascial sling, without the morbidity associated with the abdominal procedures and slower postoperative recovery. The 5% additional risk of mesh complications is specific to the TVT.

The most recent NICE guidance recommends that women should be offered the choice of open/laparoscopic colposuspension and autologous rectus fascial sling. Retropubic mid-urethral mesh sling should also be included as an option.

Urethral bulking agents

Urethral bulking agents are a minimally invasive surgical treatment for SUI, involving the injection of synthetic materials around the urethra. Urethral bulking agents have typically been used in women wishing to avoid major surgery or mesh tapes or who failed primary surgery. Women accept a lower cure rate in favour of a less invasive procedure with a lower risk of voiding difficulty, and is suitable for women with comorbidities precluding invasive surgery requiring anaesthesia.

Intramural bulking agents can be considered for SUI if alternative surgical procedures are not suitable or acceptable to the woman. Women who are considering bulking agents should be made aware that they are permanent materials, repeat injections may be needed to achieve efficacy, efficacy is inferior to alternative

surgical procedures, durability is poor and there is limited evidence on long-term efficacy and adverse events.[6] Side-effects include urinary tract infection, pain and 3% risk of urinary retention.

Laser treatment for stress urinary incontinence

Laser treatment was adopted from dermatology and uses two types: non-ablative photothermal Erbium:YAG (Er:YAG) and microablative fractional CO2-laser. These were introduced initially for the treatment of vaginal atrophy and then later for pelvic organ prolapse and urinary incontinence. The CO2-laser produces a thermal effect that stimulates tissues to synthesise collagen. The effect is newly-formed connective tissue, the recovery of sub-mucosal capillaries and increased thickness of the epithelium. The Er:YAG laser thermal effect causes shrinkage of collagen fibres and a mechanical pull of lower structures. In addition, the collagen remodelling and new collagen formation process continues for six months.

Studies reporting improvement for objective and subjective outcome measures however, remain small and lack RCTs comparing other treatments. Side-effects include mild pain, burning and a sense of warmth and, after treatment, an increase in vaginal discharge. There are no long-term safety data available and NICE guidelines on the use of laser for stress incontinence are due in mid-2021.[13]

Conclusion

Treatment for urinary incontinence involves a thorough assessment of the type of incontinence experienced and relies initially on conservative and lifestyle modifications and physical therapy. The pause on mesh procedures for stress incontinence has had a significant impact on the surgical options offered to women.

Susmita Sarma is a consultant obstetrician/gynaecologist at University Hospital Galway

References

1. National Collaborating Centre for Women's and Children's Health. Urinary Incontinence: The Management of Urinary Incontinence in Women.NG123. London: NICE, 2019
2. Madhuvrata P, Cody JD, Ellis G et al. Which anticholinergic drug for overactive bladder symptoms in adults. Cochrane Database of Systematic Reviews 2012, Issue 1. Art. No.: CD005429
3. Oral Medicines for the Management of Urinary Incontinence, Frequency & Overactive Bladder Medicines Management Programme, Version 1.0, 2014 Oct
4. Veenboer PW, Bosch JLRH. Long-term adherence to antimuscarinic therapy in everyday practice: a systematic review. J Urology 2014; 191(4):1003-1008
5. Wagg A. Treating overactive bladder in the elderly. Can Urol Assoc J. 2011;5(5 Suppl 2)S149-5114
6. LacknerTE, Wyman JF, McCarthy TC et al. Randomized, placebo-controlled trial of the cognitive effet, safety, and tolerability of oral extended-release oxybutunin incognitively impaired nursing home residents with urge urinary incontinence. J AM Geriatric Soc 2008; 56:862-70
7. Wagg A, Staskin D, Engel E et al. Efficacy, safety, and tolerability of mirabegron in patients aged > 65 years with overactive bladder wet: a Phase IV, double-blind, randomised, placebo-controlled study. (PILLAR).Eur Urol 2020; 77(2):211-220
8. Drake MJ, Chapple C, Esen AA et al. Efficacy and safety of mirabegron add-on therapy to Solifenacin in incontinence overactive bladder patients with an inadequate response to initial 44-week solifenacin monotherapy: a randomised double-blind multicentre Phase 3B Study (BESDIE). Eur Urol 2016; 70(1):136145
9. Friedman F, Weiss JP. Desmopressin in the treatment of nocturia: clinical evidence and experience. Ther Adv Urol. 2013 Dec; 5(6) 310-317
10. Kasman A, Stave,C, Elliott CS. Combination therapy in overactive bladder-untapped research opportunities: A systematic review of the literature. Neurourol Urodyn 2019 Nov; 38(8):2083-2092
11. Tincello DG, Kenyon S, Abrams KR et al. Botulinum toxin A versus placebo for refractory detrusor overactivity in women: a randomised blinded placebo-controlled trial of 240 women (the RELAX study). Eur Urol 2012; 62:507-14
12.Nitti VW, Dmochowski R, Herschorn S et al. EMBARK Study Group. OnabotulinumtoxinA for the treatment of patients with overactive bladder and urinary incontinence: results of a phase 3, randomized, placebo controlled trial. J Urol 2013; 189:2186-93
13. Mackova K, Van daele L, Page A-S et al. Laser therapy for urinary incontinence and pelvic organ prolapse: a systematic review. BJOG 2020, Oct; 127(11):1338-1346

