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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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Row over 'pay and numbers' strategy
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Meet the new Executive Council
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Eradicating cervical cancer in Ireland
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Complex menopause cases
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Community nursing

Members demand workload burden is addressed

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On the cover this issue (l-r): Debbie Carr; Kelly Keville; Mary Tully and Diane Doherty

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

Catherine Hopkins or
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at Tel: 01 664 0610 or
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catherine.hopkins@inmo.ie or
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Recruitment crisis and safe staffing

THE HSE and the Department of Health published their 'pay and numbers strategy' in July. This strategy is critical to know the level of staffing that will be available within the public health system in any given year. Publishing the strategy half way through the year without consulting trade unions representing healthcare workers is something we strongly object to. Specifically, we oppose the HSE's decision to classify all unfilled posts as at December 31, 2023 as obsolete.

Members have informed us that, as it stands, the 'pay and numbers strategy' fails to grasp the complexities of recruiting for nursing and midwifery roles. Imposing financial limits that reflect levels of service that have already been surpassed – together with growing demands on the health service – is, without doubt, an erroneous approach, *see page 7* for more details. For nursing and midwifery roles, which require a minimum of six months to fill, this decision will have a severely negative impact and will jeopardise the future of some services.

Our calculations indicate that delays in processing derogations left 2,000 whole-time equivalent (WTE) nursing and midwifery positions unfilled by the end of December 2023. This is not considering the posts filled but not rostered, ie. absence due to statutory leave, particularly maternity leave. At any one time, we are advised that maternity leave can add 3-4% to absence levels due to the higher proportion of women in our professions.

In this issue of *WIN*, we are focusing on the effect that the recruitment moratorium has had on community services, *see pages 20-22*.

We know this staffing shortfall imposes an unacceptable level of risk on nursing and midwifery professionals, who are mandated to provide safe patient care. Consequently, we have informed the HSE that it is impossible to ensure the provision of safe care under these conditions and demand engagement on service curtailment.

We plan to consult with our members following these engagements with the HSE. We have referred the issue as a dispute to the Workplace Relations Commission – one hearing has been held and at the time of going to press a date for a reconvened hearing is awaited.

While the provision of safe staffing is government policy as per the Safe Staffing Framework, this needs to be backed up with legislation and funding.

The only way to ensure that safe staffing is the norm is to pass and enact the Patient Safety (Licensing) Bill in order to give HIQA more powers. This landmark piece of legislation gives HIQA the powers to ensure its recommendations are being enacted by individual hospitals and healthcare settings it inspects. This is something the INMO will be lobbying all political parties for, as the attention turns to the upcoming general election.

In light of recent events, the INMO Executive Council will now convene earlier than planned, with a meeting scheduled for September 6 to discuss our next steps. The Executive Council was initially set to meet on September 16, but the urgency of the situation has prompted this change.

It is also anticipated that a national meeting for all INMO representatives will take place over the week of September 16. To accommodate this, notifications will be sent to branch, section and forum officers in the first week of September, allowing members to request time to attend these important discussions.

In the interim, if staffing levels are unsafe and vacancies remain unfilled, please co-ordinate with your INMO IR representative. You are not obliged to work in unsafe conditions or take on additional workloads due to unfilled vacancies.

The current allocation of posts under the HSE's 2024 strategy is insufficient to maintain last year's activity levels; thus, we cannot agree to any new services if existing service vacancies persist.

Phil Ní Sheaghdha
General Secretary, INMO

INMO director of industrial relations **Albert Murphy** updates members on recent national issues

Pay and numbers strategy – more questions than answers

THE long-awaited 'pay and numbers' strategy from the HSE was signed off by government in mid-July 2024.

This strategy, which covers workforce planning in the health sector, seeks to set the ceiling for HSE employees at 129,000. Effectively, the HSE is now re-establishing the 'employment control framework' where the recruitment and the issuing of contracts is controlled by eight designated officers in the HSE.

Of major concern to the INMO is the fact that all vacant posts as of December 31, 2023 have now been suppressed.

According to INMO data there were approximately 2,000 nursing posts vacant at that point in time. The INMO does not accept that these posts can simply be removed with the stroke of a pen, particularly when the number of nurses and midwives was within the permitted headcount at the time.

The pay and numbers strategy was raised at the last meeting of the National Joint Council (NJC), which is the industrial relations machinery for the health service.

The NJC staff panel of trade unions expressed concern over the lack of consultation in relation to the strategy, which they say fails to meet the HSE's obligations under the Employees (Provision of Information and Consultation) Act 2006.

Clearly the HSE did not have any such engagement on this strategy and simply announced it as a *fait accompli*.

The unions state that the HSE has suppressed over 2,000 posts in the HSE, across all grades, including nurses and other healthcare professionals, adding that these were funded posts and cannot be allowed to be guillotined.

The unions have also requested that the HSE provides details of the funded posts to be suppressed under the strategy, stating that they are "extremely concerned" about the potential for unsafe staffing and compromised patient care.

The staff side has called for urgent engagement with unions to ensure changes to staffing policies in the HSE don't further impact patient safety. Staff numbers need to be based on patient numbers and patient needs. This is the principle of the government's own safe staffing framework, which it is still in the process of implementing.

At the time of writing the respective unions are consulting with their members in relation to this staffing dispute and will be meeting shortly to consider all options available to them.

Pay restoration talks continue for Section 10, 39, 40 and 56 organisations

THE INMO and other unions have been engaged in talks at the Workplace Relations Commission with representatives of various government departments to attempt to negotiate a further agreement on pay for workers in Section 10, 39, 40 and 56 organisations.

While there has been some progress in the negotiations, a number of challenges remain relating to defining the scope of any proposed agreement and to whom it might apply.

When agreement was reached in October 2023 to avert a dispute the employer stated that all such organisations were covered by the WRC agreement. To date, the unions have been unable to secure a commitment which would provide confidence that the pay relationships that previously existed would be restored.

The WRC has asked all parties to reflect on their current positions in order that outstanding matters can be resolved and a further meeting was due to take place on August 30, 2024.

Following this meeting the INMO will contact the various groups of members affected by this issue such as those working in the GP Out of Hours Service and the Homecare Tendered Services.

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

Early retirees can choose job seekers benefit or supplementary pension

FROM August 1, 2024 those who retire at the minimum retirement age or on health grounds and are under 66 years of age (state pension age) can now choose to either claim Job Seeker's Benefit or to apply for immediate payment of their Occupational Supplementary Pension.

DPER Circular 12/2024 sets out the process and all HSE pension areas have been fully briefed on this new process.

This is a welcome development for nurses and midwives who are retiring and the processes for application will be streamlined by the HSE Pension Sections to facilitate the new arrangements.

Members of the INMO Executive Council and industrial relations team celebrating the trade union movement with President Michael D Higgins at Áras an Uachtaráin

President celebrates trade union movement in Áras an Uachtaráin

PRESIDENT Michael D Higgins and Sabina Higgins gave a warm welcome to representatives of the trade union movement at a community garden party in Áras an Uachtaráin, on Sunday June 30, 2024.

Through the theme of the garden party, President Higgins reflected and celebrated, the trade union movement and all that has been achieved in the long and difficult struggle for workers' rights in Ireland and across the globe.

In his speech to hundreds of guests, which included INMO president Caroline Gourley and members of the Executive Council, President Higgins said "it was a day to celebrate trade unions, a movement without borders, opposing sectarianism and racism".

President Higgins invited guests to join him in celebrating the work of current and past activists fighting for workers' rights and standing in solidarity with colleagues, fellow citizens and with people all over the world, in struggles against injustice, inequality and exclusion in the workplace.

He welcomed the 'Better in a Trade Union' campaign run by the Irish Congress of Trade Unions this year. "Initiatives like this are of such importance, aiming as they do to ensure that all working people are aware of the benefits of being part of a trade union, as well as the wider benefits to society, that flows from this and the strength that being part of a collective, representing and negotiating as a group of employees rather than as individuals means for one's development and fulfilment.

"I particularly welcome the emphasis of the campaign on standing up for social justice on a human rights basis, including LGBTQ+ and women's rights, as well as campaigning on issues such as housing and healthcare."

Recruitment caps put patient safety at further risk

THE "extremely limiting" recruitment caps enforced by the HSE are putting patient safety at risk and will prevent much-needed new hospital beds from being opened, the INMO has warned.

INMO general secretary Phil Ní Sheaghdha said: "The decision by the HSE to put extremely limiting caps on the number of nurses, midwives and other healthcare professionals that can be recruited into the public system at both community and hospital levels will impact on the ability to provide safe care to patients.

"There have been vacancies across all community settings and in wards in each hospital since the recruitment freeze was imposed last November. The INMO conservatively estimates that there are over 2,000 nursing vacancies alone. When you couple this with the fact that over 3,500 new hospital beds are due to come on stream across the country, it is hard to see how these beds can be opened safely.