Hepatitis C: The way ahead is becoming clear

GPs registered to prescribe methadone can now be trained to **treat Hepatitis C in the community**[1]

Hepatitis C can be **cured* using oral regimens** over 8-12 weeks[2]

The World Health Organisation established the goal of **eliminating Hepatitis C as a major public health threat by 2030**[3]

AbbVie is committed to eliminating Hepatitis C in Ireland[4]

* Patients who achieve a sustained virologic response (SVR12), defined as undetectable HCV RNA 12 weeks after treatment completion, are considered cured of Hepatitis C.[2]

References: 1. HSE 2020, National Hepatitis C Treatment Programme Clinical Advisory Group Community Treatment Guidelines. Accessed March 2021. Available at: https://www.icgp.ie/go/library/catalogue/item?spId=FE497472-496A-4229-99A1783EA2C8095B. **2.** European Association for the Study of the Liver. J Hepatol 2020; 73:1170-1218 DOI: 10.1016/j.jhep.2020.08.018. **3.** WHO Global Health Sector Strategy on Viral Hepatitis 2016–2021, 2016. accessed March 2021. Available at: http://www.who.int/hepatitis/strategy2016-2021/ghss-hep/en/ **4.** AbbVie 2021. Accessed March 2021. Available at: https://www.abbvie.com/our-science/therapeutic-focus-areas/virology.html

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abbvie

The Hepatitis C Partnership is a collaborative network aiming to educate and support those affected by hepatitis C, writes **Nicola Perry**

Erasing hepatitis C

ACCESS to diagnosis and treatment for many patients with HCV continues to be a challenge. Despite HCV being the leading cause of chronic liver diseases worldwide, only 11 high income countries are on track to meet the WHO's HCV elimination by the 2030 target. Unfortunately, Ireland is one of 34 countries set to fall short.

There is a sense of disappointment about our status given the known risks of communicable diseases and the availability of highly effective curative treatments. The reasons for this are complex but in the simplest of terms, systemic barriers in the care cascade have resulted in patients being lost to care or follow-up. Searching and advocating for these lost patients is where we as an organisation find ourselves. The Hepatitis C Partnership (HCP) is a national collaborative network of stakeholders from across the public and NGO sector who lobby, educate, and support those impacted by HCV.

Making access easier

"I was told that if I didn't stop drinking, I would be dead in six months. Then I was given my next appointment for seven months later."

– Cynthia, Hepatitis C Partnership client

How can we simplify the care pathway to ensure experiences such as Cynthia's are not repeated and what role can primary health play in transforming the health status of those impacted by HCV? With the introduction of direct-acting antiviral agents (DAAs), ensuring HCV is a rare disease has never been so achievable. Carving out a roadmap to elimination involves the decentralisation of hospital-based clinics and a move towards a simplified shared model of care. Specialist nurse prescribers and GPs are well placed to treat most patients with support from hepatology specialists. Many countries have successfully implemented community treatment programmes based on the premise of simplifying patient pathways.

Geographical inequality

"Accessing treatment for me meant a seven-hour train journey given limited access to treatment in the midwest."

– Cynthia, HCP client

Cynthia's journey represents the experiences of many of our clients who face significant barriers to accessing care. Longer waiting times, transport challenges and the absence of community treatment outside of an opiate substitute treatment (OST) clinic means many patients can face considerable health implications while awaiting treatment. Having primary health involved in curing people like Cynthia means patients can be treated in their own communities and supported by a network of healthcare professionals to ensure treatment success, saving travel time, expenses and stress.

Reducing stigma

Part of this success must endeavour to minimise the stigma often experienced by at-risk populations including homeless people, prisoners and people who inject drugs. The impact of this stigma can often be greatly felt among women who experience multiple barriers to accessing substance abuse treatment. It is essential that healthcare providers create a positive environment that encourages help seeking. Having the opportunity to receive treatment from a familiar face may be preferable to navigating anonymous hospital clinics, disclosing personal history to strangers.

Peer support

"I was treated with great respect and dignity by the Liver Centre. I have never been an intravenous drug user but instead I'm an employed educated woman."

– Sophia, HCP peer

For many clients like Sophia, the journey towards cure came from her engagement with peer support. As she says: *"Without treatment I ran the risk of liver cancer or cirrhosis which scared and frustrated me".*

Peer workers are trained HCV specialists who can advise, educate, and support individuals across the care continuum. Sophia is one of many HCP clients who have gone on to complete our HepFriend training programme in collaboration with the Mater University Hospital. Thanks to her efforts, many clients have gone on to access treatment. The experience of talking to someone who has been through what you are going through is cited as hugely helpful by our client group.

The success of our HepFriend training has led to its delivery in a multitude of settings including Irish prisons, addiction services and homeless services. HepFriends can bridge the knowledge divide between professionals and at-risk groups, allowing patients to feel part of the treatment process. A study by HepCareEU highlighted the need for HCV education across the entire care cascade to help knowledge transfer and prevent reinfection. It is our hope that a train-the-trainer programme will be offered at some point this year allowing for a connected network of peers across all regions.

"Meeting someone who knew about hepatitis C and could get me started on treatment changed my life."

– Stephen, HCP client

Not just a cure

For many, being cured of hep C goes well beyond any positive physical impacts. It can represent the first time something positive has been achieved, a problem faced up to and overcome. In our experience the psychological benefits of curative treatment can be far reaching, particularly in terms of their broader recovery.

RoadMap to HCV elimination

In these trying times let us harness the flexibility, adaptability and innovation we have shown and apply this to a RoadMap to Zero. In December 2020 we kicked off this ambitious initiative with a round-table examining key strategies of Scotland's elimination success. Building on these insights we aim to bring together a multitude of stakeholders to scope out a pathway for elimination in the coming months. See: **www.hepcpartnership.ie/roadmap-to-zero**

We want to bring together the views of those working to support the HCV community and deliver recommendations that not only place the patient at the centre of the pathway, but represent the views of service providers. This is an opportunity to put Ireland on the world stage as leaders in public health. We hope that you will join us.

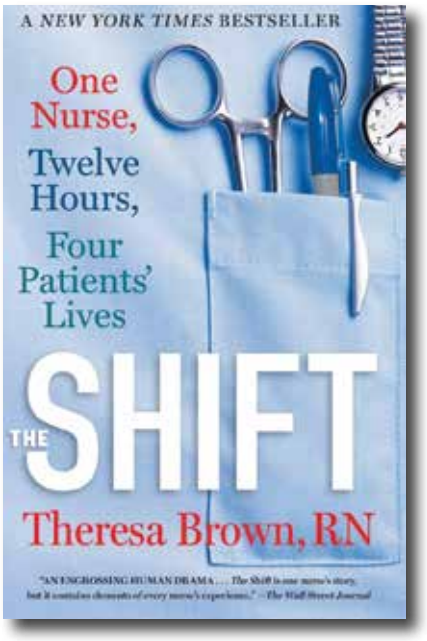
Nicola Perry is service manager at Community Response
www.hepcpartnership.ie

One nurse, 12 hours, four patients

IF YOU have ever wanted to give a non-nurse an insight into what a pre-Covid 12-hour shift as a nurse feels like, *The Shift* will certainly help. Written in the first-person by registered nurse Theresa Brown, the book takes you through a day on an oncology ward of a busy acute hospital in the US from the nurse's perspective.

On this day Ms Brown's patients are Mr Hampton, a man with lymphoma to whom she must administer rituximab, a drug that could cure him or kill him; Sheila, a woman in her 40s with antiphospholipid antibody syndrome who is experiencing mysterious abdominal pain and may have been dangerously misdiagnosed; Candace, a returning patient with high expectations who arrives with her own disinfectant wipes and a list of demands; and Dorothy, a woman in her 50s with leukaemia who is waiting for her lab work to return to normal so she can be discharged after six weeks in the hospital.