Ms Ní Sheaghdha said the only way to ensure safe staffing is to pass and enact the Patient Safety (Licensing) Bill, which would give the Health Information and Quality Authority (HIQA) more powers.

"This landmark piece of legislation gives HIQA the powers to ensure its recommendations are being enacted by the individual hospitals and healthcare settings that it inspects," she said .

The INMO has met with the HSE to set out the need to ensure that patient safety is at the centre of the lifting of the recruitment moratorium.

"Our members want to provide safe care in a timely manner, they cannot do that if they are working in a system that is always playing catch up on itself due to self-imposed recruitment controls," Ms Ní Sheaghdha said.

Tell us about your day!

The INMO's storytelling tool is open to nurses and midwives across the country, to help us advocate and organise on the issues that matter most to our members.

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INMO

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

2024 Nurse and Midwife Representative Training

The INMO provides Representative Training to our members.

The aim of the Basic Representative Training Course is to provide members in the workplace with the knowledge, skills and confidence to represent and support members in the workplace. The Representative also acts as a liaison between the INMO Members, INMO Officials and INMO Head Office.

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

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

If you are interested in attending a Representative Training Course in 2024, please make contact with your INMO Official.

Month	Date	Location
OCTOBER	3 & 4	Sligo
	8 & 9	Cork
	14 & 15	Dublin
NOVEMBER	5 & 6	Dublin - Advanced

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

CONTACT YOUR INMO OFFICIAL

Dublin: 01 6640600, Cork: 021 4703000, Galway: 091 581818 and Limerick: 061 308999

New Executive Council convenes

INMO Executive Council 2024-26 and management team:
Back row, l-r: Annette Keating, George Jefferies, Audrey Horan, Damien Farrell, Margaret Birtley, Tracey O'Fiach, Shyam Krishnan and Chris O'Dwyer,
Middle row, l-r: Jude Maher, secretary to Executive Council; Tony Fitzpatrick, director of professional services; Nicola Ennis; Phil Ní Sheaghdha, general secretary; Sarah Meagher; Eilish Corcoran; Nicola Ross; and Caroline Kennedy
Front row, l-r: Bairbre Webb O'Maolágain;, Mary Tully; Thressia Devassy; Elizabeth Egan, second vice-president; Caroline Gourley, INMO president; Ester Fitzgerald, first vice-president; Jibin Soman Mattathil; Aoife Brady; and Edward Mathews, deputy general secretary (see pages 16-19 for profiles of Executive Council members)

PHN managers serve notice of action at HSE's failure to ease pressures

THE INMO has served notice of industrial action on HSE West and North West.

This comes as public health nurse management in Galway have voted to take industrial action following the failure of the HSE to implement recommendations to help ease the extreme pressure on staff in the area.

David Miskell, INMO professional and regulatory officer, said: "The pressure that directors of public health nursing are under in Galway is intolerable. The national average for a catchment area for a director of public health nursing is 150,000 people while in Galway that average is increasing towards 285,000 people. The population of Galway is unique compared to other parts of the country, with a large geographic area with an urban-rural mix, island populations and a growing population.

"Despite local engagement and two conciliation conferences that took place under the auspices of the Workplace Relations Commission, no meaningful resolution has been reached, with the additional resources required to maintain safe and effective care for the people of Galway not being put in place.

"The fact that staffing and resources in the area are not at the level which they should be means that patient care is falling short. The health and safety of INMO members in public health nursing in Galway is significantly compromised.

"Public health nurse management in Galway are at a juncture now where they feel like they have no other option but to engage in industrial action.

"HSE West and North West must now urgently and meaningfully engage with the INMO in relation to the matters at the centre of this dispute. The provision of putting all resources that are necessary to provide a safe public health nursing service for the people of Galway must be a priority.

"If the HSE fails to engage, regrettably this industrial action will escalate over the coming weeks."

Focus on collective bargaining in private sector

THE INMO is now represented by the deputy general secretary, Edward Mathews, on ICTU's Private Sector Committee.

Participation on this committee will assist the INMO in developing an approach to increasing membership density in the private sector and to work with others to improve access to collective bargaining for nurses and midwives working in the private sector.

The INMO Executive Council has also established an INMO private sector subcommittee to develop further services for members in the private sector, including increased access to collective bargaining and improved terms and conditions.

The INMO Executive Council has also pledged support for the Respect at Work Campaign, which aims to improve workers' rights in Ireland.

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MAT-IE-2400247 (V1.0) | Aug 2024

Prescribing Information: Beyfortus ▼ (nirsevimab) solution for injection in pre filled syringe
Please refer to the Summary of Product Characteristics (SPC) before prescribing.

Presentation: Beyfortus 50 mg solution for injection in pre-filled syringe. Each pre-filled syringe contains 50 mg of nirsevimab in 0.5 mL (100 mg/mL).
Beyfortus 100 mg solution for injection in pre-filled syringe. Each pre-filled syringe contains 100 mg of nirsevimab in 1mL (100 mg/mL).
Nirsevimab is a human immunoglobulin G1 kappa (IgG1κ) monoclonal antibody produced in Chinese hamster ovary (CHO) cells by recombinant DNA technology.
Indication: Beyfortus is indicated for the prevention of Respiratory Syncytial Virus (RSV) lower respiratory tract disease in: i. Neonates and infants during their first RSV season. ii. Children up to 24 months of age who remain vulnerable to severe RSV disease through their second season RSV season (see SmPC). Beyfortus should be used in accordance with official recommendations.
Dosage and Administration: *Infants during their first RSV season:* Beyfortus is recommended as a single dose of 50 mg administered intramuscularly for infants with body weight <5 kg and a single dose of 100 mg administered intramuscularly for infants with body weight ≥5 kg. It is administered intramuscularly, preferably in the anterolateral aspect of the thigh. The gluteal muscle should not be used routinely as an injection site because of the risk of damage to the sciatic nerve. If two injections are required, different injection sites should be used. Dosing in infants with a body weight from 1.0 kg to <1.6 kg is based on extrapolation, no clinical data are available. Exposure in infants <1 kg is anticipated to yield higher exposures than in those weighing more. The benefits and risks of nirsevimab use in infants <1 kg should be carefully considered. There are limited data available in extremely preterm infants (Gestational Age [GA] <29 weeks) less than 8 weeks of age. No clinical data available in infants with a postmenstrual age (gestational age at birth plus chronological age) of less than 32 weeks (see SmPC). Beyfortus should be administered from birth for infants born during the RSV season. For others born outside the season Beyfortus should be administered ideally prior to the RSV season. *Children who remain vulnerable to severe RSV disease through their second RSV season:* The recommended dose is a single dose of 200 mg given as two intramuscular injections (2 x 100 mg). Beyfortus should be administered ideally prior to the start of the second RSV season. For individuals undergoing cardiac surgery with cardiopulmonary bypass, an additional dose may be administered as soon as the individual is stable after surgery to ensure adequate nirsevimab serum levels. If within 90 days after receiving the first dose of Beyfortus, the additional dose during the first RSV season should be 50 mg or 100 mg according to body weight, or 200 mg during the second RSV season. If more than 90 days have elapsed since the first dose, the additional dose could be a single dose of 50 mg regardless of body weight during the first RSV season, or 100 mg during the second RSV season, to cover the remainder of the RSV season. The safety and efficacy of nirsevimab in children aged 2 to 18 years have not been established. No data are available.
Contraindications: Hypersensitivity to the active substance or to any of the excipients listed in SmPC.
Warnings and precautions: *Hypersensitivity including anaphylaxis:* Serious hypersensitivity reactions, including anaphylaxis, have been observed with monoclonal antibodies. If signs and symptoms of a clinically significant hypersensitivity reaction or anaphylaxis occur, immediately discontinue administration and initiate appropriate medicinal products and/or supportive therapy. *Clinically significant bleeding disorders:* As with any other intramuscular injections, nirsevimab should be given with caution to individuals with thrombocytopenia or any coagulation disorder. *Immunocompromised children:* In some immunocompromised children with protein-losing conditions, a high clearance of nirsevimab has been observed in clinical trials (see SmPC), and nirsevimab may not provide the same level of protection in those individuals.
Interactions: No interaction studies have been performed. Nirsevimab does not interfere with reverse transcriptase polymerase chain reaction (RT PCR) or rapid antigen detection RSV diagnostic assays that employ commercially available antibodies targeting antigenic site I, II, or IV on the RSV fusion (F) protein.*Concomitant administration with vaccines:* Since nirsevimab is a monoclonal antibody, a passive immunisation specific for RSV, it is not expected to interfere with the active immune response to co administered vaccines. There is limited experience of co administration with vaccines. In clinical trials, when nirsevimab was given with routine childhood vaccines, the safety and reactogenicity profile of the co administered regimen was similar to the childhood vaccines given alone. Nirsevimab can be given concomitantly with childhood vaccines. Nirsevimab should not be mixed with any vaccine in the same syringe or vial (see SmPC). When administered concomitantly with injectable vaccines, they should be given with separate syringes and at different injection sites.
Fertility, pregnancy and lactation: Not applicable.
Adverse Reactions: Uncommon (≥1/1,000 to <1/100): The most frequent adverse reaction was rash, reported in 0.7% subjects receiving Nirsevimab and 0.3% in placebo occurring within 14 days post dose. Additionally, pyrexia and injection site reactions were reported at a rate of 0.5% (0.6% in placebo) and 0.3% (0% in placebo) within 7 days post dose. Prescribers should consult the SmPC in relation to other adverse reactions.
Legal Category: POM
Marketing Authorisation Number: EU/1/22/1689/001-002, EU/1/22/1689/004-005
Marketing Authorisation Holder: Sanofi Winthrop Industrie, 82 avenue Raspail, 94250 Gentilly, France
Further information is available from: *IE:* Sanofi, 18 Riverwalk, Citywest Business Campus, Dublin 24 or contact IEmedinfo@sanofi.com
Date of preparation: August 2024

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The power to help reduce the chaos of RSV season

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Beyfortus®▼(nirsevimab) is a long-acting monoclonal antibody that offers protection against RSV LRTD for at least five months.[9]

It confers protection directly through the delivery of antibodies rather than depending on the maturation of the infants immune system to produce their own antibodies.[10]

Indication: Beyfortus is indicated for the prevention of Respiratory Syncytial Virus (RSV) lower respiratory tract disease in:

i. Neonates and infants during their first RSV season.

ii. Children up to 24 months of age who remain vulnerable to severe RSV disease through their second season RSV season (see SmPC). Beyfortus should be used in accordance with official recommendations.

Safety Profile:

The most frequent adverse reaction was rash (0.7%) occurring within 14 days post dose. The majority of cases were mild to moderate in intensity.[10] Additionally, pyrexia and injection site reactions were reported at a rate of 0.5% and 0.3% within 7 days post dose, respectively. Injection site reactions were non-serious.[10] These were all uncommon (≥1/1,000 to <1/100).[10]

Serious hypersensitivity reactions, including anaphylaxis, have been observed with monoclonal antibodies. If signs and symptoms of a clinically significant hypersensitivity reaction or anaphylaxis occur, immediately discontinue administration and initiate appropriate medicinal products and/or supportive therapy.[10]

As with any other intramuscular injections, nirsevimab should be given with caution to individuals with thrombocytopenia or any coagulation disorder.[10]

In some immunocompromised children with protein-losing conditions, a high clearance of nirsevimab has been observed in clinical trials and nirsevimab may not provide the same level of protection in those individuals.[10]

For full list of adverse events please refer to the Nirsevimab summary of product characteristics.

For information and support items on Beyfortus visit the Sanofi promotional Campus website

▼This medicinal product is subject to additional monitoring. This will allow quick identification of new safety information. Healthcare professionals are asked to report any suspected adverse reactions

Adverse events should be reported. Reporting forms and information can be found at www.hpra.ie; email: medsafety@hpra.ie. Adverse events should also be reported to Sanofi Ireland Ltd: Tel: 014035600.Alternatively, send via email to IEpharmacovogilance@sanofi.com

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Prescribing Information is available on the previous page.

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CHI: Delays in payment of travel allowances

MEMBERS contacted the INMO regarding outstanding travel and subsistence claims not paid from late last year, despite an agreement having been reached between the INMO and Children's Health Ireland (CHI) in May 2023.

The INMO engaged with management on this, noting that these members of staff had agreed to rotate to CHI at Connolly Hospital to maintain the service and meet the service needs requirements on the basis of management's confirmation that travel and subsistence would be paid.

Following the INMO's engagement with management, members now report that they have received all outstanding travel and subsistence allowances owed.

– Bernie Stenson

INMO lobbies for faster residency permit process

DUE to lengthy delays experienced by members in the Southern and Western regions when renewing their residency permits, the INMO lobbied the Department of Justice to have the process speeded up.

Members working in Cork contacted their local INMO officials in relation to ongoing issues in the area regarding lengthy delays in processing and renewing their Irish residency permits. This was impacting members significantly in accessing necessary services such as applying for a driving licence. This critical issue was further highlighted by members at recent INMO information clinics as well as throughout Trade Union Week. The INMO International Section chairperson Reema Antony, with support from the INMO Cork Office, wrote to the Department of Justice.

The outcome for members impacted by this issue is that, as of July 8, 2024, renewals will be processed in the Garda National Immigration Bureau (GNIB) in Dublin. This should significantly shorten waiting times and should streamline the process.

Members across the country can now renew online thereby removing the requirement to attend in person which was causing significant backlogs and delays in Cork and Limerick.

– Liam Conway, INMO IRO

Location allowance win at CHI, Crumlin

ON BEHALF of members working in the interventional radiology department at CHI, Crumlin the INMO lodged a claim seeking application of the location allowance.

This claim was based on the fact that nurses were now undertaking roles that were previously undertaken in the operating department which attracted the allowance.

The INMO has engaged extensively with management on this since November 2023. CHI management has now conceded the claim, with retrospection to April 2023 when members took on these duties.

– Bernie Stenson, INMO assistant director of IR

Cork Indian nurses celebrate at summer fest

THE INMO took part in the Cork Indian Nurses Association (COINNS) annual summer fest on Sunday, June 16 in Togher, Cork. This was the third successful organisation of the summer fest, which aims to celebrate Indian culture and promote multiculturalism.

The summer fest was a vibrant and inclusive celebration of cultural diversity, with attendees from different corners of India and various other countries coming together to enjoy the festivities. The event highlighted the importance of celebrating diversity and fostering cultural exchange and showcased a rich tapestry of performances, including traditional dances, music and fashion shows.

Edward Mathews, INMO deputy general secretary addressing the COINNS summer fest

INMO deputy general secretary Edward Mathews and IRE Kathryn Courtney joined the festivities, emphasising the collaborative efforts between the INMO and COINNS in supporting and empowering nurses in Cork. Other guests included Minister for Finance Michael McGrath and Lord Mayor of Cork City Dan Boyle.

Reema Antony, CNM3 at Cork University Hospital and chairperson of the INMO International Section, said: "Summer fest successfully promoted multiculturalism and strengthened the bonds of friendship and understanding among nurses from different backgrounds. The event served as a testament to the organisation's commitment to creating a supportive and inclusive community, fostering a sense of unity and collaboration among its members."

– Kathryn Courtney, INMO IRE

Progress made in UHL paediatric unit

THE INMO met in August with local management on a range of issues in the paediatric unit at University Hospital Limerick, including the approved shift leaders/CNM2 posts to provide 24/7 nursing governance.

This specialist unit has expanded in acuity and activity since it opened 25 years ago and has Ireland's only paediatric high dependency unit outside of the Children Health Ireland (CHI) hospitals.

The INMO raised concerns on nursing governance over a lengthy period up to a senior level in the HSE, where approval was given for the appointment of six shift leader posts. The recruitment process to fill the positions is not yet complete.

Nurse to patient ratios remain on the agenda with management confirming recent engagement with Shelford Safer Nursing Care Personnel and management are due to undertake a pilot towards the end of this year, which the union welcomes.

Issues related to the provision of care to child and adolescent mental health admissions (CAMHS) to the unit has led to the development of a much-improved operational protocol that is due to be audited at this time.

In the interim the INMO advises all nurses to document all shortfalls in nurse-to-patient staffing levels or any safety concerns at work. These may be recorded on the Q-Pulse system and by contacting the assistant director of nursing on duty, along with a follow-up email to document concerns.

– Mary Fogarty, INMO assistant director of IR

HSE seeks to extend MAU opening hours

In early August the HSE sought to engage with the health service unions in relation to extended opening hours of the medical assessment units (MAUs) at Ennis Hospital and Nenagh Hospital. The unions responded seeking full details of the HSE's proposal in relation to extended opening times as required under the Public Services Agreement.

– Mary Fogarty

New terms at Galway Hospice

THE INMO engaged with management of the Galway Hospice Foundation to standardise the terms and conditions of members following its redesignation from a Section 39 to a Section 38 organisation on February 1, 2024. The union secured implementation of pregnancy related sick pay, improvements in premium pay for unsocial hours worked and access to the enhanced practice contract for staff nurses. If members have any query on these issues, contact the INMO Galway office, email inmogalway@inmo.ie

– Christopher Courtney, INMO IRE

HSE failed to consult on cancellations in Mid-West

THE INMO, along with other health sector unions, responded to the email communication issued by the HSE cancelling significant elective hospital activity across the Mid-West region seeking an urgent meeting.