Over her shift we see how she is torn between her patients and observe that prioritising and ministering to their needs takes skill and sensitivity.



The Shift takes us step-by-step through several procedures, many of which are repetitive and all weighed down with paperwork. In the middle of all these routine tasks there are many sub-tasks and a constant flow of unexpected issues. Tasks are constantly reprioritised as more pressing events arise. For every item marked off the list, more are added.

The author describes multiple interruptions encountered while trying to discharge a patient that as a reader had me feeling anxious that the end of the to-do list would never be reached or that something vital would be dangerously delayed.

She takes the reader through many of the thought processes a nurse faces in a day in terms of making the right call, at the right time.

"If I sound the alarm and the patient is okay, then I over-reacted and have untrustworthy clinical judgment. If I don't call in the cavalry when it's needed, then I'm negligent and unsafe for patients."

The book is well written, as you might expect from a former English lecturer and *New York Times* columnist who turned to nursing as a second career after experiencing firsthand nursing/midwifery care when her children were born. *The Shift* offers a view into the medical responsibilities, paperwork burden and need to advocate for patients – as well as the challenge to take a break – that nurses face everyday.

– Alison Moore

The Shift by Theresa Brown is published by Algonquin Books. ISBN 978-1616206024

CROSSWORD Competition

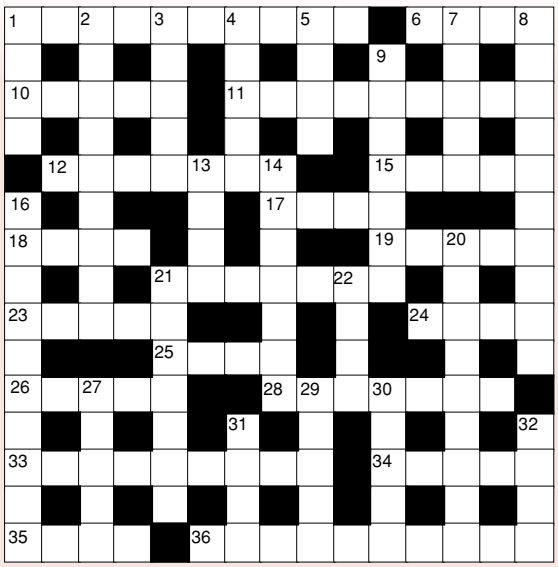
WIN a €50 gift voucher

Across

1 With such material, one grabs flies differently (10)
6 Spin a coin (4)
10 Work some dough (5)
11 Army officer (9)
12 Give a sudden surprise to (7)
15 Great poet, author of 'The Inferno' (5)
17 A good number take Mother to new York (4)
18 Leave undone (4)
19 Whale-food is murder? That's about right! (5)
21 Treat your body to some water (7)
23 Imprecise (5)
24 Confidence trick, swindle (4)
25 Female pigs (4)
26 Midlands county (5)
28 Cleaned out thoroughly (7)
33 Slap paint around to effect a lumbar puncture (6,3)
34 Relented, abated (5)
35 Ova (4)
36 Using heat strips, they will do you good! (10)

Down

1 Imitation, counterfeit (4)
2 Inhaling and exhaling (9)
3 Aged member of the community who is greatly respected (5)
4 Tag (5)
5 Mentioned (4)
7 Constellation named for a giant hunter (5)
8 The plaster met with destruction - this can be illuminating to the public! (6,4)
9 Style of beard named for a (misspelled) Dutch artist (3,4)
13 Ancient city besieged for ten years (4)
14 Female ruler (7)
16 Rest and recuperate, once calves are scattered (10)
20 Grows in size or number (9)
21 Is Shane about to create material? (7)
22 Dorothy's dog in 'The Wizard of Oz' (4)
27 Due (5)
29 Frolic like a pickled ingredient (5)
30 Avail of one's allocation to the limit (3,2)
31 US State associated with Mormons (4)
32 Lyric poems (4)



July/August solution

Across: 1&15 Alimentary canal 6 Womb 10 Maori 11 Undamaged 12 Karaoke 17 Lair 18 Raid 19 Overt 21 Chignon 23 Ninth 24 Stye 25 Aden 26 Psalm 28 Tankard 33 Apple tart 34 Osaka 35 Trey 36 Horse sense