While understanding the imperative in addressing the unacceptable and growing overcrowding at University Hospital Limerick, the unions notified the HSE of its obligation to consult and agree the mechanism by which de-escalation will occur when it impacts on the working conditions of union members.

While awaiting this meeting, the INMO advised all members to report for work at their normal work location and adhere to their normal working hours until consultation has taken place and agreement is reached.

– Mary Fogarty

SPC contracts to be regularised in CHO3

FURTHER to representation from the INMO on behalf of a significant group of nurses working in older persons services in CHO3, the INMO has secured commitment from the HSE to regularise staff nurses currently on a specified purpose contract (SPC) into a permanent contract from early August 2024.

There is a considerable number of nurses, primarily recruited via international recruitment processes, occupying a permanent vacant role so there is no cost involved in this process.

It should be noted that this does not include SPCs for promotional posts – in which cases normal recruitment processes must apply.

Any queries on the regularisation process for nurses working in residential older persons services should be directed to the local director of nursing in the first instance, who will be the point of contact with HSE human resources regarding gathering detail around each case.

– Karen Liston, INMO IRE

Retirement of two Clare Branch reps

IN JULY the INMO and the Clare Branch bid farewell to two longstanding union representatives – Mairead Doohan from St Joseph's Hospital, Ennis and public health nurse Mary Donnelly from Ennis.

Both represented their nursing colleagues' interests at local level and at the INMO annual delegate conferences over many years. Their work on the ground helped greatly to strengthen the voice of nurses working on the frontline, improving working conditions and advocating for better services for patients and families.

On behalf of the INMO, I would like to extend sincere thanks to both Mairead and Mary for all their work throughout the years and wish them a long and happy retirement.

– Mary Fogarty

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

INMO deputy general secretary **Edward Mathews** rounds up global nursing

#NursesforPeace campaign aims to stop attacks on health workers

THE International Council of Nurses (ICN) #NursesforPeace campaign continues to support and fund nurses who are living and working in conflict zones and in areas that have experienced natural disasters.

ICN president Dr Pamela Cipriano has called on the UN secretary general Antonio Guterres to take firm action to stop the attacks on nurses and other health workers in conflict zones.

The ICN reiterated its warning against the normalisation of such attacks and highlighted how ICN's interventions at the World Health Assembly underscored the fundamental link between health and peace.

The ICN's #NursesforPeace campaign aims to provide support for nurses in Ukraine, Sudan, Palestine and Israel, with testimonies from nurses on the ground.

ICN launched the campaign to raise funds for nurses working on the frontlines of emergency situations and to draw public attention to the associated threats to public healthcare systems.

Further details are available on the ICN website **icn.ch**

ICN urges South Korea to back a Nursing Act

NURSES in South Korea have undertaken a long campaign for a new law to establish nursing as a stand-alone profession, but their government has not enacted a Nursing Act, which is the foundation of advanced practice nursing. This means nurses are still considered to be subordinate to physicians only able to act as assistants rather than as autonomous health professionals.

The decision not to pass a Nursing Act undermines the professional development of nurses, limiting options for improving access to healthcare services. The introduction of a new cadre of nurses called 'physician assistant nurse', as a response to worsening shortages of physicians, weakens and confuses well established globally recognised advanced practice nursing roles.

Physician assistants are recognised in many different countries as clinicians who work under the direct supervision of physicians. They are separate to nursing and by definition have a completely different role. Joining two distinct professional groups into a combined role is counterproductive to international best practice.

A well established and internationally recognised option to improving access to quality healthcare in the presence of physician workforce shortages is the investment in nurses working to their full scope of practice. In particular, creating environments in which nurses can continue their professional career into Advanced Practice Nursing roles is optimal.

The evidence clearly supports the effectiveness of advanced practice nursing as an effective strategy for health systems responding to rising costs, increased healthcare demands and the desire to place people at the centre of care. In its Guidelines on Advanced Practice Nursing, the ICN clearly articulates its position that the way forward is to implement proven, standardised, well established APN roles, rather than developing a new type of nurses.

The ICN previously warned that some countries have responded to nursing shortages by making these kind of ill-advised choices and creating new cadres of healthcare workers rather than investing in nurses. The evidence clearly supports the effectiveness of advanced nurse roles and that is the right choice for health systems looking to respond to rising healthcare demands and delivering people-centred services.

New Alliance of Student and Early Career Nurses

THE International Council of Nurses has approved the formation of an innovative ICN body representing student and early career nurses.

For many years, the ICN has involved student and early career nurses in its work, through its Nursing Student Steering Group and Student Assembly during ICN Congress.

Now, the ICN Alliance of Student and Early Career Nurses, embedded in the ICN's work, represents a significant additional investment in student and early career nurses. The alliance will amplify their voices and enhance their influence on relevant issues in the work of the ICN and its member national nursing associations (NNAs).

Many NNAs around the world have student and early career nurse members and the ICN is intent on growing their numbers and uniting them through this global alliance.

The alliance will increase the presence of the views and advice of student and early career nurses, which the ICN board is eager to hear, building on important contributions they have already made to ICN policy, including on the attractiveness of nursing as a career, the future of the profession, nursing education and climate change and health.

The INMO already has a well-established Student Nurses and Midwives Section, as well as a dedicated staff member responsible for students and new graduates – Jamie Murphy. Ms Murphy and the Student Section will no doubt contribute substantially to the work of the ICN's new alliance.

and midwifery news

ICM call midwives to action to help boost breastfeeding rates globally

WITH suboptimal rates of breastfeeding worldwide, the International Confederation of Midwives (ICM) is calling on midwives to increase knowledge and skills and step up to support women postnatally.

By adopting policies and attitudes that value women and breastfeeding, midwives are taking action to help women to breastfeed for longer.

The ICM supports WHO/UNICEF 2020 recommendations for all newborns to receive exclusive breastmilk and breastfeeding for the initial six months, with continued breastfeeding for two years and beyond. Breastfeeding rates continue to be suboptimal across the world, with infant formula sales increasing by 50% over the past 20 years. For some newborns failure to breastfeed exposes them to disease and death. For many women, inability to establish breastfeeding and an adequate milk supply leads to early cessation of breastfeeding.

A paper entitled *Having enough milk to sustain a lactation journey: a call to action* available on the ICM website, identifies women who are more likely to encounter issues establishing breastfeeding where the physiology of lactation is disrupted.

It outlines the conditions and circumstances that hinder normal development of breast tissue, the physiological production of milk and the contributing factors related to the mother, the infant or to the birth.

Recognising these risk factors provides an opportunity for midwives and other health workers to intervene to encourage lactation rather than treat low milk supply in the days following birth. The first few days after birth are a critical window to optimise milk production. Effective strategies to promote breastfeeding include prenatal education, early skin-to-skin contact, support to latch within the first hour, rooming-in, no supplementation that is not medically indicated and no pacifiers.

Clinician support is vital to identify risk factors for establishing lactation, to provide education for the mother and her family network and to proactively plan to increase supply from the outset. Breastfeeding shouldn't be just for women without complications and risk factors.

Introducing Executive Council 2024/2026

Officers

President

Caroline Gourley is director of nursing, older person services in CHO Dublin North City and County. She holds a diploma in first-line supervisory management, a BSc in nursing management, an MSc in palliative care and an advanced diploma in medical law. She has been an INMO rep since 1990 and sits on the National Taskforce for Safe Staffing and Skill Mix. She pledges to represent the voice of members and advocate for safe staffing and the advancement of our healthcare system. Ms Gourley also holds one of the administration seats.

First-vice president

Ester Fitzgerald is CNM2 in the ICU at Cork University Hospital. After her general training, Ms Fitzgerald went on to complete a HDip in critical care before returning to Cork to take up her current role. She is chair of the Cork HSE Branch and was secretary of the 2019 strike committee. She completed a BA in law and a master's degree in healthcare risk management and quality. She will advocate for swift implementation of national agreements, the rollout of the Framework for Safe Staffing and Skill Mix and the fulfilment of pay awards and supporting claims.

Second-vice president

Elizabeth Egan is a CNM2 in Southside Disability Services. She trained as an RNID and later completed a BSc in nursing management at the RCSI. She has carried out training in enabling excellence and ensuring that those she supports reach their full potential. She has worked in community, respite, residential and acquired brain injury, and has been active as a local rep and chaired the RNID Section. She intends to advocate for the implementation of all national agreements and support the needs of all members.

Clinical

Aoife Brady is a CNM1 at Our Lady's Hospital, Navan. She qualified in 2002 having completed her training at DCU and Connolly Hospital, Dublin. She has worked on medical wards, in care of the older person settings and in cardiology. She is a health and safety rep and chairperson of the Meath Branch. She aims to improve working conditions and advocate for safe staffing and skill mix with a view to retaining student and new graduates.

Margaret Birtley is a PHN in Cork. She has worked as a theatre nurse, practice nurse, community RGN and PHN. She has a BSc degree, a postgraduate diploma in public health nursing and an MSc in nursing and healthcare quality improvement. She is chair of the Mallow Branch and is advocating for improved staffing levels, more sponsorship places for PHNs and CRGNs, as well as the introduction of the location/special qualification allowance for CRGNs.

Eilish Corcoran is a CNM2 in OPD in South Infirmary Victoria University Hospital, Cork (SIVUH). She holds a degree in nursing and a certificate in emergency nursing, and has served on the board of directors and committee of management of SIVUH, where she has been the INMO workplace rep since 1998. She is active with the Cork Voluntary/Private Branch. Her priority is to address unsafe working conditions by ensuring the implementation of safe staffing levels in all settings.

Nicola Ennis is a staff nurse in Sligo University Hospital's ED. She returned to college and qualified as a mature student from St Angela's College, NUI Sligo, in 2016. She worked in the ophthalmology department first but was later redeployed to the ED. As a student she was an INMO rep and became a workplace rep in 2020. She is also secretary of the Sligo Branch. She aims to work towards a culture of safety, respect and support for all.

Damien Farrell is a CNM1 in the MAU at Roscommon University Hospital. Previously he worked in the Galway Clinic and Bon Secours, Galway, before moving to Portiuncula University Hospital's ED, where he was INMO rep. He trained in Connolly Hospital and Tallaght Children's Hospital, Dublin and received his degree and postgraduate diploma from Trinity College. He aims to ensure members' voices are heard in relation to safe staffing levels, pension rights and entitlements.

Audrey Horan is a staff midwife at University Maternity Hospital Limerick (UMHL). She qualified as an RGN in 1994 and obtained her certificate in midwifery in 1998 from UMHL. She works in an antenatal clinic providing care for mothers and infants. She has been an INMO member since her student days and took part in the 1999 strike. She also served on the strike committee during the 2019 strike. This is her second term on the Executive Council. She holds the midwifery seat.

George Jefferies is a CNS in older person services in the ED at Connolly Hospital, Dublin. He trained in Portiuncula Hospital before moving to Cork Regional Hospital and later Connolly Hospital. He has a postgraduate diploma in emergency nursing and gerontology nursing from Trinity College. He is INMO rep in Connolly Hospital and chair of the Dublin North Branch. He commits to supporting students, promoting postgraduate education and giving members a voice in policy development.

Caroline Kennedy is a CNM2 in oncology in Naas General Hospital, Co Kildare. She has been an INMO member since her student days, a rep for 25 years and a branch officer for more than 20. She is secretary of the Kildare Branch and sat on the 2019 strike committee. She vows to work towards the full implementation of the Framework for Safe Staffing and Skill Mix and address the challenges in recruitment and retention. She will also join the call for greater government investment in healthcare.

Clinical

Jibin Soman Mattathil is a staff nurse in Cork University Hospital. He holds a BSc in nursing and has worked in emergency, intensive care and neurosurgical nursing. He served on the executive council of the All-India Institute of Medical Sciences and moved to Ireland in 2017. He was chair of the International Section from 2022 to 2024 and is a founding member of the Cork Organisation for Indian Nurses. His priority is to support international members and members experiencing housing difficulties.

Sarah Meagher is a CNM2 at Letterkenny University Hospital. She qualified in 2001 having completed her training in Letterkenny, and has worked in the ED there as a staff nurse, CMN1 and CNM2. During the 2019 strike she served as secretary on the local strike committee and has been a health and safety rep for the past 15 years. She aims to progress the full implementation of the Framework for Safe Staffing and Skill Mix and the National Maternity Strategy and to highlight the dangers of workplace-related stress.

Tracey O'Fiaich is a senior staff nurse at Mullingar Regional Hospital. She trained in University Hospital Galway and worked in Beaumont and in the UK. She holds a BSc and a Master's in nursing, ENB 100 and a diploma in healthcare management. She is chair of the Mullingar Branch and also chaired the strike committee in 2019. She aims to raise awareness of hazards in the workplace, including violence towards nurses, to promote dignity in the workplace and advocate for the implementation of safe staffing.

Emma Ross is a senior staff nurse in Louth County Hospital, Dundalk. She holds a diploma in general nursing, a BSc in nursing and certificates in advanced clinical assessment and leadership and management. She has been an INMO rep for more than 15 years and chairs the Dundalk Branch. Her goal is to advocate for members at local and national levels to enhance working conditions for all. She believes nurses and midwives deserve greater recognition and compensation for their unwavering dedication.

Clinical

Shyam Krishnan is a CNM2 in Waterford residential care. He trained as an RGN and midwife in India and has been working in care of older persons services since moving to Ireland in 2012. He is also a registered nurse prescriber. He has been secretary of the Waterford Branch since 2019 and workplace rep since 2017. He will work towards safe staffing in all hospitals and would like to see staff wellbeing included in the health and safety agenda in all settings. He will advocate for housing supports for members.

Mary Tully is a PHN in primary care in Cavan. She is qualified as a nurse and midwife. She is chair of the PHN Section and Cavan Branch, and has served on the Executive Council for five terms, most recently as first-vice president. She is committed to taking action on pay, recruitment and retention and issues affecting students. Her vision for the INMO is one of inclusiveness, innovation, participation by all members and unwavering dedication to the improvement of healthcare outcomes for all.

Bairbre Webb-O'Maolagáin is the paediatric liaison CNS in the National Orthopaedic Hospital, Cappagh, Dublin. She has worked as a clinical nurse in CHI Temple Street and holds a dual qualification, having originally trained as an RGN in St Vincent's University Hospital. She is chair of the Children Nurses Section and is an advocate for improving working conditions. This is her second term on the Executive Council. She is committed to representing children's nurses so they can advocate for the children in their care.

Education

Annette Keating registered under the tutor's division of the NMBI register in 2001. A midwife teacher for five years in St Finbarr's Hospital, Cork, she transferred to UCC in 2006 as a lecturer before returning to the HSE Centre of Nurse/Midwifery Education as a midwife teacher in 2007. She is vice chair of the INMO Education Section and was awarded a master of philosophy in 2007 from Glasgow Caledonian University. This is her second term on the Executive Council representing members who are actively engaged in nurse/midwifery education.

Administration

Varghese Joy is assistant director of nursing at Cherry Orchard Hospital, Dublin. He has more than 20 years experience in nursing and has been an INMO member since moving to Ireland in 2007. He holds a BSc in nursing, an MSc in palliative care nursing and a postgraduate certificate in healthcare management. He is co-founder of Migrant Nurses Ireland, which works with the INMO to unionise migrant nurses and midwives working in Ireland. He vows to uphold the ethos of the INMO to enhance the welfare of all members.

Thressia Devassy is a CNM3 in infection prevention control at the Mater University Hospital, Dublin. She has worked as assistant director of nursing at St Doolagh's Park Care and Rehabilitation Centre and as a CNM2 at Beaumont and Bon Secours Hospitals. She has a master's degree in healthcare management, a graduate certificate in healthcare education, a postgraduate diploma in infection prevention and control and in neurological and neurosurgical nursing. She is also a fellow of the Faculty of Nursing, RCSI. She has received various awards for her contributions to nursing.

Student

Chris O'Dwyer is a general nursing student from UCD and the Mater Hospital, Dublin. They joined the INMO in 2022 and became involved in the Student Section, serving as chair since 2023. Mx O'Dwyer comes to nursing after a career in homeless services, where they held a number of positions, including in the development and training of social work and social care students. Mx O'Dwyer is passionate about education and professional development; they are keen to make careers in nursing and midwifery more attractive and to campaign for a student salary.

INMO Professional

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SAVE THE DATE

Inclusion Health Section Conference

Theme: 'Inclusion Health Everybody's Business'

Friday, 13 September 2024

Venue: **The Richmond Education and Event Centre, Dublin**

Times: **9am - 4pm**

Fee: **€30 INMO members; €45 non members**

KEYNOTE SPEAKER

Dr Mary Tilki

Retired University Lecturer and Researcher with a specialist experience of working within ethnic health inequalities, transcultural nursing, the health of Irish people in Britain, ageing and dementia in minority ethnic groups

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For more information go to www.inmoprofessional.ie/conference

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Fairways Hotel, Dundalk, Co Louth

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Introducing Executive Council members

Ester Fitzgerald

First-vice president
CNM2, Cork University Hospital

ESTER FITZGERALD is first-vice president of the INMO. She works as CNM2 in the intensive care unit in Cork University Hospital (CUH). Visiting public health nurses inspired her to pursue a career as a nurse when her family was looking after her elderly grandparents in their home.

On leaving school she trained as a nurse in CUH and went on to work in the Mater Hospital in Dublin for four years. She completed a higher diploma in critical care in UCD and a masters in risk management.