Down: 1 Alms 2 Isolation 3 Evita 4 Trunk 5 Rudd 7 Organ transplant 8 Bedclothes 9 Omicron 13 Ouch 14 Elegant 20 Entertain 21 Chamber 22 Oban 27 Ample 29 Altos 30 Knots 31 Sago 32 Dane

The winner of the July/August crossword is: Elaine Whelan Cahir, Co Tipperary

You can email your entry to us at nursing@medmedia.ie by taking a photo of the completed crossword with your details included and 'crossword' in the subject line.
Closing date: Tuesday, September 21, 2021
If preferred you can post your entry to: Crossword Competition, WIN, MedMedia Publications, 17 Adelaide Street, Dun Laoghaire, Co Dublin, A96E096

Name:
Address:

Ireland 'lags significantly behind' on delivery of personalised healthcare

Report finds disconnect between healthcare policy and implementation

IRELAND lags significantly behind on the delivery of personalised healthcare and displays a sharp disconnect between policy and implementation of this form of care, according to the FutureProofing Personalised Health Index.

The index, on which Ireland ranked 19th out of 34 countries, also found that the Irish public's willingness to share data for medical research and care improvements was low, with a score of 4 out of 10.

In response to the findings, a panel of Irish healthcare and policy experts – which included former INMO general secretary Liam Doran – was assembled to investigate the findings of the index and develop recommendations for improvement in this area.

The panel found that the deficiencies are due to a lack of infrastructure and delays in implementing data-sharing policies, meaning that Ireland is losing out on opportunities in research, clinical trials and advancements in genomic testing, to the detriment of patients and the Irish healthcare system.

The report outlines the following recommendations:

- The rollout of the national electronic health record (EHR) system to enable an efficient healthcare delivery system and pave the way for digital health
- Significant investment is required, however Sláintecare is the most suitable form of delivery of personalised care and could provide necessary funding for the upgrading of data and IT systems
- The development of an interdepartmental strategy, aligning academia, medical schools, clinical research and primary/secondary/tertiary care to enable personalised healthcare by overcoming bureaucracy and putting the patient first
- A formalised national policy for genomic testing, as well as an appropriately funded genome resource to maximise the benefits of pre-existing and forthcoming targeted therapies and enable the use of data in clinical research
- A coherent and extensive public awareness campaign to educate the public on the value of sharing data for the advancement of medical care and clinical research.

Commenting on the report, panel member Dr Nina Byrnes, GP and medical director of Generation Health Medical Clinics, said: "The index revealed significant scope for improvement in Ireland before fully integrated implementation of personalised healthcare can be achieved.

"Other countries were found to be far ahead in terms of sharing medical data seamlessly across their health systems and embedding this data in research to further benefit patients and citizens overall. This is something we in Ireland need to prioritise. For example, telemedicine has advanced significantly here but for it to reach its full capability we need to utilise technology to capture medical data and make it accessible to healthcare professionals and the research community across our health system."

To learn more about the index and the panel's analysis of its results, visit: **www.futureproofinghealthcare.com/en/personalised-health-index-ireland**

'A Decade of Care': LauraLynn celebrates 10th anniversary

LAURALYNN, Ireland's only children's hospice, will celebrate a 'Decade of Care' this month as the hospice marks its 10th anniversary on September 27.

Since 2011, when LauraLynn House opened its doors in Leopardstown, Dublin for the first time, LauraLynn Children's Hospice has been providing holistic care to children with life-limiting conditions and palliative care needs, as well as to their families.

Anne-Marie Carroll, director of nursing at LauraLynn Children's Hospice, said: ''It's a real privilege to be part of the nursing team at LauraLynn and witness the difference you make in the lives of children and their families".

Care for children with life-limiting conditions can be provided at the purpose-built hospice in Dublin, at hospital, in the community or in the family home, depending on the preference of the child and their family, geographic location and the specific medical needs of the child.

In response to the impact of the Covid-19 pandemic, LauraLynn now offers virtual hospice care.

There are more than 3,840 children in Ireland living with a life-limiting condition, which is defined as a condition, illness or disease that is progressive and fatal, the progress of which cannot be reversed by treatment.

Currently, LauraLynn provides holistic, family-centred care and support for more than 340 children and their families from across the 26 counties.