Returning to Cork, she joined the Cork HSE Branch, of which she has been chair since 2020. This is her second term on the Executive Council.

She told *WIN*: "While the election process was lengthy, the atmosphere and the encouragement during the election was so positive. It just shows the strength of the representation on the Executive Council. When so many people are willing to put themselves forward it's a testament to the good health of the Organisation."

Ms Fitzgerald wants to amplify members' voices and despite working full time on the frontlines, she is determined to make time for any members who needs her support. She is determined to fight for the extension of special leave with pay for members suffering from long Covid.

She believes critical care has always been a challenging place to work, but during and after the pandemic it became difficult in terms of the acuity of patients, the ongoing risk to staff and accessing vaccines and testing.

"Members really came to appreciate their union during that time. The INMO kept us safe. There are currently around 130 INMO members impacted by long Covid. Critical care nurses were particularly affected by long Covid and we need to make sure that none of our colleagues are left behind," she said.

Another priority for Ms Fitzgerald in her role as first-vice president will be to pursue the timely fulfilment of agreed pay deals. She also believes the recruitment embargo was a crude tool used to try to gain control of HSE spending, the effects of which were far reaching and will take months, if not years, to recover from.

"It takes six to eight months to recruit a nurse, so with the embargo which was only recently lifted, it's going to be another year before we start to see staff flowing back into hospitals. And the level of service hasn't changed, if anything it has increased.

"We are constantly expected to do more with less. Every nurse and midwife should protect their registration by joining a union. It's the only sure way to protect their income and their livelihood. Nursing and midwifery are high-risk professions," Ms Fitzgerald added.

Professionally, she supports the growth in community care and has been encouraged by the advances in acute care, with two of our national acute hospitals – the Mater and CUH – designated as major trauma centres. She sees this as a major step forward for the national trauma strategy.

Elizabeth Egan

Second-vice president
CNM1, Southside Disability Services

ELIZABETH EGAN is second-vice president of the INMO. She works as a CNM1 in Southside Disability Services and is based in Maynooth since February 2024. In her teens she volunteered with the Brothers of Charity in her home town of Boyle, Co Roscommon and knew from that point on that she wanted to work in intellectual disability nursing.

Ms Egan trained in Craig House and St Angela's College, Sligo. After qualification she worked for a brief period with the Brothers of Charity, with St Michael's House in Dublin and then in the UK caring for people with acquired brain injuries. Over the course of the next 19 years she worked in a variety of settings for St John of God before moving to her current workplace.

Ms Egan became an INMO member as a student and was class rep. She started her training in 1998 and was active during the 1999 strike. This gave her a keen insight into what the union could do for its members. In 2007 she became the INMO rep for St John of God. She also joined the Kildare Branch and the RNID Section and held numerous officer roles, including currently as the chair of the section.

"Working as a collective towards a common goal is hugely beneficial," Ms Egan told *WIN*.

"It's easy to give your time when you feel like you're accomplishing something. Its about cohesion. There are also great gains to be made from joining a section, particularly in terms of sharing information and best practice. ID nurses tend to be spread across the country and across a variety of different services so the section allows us greater cohesion.

"You can be proactive in ensuring that your profession is protected. The branches and sections are like the scaffolding of the Organisation. People often wait until it's too late and there's actually something wrong. If they're involved proactively in their union they will already be armed with much of the information and support they need to protect their rights in their workplace."

Ms Egan believes that every person with an intellectual disability has the right to equity in healthcare.

"When we balance equality with equity it becomes apparent that access to RNIDs in the acute hospitals and nursing homes would be really beneficial for those patients and clients."

She believes all nurses and midwives should be shown respect and recognition for the work that they do.

"We work in challenging circumstances, with increased caseloads, sometimes in really unsafe settings. I will fight for implementation of all recommendations and agreements that will make our professional lives safer and afford us the respect we deserve."

Forced to do more with less

With community nursing continuing to be under resourced and short on staff, PHNs and CRGNs are speaking out against the policies that have led us to this point. **Freda Hughes** reports

PUBLIC health nurses (PHNs) and community registered general nurses (CRGNs) face serious challenges in terms of workload and staffing, a recent INMO survey of both groups revealed. The survey found that this is having a serious impact on staff wellbeing and their ability to deliver optimal care.

PHNs and CRGNs typically work at a primary healthcare centre in the community, but much of their practice is done alone and much of their days are spent on the road between house calls. There are major discrepancies between acceptable staffing levels and the number of PHNs and CRGNs registered and working in the health service.

The INMO is seeking greater opportunities for CRGNs to specialise and take on clinical nurse specialist roles and that the caseload allowance agreed for those with responsibility for caseloads should be paid to them. The INMO is also calling for an increase of 75 PHNs per year, an immediate end to recruitment caps and the development of an effective workforce strategy that will support continuous recruitment. This will require an increase in the number of PHN training places and the inclusion of community nursing within the undergraduate curriculum.

Unsustainable model

Diane Doherty, a senior CRGN based at Buncrana Primary Care Centre, told *WIN* that more staff are needed and that community nursing must be incentivised.

"We need an increase in CRGN numbers. Issues like security of bases, weekend working, caseload allowances and/or location allowances would make the role more attractive. Further additions of auxiliary staff to the community care team would also help, for example home care services could be brought into the team since we are already so closely allied," she said.

"I appreciate this will take some time and will require us to be open to change and innovative in our approach to delivery of care, but as the figures suggest, our elderly population is growing and the ability of our health service to deliver care as it currently exists will be unsustainable."

Debbie Carr is a PHN working in Ballyfermot Primary Care Centre, Dublin, which is staffed by six PHNs and three part-time CRGNs. The centre covers Chapelizod, Clondalkin, Ballyfermot, Cherry Orchard and Palmerstown. Within that heavily populated area are many under privileged communities. The service is currently short of four PHNs and three CRGNs. This means that the existing staff have to maintain the same level of service to the community they serve but with fewer members of staff to do so.

"We can't plan our weeks anymore as the whole team is involved in so much cross cover. We strive for continuity of care with families and we build up a rapport with them," Ms Carr said.

"We're here to support our communities but due to staff shortages and increased workloads we are spread much too thinly."

The INMO survey revealed that 83% of respondents cover for colleagues due to short staffing, mainly for annual leave, sick leave and maternity leave. Over half of the directors of nursing in public health said they must arrange cross-cover daily due to staffing shortages. The HSE's recruitment moratorium has contributed significantly to increases in workload and shortages in staffing across the community. These pressures, in turn, are resulting in many nurses in the community taking early retirement and a further reduction in staffing numbers.

Stretched thin

Despite some success on the part of the INMO in campaigning for better pay for PHNs, there has been a 6.8% decrease in the number of PHNs in the health service since 2019. Between the months of April and May 2024, 77 PHNs left the service. Increased workloads compound stress and lead to an unhealthy work-life balance for many nurses, with one in 10 PHNs/CRGNs working 12 days or more without rest days in the previous month.

Mary Tully is one of the longest serving PHNs in Ireland, with 39 years of service in public health nursing under her belt. She has worked in a broad variety of communities, from inner-city Dublin to the rural Aran Islands. For the past 20 years she has been working in Cavan in the Bailieborough Primary Care Centre. Alongside two other PHNs and three CRGNs, Ms Tully covers a mix of urban and rural areas with a total population of around 5,000 people. Apart from staffing shortages, she noted a major increase in paperwork associated with the job.

"Recruitment and retention are huge issues in public health. The lack of staff puts public health in a negative light. Admin takes up so much of our time and takes us away from our work in the community. The paperwork is unreal, especially when we have no admin support, and no extra time for it.

"Trying to prioritise and give the best possible service to the greatest number of people is very difficult in these circumstances. We are trying to do more with less and end up working over our contracted hours. This can cause dreadful burnout and stress. Flexibility would be great so we could work part time or split shifts, but this hinges on recruiting more staff," she continued.

Kelly Keville, a CRGN with the North Longford Integrated Team, added: "What I love about my job is knowing I've made a difference to someone's life, but the biggest source of stress is knowing we're

Debbie Carr: "Community healthcare is the scaffolding that holds up the rest of the health service"

Diane Doherty: "The ability of our health service to deliver care as it currently exists will be unsustainable"

Kelly Keville: "We're overstretched with the endless mounds of paperwork, metrics and figures"

Margaret Birtley: "PHNs and CRGNs are the back bone of our health service"

Mary Tully: "We are trying to do more with less and end up working over our contracted hours"

overstretched with the endless mounds of paperwork, metrics and figures."

Margaret Birtley, a PHN in North Cork, feels that factors outside the remit of nursing also compound the pressure felt by PHNs and CRGNs. She cited the lack of interventions for children who may need it due to long waiting lists for services and the lengthy wait times older people face for home help support.

While people wait for appropriate services the primary health care centre is often their only place to turn for support. Ms Tully also pointed out that lack of proper respite care is placing huge stress on families and on community care. Carers are not always available when people are discharged from hospital and long waiting lists for physios, occupational therapy and speech and language therapists push everything back into the community.

Ms Carr echoed Ms Tully's sentiment.

"Much of our catchment area is underprivileged. There is no nursing home and no elderly day centres, especially for those with compromised mobility," she said.

"We used to do yearly reviews for access to home care packages, but due to staff shortages this has been put on hold. Developmental checks are also on hold due to staff shortages which is, in effect, delaying early intervention therapy for children,.

Education opportunities

The INMO survey revealed that staffing shortages are exacerbated by the limitations in annual training capacity and financial obstacles to undertaking PHN programmes. Currently, only 150 training places are available per year for nurses wishing to train in public health. On top of this, existing PHNs and CRGNs struggle to undertake mandatory training and professional development activities. The INMO is calling for an increase in PHN training places and protected time to facilitate this training in line with NMBI requirements.

Ms Birtley stressed that further opportunities in education and career progression for PHNs and CRGNs are essential as "they are the back bone of our health service".

Ms Tully added: "If a nurse wants to do the public health course she will have a reduction in her salary as she is then paid as a student regardless of previous experience. I also think more regional courses would be great so that nurses don't have to travel so far to train."

PHNs have fought hard through the INMO to ensure that they can avail of qualification and location allowances offered to those working in the acute sector. At present, a qualification allowance of €3,960 is available to PHNs who hold a midwifery qualification. A location allowance of €2,637 is extended to PHNs not holding a midwifery qualification but engaged in the provision of midwifery services as part of their duties. PHNs with a paediatric qualification can also receive the specialist qualification allowance. Work is still ongoing in this area.

"There is very little acknowledgement of our expanding role," Ms Keville said. "If CRGNs were paid a location allowance and a caseload allowance that would help. CRGNs want to upskill and take on new roles but with remuneration. There is not enough done to entice more nurses to work in the community."

Capacity to improve

Ms Carr made the case for staffing and funding community health adequately.

"Community health is the scaffolding that holds up the rest of the health service. Properly staffed and funded, we have the capacity to greatly improve not only waiting lists and overcrowding in the acute sector, but also health outcomes for the populations we serve."

The INMO survey revealed a major commitment to patient care despite the challenges posed by demanding workloads and staff shortages. In spite of being asked to do more with less, PHNs and CRGNs manage to complete their essential workloads, often working unpaid overtime to finish the paperwork associated with their roles. However, staffing shortages can lead to rushed visits, overlooked symptoms and missed or delayed care. These pressures are leading many to consider early retirement, highlighting the urgent need to address these staffing and workload issues.

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13 SEP	**Inclusion Health Section** The Richmond Education and Event Centre, Dublin
24 SEP	**Telephone Triage Section** The Richmond Education and Event Centre, Dublin
05 OCT	**Operating Department Nurses Section** Slieve Russell Hotel, Cavan
08 OCT	**Clinical Placement Co-ordinator Section** The Richmond Education and Event Centre, Dublin
16 NOV	**National Childrens Nurses Section** Online Webinar
21 NOV	**All Ireland Midwives Conference** Fairways Hotel, Dundalk, Co Louth
30 NOV	**Public Health Nurses Section** Online Webinar
06 DEC	**Occupational Health Nurses Section** The Richmond Education and Event Centre, Dublin

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Staffing in community care remains key issue for staff and patients

The INMO wants hiring caps scrapped and a funded workforce strategy put in place to support ongoing recruitment

THE INMO has recently updated its position paper on staffing and conditions in the community, based on 2024 surveys of public health nurses (PHNs) and community registered general nurses (CRGNs). The results demonstrate significant challenges in terms of workload and staffing, with effects on staff wellbeing and patient care.

The number of PHNs has decreased by 6.8% since 2019, from 1,539 to 1,401. It has been noted that there are continual recruitment and retention difficulties in some parts of the country, such as Dublin Mid-West. The latest HSE Employment Report shows a reduction of 77 PHNs in the past month, going from 1,478 in April 2024 to 1,401 in May 2024.

The INMO survey revealed that many PHNs and CRGNs are under immense pressure due to short staffing:

- 83% cover for colleagues due to short staffing, mainly for annual leave (80%), sick leave (72%) and maternity leave (43%)
- 30% of respondents said that they have to cross-cover other areas on a daily basis
- 41% provide essential weekend calls and 30% cover colleagues daily or several times a week
- One in 10 PHNs/CRGNs have worked 12 days or more without rest days in the past month.

A survey of directors/assistant directors of PHNs further found that:

- Over two-thirds (67%) of respondents said it takes more than a year to release a PHN after they accept a transfer due to staffing shortages
- More than half of the respondents (51%) said they must arrange cross-cover for PHNs/CRGNs daily and 63% said they provide palliative care services over weekends.

The recruitment moratorium has contributed significantly to increases in workload and shortages in staffing across the community, which has been exacerbated by a high rate of illness among nurses. These pressures are leading many to consider early retirement, highlighting the urgent need to address these staffing and workload issues.

Education and professional development

Staffing shortages are currently being exacerbated by the limitations in annual training capacity and financial obstacles to undertaking PHN programmes.

To ensure a robust and effective primary and community health service it is essential to increase the number of PHN education places, as the current annual training capacity of 150 only maintains existing service levels, accounting for resignations and retirements, without accommodating the projected rise in demand. The HSE must boost the number of sponsorship programmes and add at least two more higher education institutions (HEIs) to improve regional availability.

Given the workload demands on PHNs and CRGNs, concerns about their ability to undertake mandatory training and professional development activities have also been raised and protected time must be established and maintained to facilitate this training in line with NMBI requirements.

Missed or delayed care

In recent years, PHNs and CRGNs have encountered substantial pressures from rising demand and staff shortages. When these staffing constraints impact service delivery, the National Caseload Prioritisation for Public Health Nursing Service is activated. This prioritisation can further impact service delivery in the community.

Insufficient staffing can lead to rushed visits, overlooked symptoms and missed or delayed care. Nurses burdened with excessive caseloads may struggle to provide the level of attention and care that each patient requires.

The survey results highlight a strong commitment to patient care despite the challenges posed by increasingly demanding workloads and staff shortages. Essential activities across all cohorts of patients were largely completed without delays, reflecting the high level of dedication among the PHNs and CRGNs.

Key findings included:

- 27% of respondents indicated that newborn home visits post-discharge were never missed despite staff shortages.
- A small percentage, 3%, reported that these visits were regularly missed
- Over three-quarters (79%) of respondents reported that the first-week check after birth was never or rarely missed or delayed
- A majority, 68% of respondents, reported that wound management activities were never or rarely missed or delayed
- Similarly, 82% reported that bowel care activities were never or rarely missed or delayed.

However, some care activities are of concern. These results reveal the strain on PHNs and CRGNs because they must prioritise their work due to staff shortages:

- Over three-quarters (77%) reported missed parenting group activities
- 63% reported missed support/information on parenting
- 33% of respondents occasionally missed managing requests for home support services, with another 37% reporting frequent misses or delays
- 75% said identifying the need for home support for older adults was missed or delayed
- 72% noted that following up on care plans was missed frequently or always.

The INMO Is calling for an immediate end to recruitment caps and the development of an effective workforce strategy to produce annual funded-workforce plans that support continuous recruitment. An annual increase of 75 PHNs should also be accommodated until reaching a critical mass of 2,500 whole-time equivalents.

This requires an immediate increase in the number of PHN training places and the inclusion of community nursing within the undergraduate curriculum, with incentives for graduated nurses to undertake the public health nursing course.

Section focus

INMO Professional

Jean Carroll, Section Development Officer

Midwifery Section to jointly host national maternity conference and exhibition

THE INMO Midwifery Section will join the Royal College of Midwives, Northern Ireland in co-hosting the All-Ireland Midwifery Conference and Exhibition in November.

The theme of this year's conference will centre around sustainability in maternity care. Sessions will focus on how midwives can ensure that they are at the forefront of sustainable development and how they can make a difference to women, babies, their families and the community.

There will be opportunities to network with peers and engage with exhibitors on a wide range of maternity products and services.

Bookings can be made by contacting the INMO on 01 6640618 or by emailing education@inmo.ie To make a submission to the conference's poster competition, download the guidelines from the INMO website or contact niamh.adams@inmo.ie

See *page 18* for further information.

International Section receives presidential treatment

MEMBERS of the Internationally Educated Nurses and Midwives Section visited Áras an Uachtaráin in the Phoenix Park in July and enjoyed an informative tour of the house and grounds *(see photo right)*.