Caring for children with a life-limiting condition requires a multidisciplinary approach involving a paediatrician, clinical nurse specialists and the nursing team, supported by the family support team, which includes a psychologist, social worker, chaplain, physiotherapist, occupational therapist, dietician and music and play therapists.

Referral to the children's hospice can be made by parents or any member of the multidisciplinary team involved in the child's care.

A programme of events is being organised to celebrate the anniversary. To find out more, visit: **www.lauralynn.ie**

All of the meetings and conferences listed below will take place online

September

Saturday 4
School Nurses Section meeting. From 10am to 11.30am

Saturday 11
PHN Section meeting. 11am

Saturday 11
Midwives Section meeting. 11am

Wednesday 15
RNID Section meeting. 11am via Zoom

Wednesday 15
ODN Section meeting. 7pm via Zoom

Monday 20
TT Section webinar

Thursday 23
Retired Section meeting. 11am via Zoom

Thursday 23
Assistant Directors Section meeting. 2pm via Zoom

Saturday 25
SEN Section meeting. 10am

Thursday 30
Directors Section and Assistant Directors Section webinar

October

Tuesday 5
SALO meeting. 12pm

Saturday 16
PHN Section webinar

Monday 18
National Children's Nurses Section meeting. 11am via Zoom

Tuesday 19
Care of the Older Person Section meeting. 2pm via Zoom

November

Thursday 11
All-Ireland Midwifery Conference. Bookings can be made online at: **www.inmoprofessional.ie**

Wednesday 17
CPC Section meeting. 11am via Zoom

Saturday 20
PHN Section meeting. 11am via Zoom

Saturday 20
National Children's Nurses Section conference. Online from 11am

Thursday 25
ADON Section meeting. 2pm

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

INMO Membership Fees 2021

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

Notice: Retired Section Holiday

- **When:** Sunday, October 3, 2021 for four nights/five days
- **Where:** The Great Northern Hotel, Bundoran, Co Donegal
- **How much:** €340 per person sharing. Single room supplement €15 per night (maximum 14)
- **Contact:** Annette McGinley at Tel: 074 9135201 or by email: jmgtravel@eircom.net

Condolences

- The INMO wishes to extend its deepest sympathies to the family of Jisha Susan John, who recently passed away in St Vincent's Hospital, Dublin. Jisha was a staff nurse at the National Forensic Hospital and had previously worked in St John of God Hospital in Dublin. She will be dearly missed by all of her colleagues and friends, her family and her husband Rajish Paul, who is also a nurse. May she rest in peace
- The INMO extends its deepest sympathies to the family of nurse Nora Quill from Bantry. Nora worked as a public health nurse in West Cork and will be sorely missed by her colleagues and friends. We are thinking of her husband Frank and children Eoin, Therese and Mary Claire at this difficult time. *Ar dheis Dé go raibh a hanam*
- The INMO was shocked and saddened to hear that nurse Mary Hayes passed away recently in St Vincent's Hospital, Dublin. Mary lived and worked in Cork and was an active INMO member. Her dedication and commitment were invaluable during the 2019 national strike and she was always a pleasure to work with. She will be remembered warmly by her brothers and sisters, extended family and friends and all of her colleagues. May she rest in peace
- The INMO offers its sincere condolences to nurse Manimegalai Boopathy whose husband Pinnamaneni Chandrasekhar passed away in St Vincent's Hospital, Dublin recently after a short illness. He will be missed by his loving wife, son Jayachander, granddaughter, daughter-in-law, extended family and friends in Ireland and in India
- The INMO extends its deepest sympathies to INMO rep Mary Barrett from St Brendan's Loughrea on the recent loss of her dear brother Mike Flanagan. INMO staff in the Galway office and Mary's colleagues in the Galway Branch send their condolences and thoughts to Mary and her family at this sad time
- The INMO Clare Branch and staff at the Limerick INMO office wish to extend their deepest condolences to their colleague Grainne Ryan, director of public health nursing, on the recent loss of her mother Bridget O'Regan. May she rest in peace

Retirements

- The Limerick Branch of the INMO wishes to extend their congratulations to their colleague Ailish Bredin on her recent retirement after 40 years at the Brothers of Charity Services Bawnmore. Ailish has been a wonderful rep – instrumental in the implementation of the 37.5-hour working week in 2008. We wish you every best wish in your retirement Ailish
- The INMO wishes Geraldine Kennedy, assistant director of nursing with the Nursing and Midwifery Planning and Development Unit, many happy years of retirement and thanks her for her positive support, especially to student nurses and midwives
- The INMO would also like to acknowledge the contribution of our colleagues Anne-Marie Ryan who recently retired from her post with the Nursing and Midwifery Board of Ireland (NMBI), Donna Kinnair on her resignation from the Royal College of Nursing (RCN) and Judith Kiejda, assistant general secretary of the New South Wales Nurses and Midwives' Association (NSWMA). All three of these women have been powerful voices for our professions throughout their careers

WIN Recruitment & Training

Mailed directly to Irish nurses and midwives every month

Acceptance of individual advertisements does not imply endorsement by the publishers or the Irish Nurses and Midwives Organisation

Nurse required

Home Instead Tipperary is looking to recruit a nurse on a part-time or bank shift basis to support an established team. This is an excellent opportunity to gain knowledge and experience in caring for an adult client at home with complex needs, assisting with activities of daily living and to enable them to live to maximum potential. Work within an established team with clinical lead support. All necessary training provided. *Call 083 829 7416 for more information.*

Practice nurse required

- GP practice nurse required for **Tipperary Primary Care Centre**
- This is a new build clinic with four GPs and four nurses
- Must have GP practice experience
- Skills in CDM, vaccination, wound care, antenatal care, ear syringing, 24-hour monitoring, phlebotomy etc. required
- Full-time post
- Please send your CV to Dr Tom Purcell by email at: **jbsurgery@hotmail.com**

Practice nurse required

Practice nurse required for **North Dublin City** practice. Experience helpful but not essential for the right candidate. Duties include but not limited to phlebotomy, ECG, vaccines, smear tests and managing smear recall system, stock ordering and chronic disease management. Hours are flexible. Salary is negotiable. Please email your CV to **practicenursevacancy@outlook.com**

Irish Nurses Rest Association

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

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

Community Health Organisation Dublin North City & County

The range of services provided by CHO DNCC:

- Primary Care
- Older Persons
- Disabilities
- Mental Health
- Health and Wellbeing
- Quality, Safety and Service improvement

Who are we?

CHO Dublin North City and County (CHO DNCC) is one of nine CHOs across the country and is responsible for providing care and services to a population of around 621,405 people. Community Health Services are the broad range of health services that are delivered outside of the acute hospital setting. They are delivered through the HSE and its funded agencies to people in the local communities, as close as possible to people's homes.

Our current vacancies

Currently we have excellent opportunities for nurses who are interested in providing quality nursing care and developing a rewarding and respected career in nursing. We can offer a wide range of rewarding career opportunities, with many benefits for nurses wishing to make a contribution to the health and lives of people living in CHO DNCC.

> "Deliver the right service, at the right time, in the right place, by the right team."

We welcome applications from all suitably qualified individuals who meet the eligibility criteria that have been outlined for these roles. Information on the eligibility criteria is available in the Job Specification for each position. All of our vacancies can be found by searching 'Rezoomo CHO DNCC Jobs' or by visiting **Rezoomo CHO DNCC Jobs**

THE MATER HOSPITAL

Nursing Career Opportunities, Dublin

Come and join our nursing team in the Mater Misericordiae University (MMUH). We have positions available at various grades in the following areas

- Acute Medicine
- Cancer/ Oncology
- Cardiology
- Cardiovascular
- Critical Care (ICU, HDU, Theatre)
- Emergency Medicine
- Endocrine
- Infectious Diseases
- Medical
- Surgical
- Renal/dialysis

We can offer you many opportunities to advance your career in specialist practice, clinical leadership and management, academia or education and training.

We lead on research and innovation such as Magnet for Europe, and the Framework for Safe Staffing and Skill Mix.

For full list of current vacancies visit our careers page
https://www.mater.ie/healthcare-professionals/job-opportunities/
For all general nursing enquires:
✉ NursingJobs@mater.ie

The MMUH is a leading model 4 acute teaching hospital serving an inner city community, and is a national service provider for specialities including:

- Heart and Lung Transplant
- Spinal Injury
- Infectious Diseases
- National Cancer Centre
- Hyper Acute Stroke
- Approved as one of two Major Trauma Centres nationally

The MMUH has over 650 inpatient beds and annual ED attendance over 80,000 patients. For more information on what we have to offer please visit our website https://www.mater.ie/

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