The delegation learned about the history of the building, the many presidents who have resided there, and the numerous dignitaries who have visited the Áras through the years.

Mosunmola Adebomi, secretary, Internationally Educated Nurses and Midwives Section, said: "It was a huge honour to visit the residence of the president, Mr Michael D Higgins. The memory will forever be in our minds.

"Unfortunately, we did not get the chance to see him in person, but we got a good tour of the house. What beautiful architecture, history and a beautiful garden. We were privileged to sit and dine in the state room. I loved every moment of it. Thanks to the Section officers who organised it."

Retired nurses and midwives enjoy busy summer calendar

In July the social committee of the Retired Section organised a Dublin Bay cruise. New members joined for this outing and a great time was had by all. One group made the journey by sea from Dublin City Centre to Dun Laoghaire, where they were met by a group of land-loving members for lunch. Pictured above at a recent social trip to Galway were members of the Retired Section, who met at the Park House Hotel for lunch

General secretary to attend GP Nurses Section meeting

THE GP Nurses Section will hold an information session on Wednesday, September 11 and will be joined by INMO general secretary Phil Ní Sheaghdha and director of professional services Tony Fitzpatrick.

The information session will focus on the benefits of being part of a trade union and what the Organisation can do for you.

A strong attendance is encouraged at this meeting, where participants and speakers will discuss the roll-out of a motion that was passed at the recent annual delegate conference regarding the launch of a campaign to secure proper universal terms and conditions of employment for GP practice nurses.

See *Diary* on *page 48* for further information.

Get in touch

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

INMO EDUCATION PROGRAMMES

In the pull-out this month…

Competency-based interview preparation

Sep 10

This short online programme will assist participants 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 dealt with previous workplace situations. The course will explore preparation, presentation and performance during the interview and briefly focus on CV preparation.

Fee: €50 INMO members; €85 non-members

Time management

Sep 11

This online course will help nurses/midwives recover lost time and take some pressure off themselves. It will help you to develop and apply your own unique strategies and practices to consciously manage your use of time. Be it reducing or eliminating lost time, overcoming procrastination, getting more done in your day or adjusting your priorities, with this course you can learn these practical skills to win back more time in your working day.

Fee: €50 INMO members; €85 non-members

Introduction to insulin management in type 1 diabetes

Sep 12

This new course aims to give nurses an insight into the management of insulin for people with type 1 diabetes. Participants will gain an understanding of insulin, an insight into different insulin types, how to manage insulin around mealtimes and how different activities affect insulin absorption.

Fee: €50 INMO members; €85 non-members

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Education Programmes

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Sep 10 **Competency-based interview skills**

This programme will assist participants 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 and dealt with previous workplace situations. It will explore preparation, presentation and performance during the interview and briefly focus on CV preparation.

Sep 11 **Time management for nurses and midwives**

This online course will help nurses/midwives recover lost time and take some pressure off themselves. It will help you to develop and apply your own unique strategies and practices to consciously manage your use of time. Be it reducing or eliminating lost time, overcoming procrastination, getting more done in your day or adjusting your priorities, with this course you can learn these practical skills to win back more time in your working day.

Sep 12 **Introduction to insulin management in type 1 diabetes**

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Sep 12 **Your safety toolbox – key aspects of workplace safety support**

This programme provides safe practice tools to protect the nurse, midwife and patient within the backdrop of staff shortages and skill mix realignment within current healthcare settings. This is an awareness session to ensure participants have an understanding of the processes involved regarding patient alerts, clinical incidents and thorough assessment, while remaining focused on the patient. It addresses patient and staff safety, and provides five key tools on areas of documentation, clinical incident reporting, safety statements, best practice guidelines regarding assessment and communication practices in the complex multifaceted health care arena.

Sep 17 **Stroke management** *(in person)*

This programme facilitates nurses working in the community setting to gain a greater understanding of caring for a person with a stroke, post discharge. The course provides an outline of the importance of the health promotion and the educational role of the nurse. Signs and symptoms of stroke are discussed, as well as communication challenges, and psychological and psychosocial changes within the person. The course examines family adjustment and also the development of a care pathway within the community setting. This introduction to stroke care programme promotes excellence in stroke care among community nurses. Fee: €110 INMO members; €185 non-members.

Sep 17 **Understanding epilepsy**

Epilepsy is a chronic disease that affects 1% of the population and can be associated with significant physical and psychosocial sequelae. A person with epilepsy often has comorbid conditions and must carefully manage their epilepsy and concomitant diseases, as well as navigate how their life is affected by their diseases. The management of patients with complex medical conditions, including epilepsy, is increasingly being overseen by nurses. 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.

Cancellation policy: For cancellations five days before the course due date, a full credit to transfer on to 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 18 **Wound care management** *(in person)*

This programme will allow participants to ensure professional competency in the area of wounds as per the NMBI Code of Professional Conduct and Scope of Practice for Nursing and Midwifery, which states that nurses must work within their competence. Fee: €110 members; €185 non-members.

Sep 19 **Telephone assessment and advice skills**

This short online programme is for nurses and midwives involved in providing telephone assessment and advice in the ED, 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 course will provide strategies and guidance on how best to communicate with each caller in a professional and tactful manner.

Sep 20 **Medication management – best practice guidance for nurses and midwives**

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

Sep 23 **Advanced library searching techniques** *(in person)*

This programme is aimed at nurses and midwives who would like to develop their information-seeking skills in order to avail of the most up-to-date information for clinical practice, reflection and policy development. This programme will assist participants who are undertaking academic programmes and will provide them with valuable lifelong skills in information literacy. Guidance will be provided on the use of keywords, Boolean logic and limiting and broadening of results. The programme involves a practical element whereby participants will have the opportunity to develop a search strategy and use it to search a database. Strategies for the evaluation and critique of online resources will also be discussed.

Sep 25 **Introduction to management and leadership**

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

Sep 26 **Risk management and incident reporting**

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

Sep 26 **Adult asthma**

This short online programme is aimed at nurses and midwives working in clinical practice who require basic knowledge and skills to care for people with asthma on a day-today 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.

Sep 27 **Falls reduction, assessment and review**

The purpose of this short online 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.

Sep 30 **Safe administration of medicines in residential care**

The aim of this workshop is to: outline the professional, legal and best practice requirements for safe administration of medicines in a residential care setting; identify the 10 rights of medication administration; outline the requirements for a valid prescription and identify the requirements for record-keeping when administering medicines in the centre.

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In person courses coming in September/October

SEP 03

Nursing records under the spotlight

This course is designed to equip nurses and midwives, working in a variety of healthcare settings, with the knowledge to maintain nursing records in accordance with legal & professional standards.

SEP 04

Phlebotomy

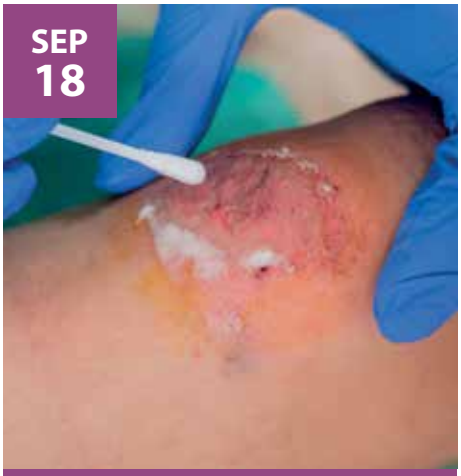
This course provides skills, theory and practice of phlebotomy. It will cover sites used for phlebotomy, criteria for evaluating a vein, principles of an aseptic technique and complications that may arise during and after the procedure.

SEP 17

Time is Brain: a guide to nursing management, assessment and treatment of acute stroke

This course will include nursing assessment, cardiac rhythm, neurological observation and rehabilitation.

SEP 18



Wound Care Management

This programme will ensure professional competency in the area of wounds as per NMBI Code of Professional Conduct and Scope of Practice.

SEP 23

Getting the most from your library: advanced library searching techniques

Develop skills in order to avail of the most up-to-date information for clinical practice, reflection and policy development.

OCT 09

Introduction to Change Management for Nurses and Midwives

The aim of this course is to enhance the understanding of nurses and midwives of change management and strategies to improve the potential for successful change initiatives.

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For more information go to www.inmoprofessional.ie/course

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Online courses coming in September/October

SEP 12

Your Safety Toolbox

This programme provides safe practice tools to protect the nurse, midwife and patient within the backdrop of staff shortages and skill mix realignment within current healthcare settings.

SEP 17

Understanding Epilepsy

for nurses and midwives

Epilepsy is a chronic disease that affects 1% of the population and can be associated with significant physical and psychosocial sequelae.

SEP 19

Telephone Assessment & Advice Skills

for nurses and midwives

This course is for nurses/midwives involved in providing telephone assessment and advice, in A&E, general practice and other community settings

SEP 20

Medication Management

Best Practice 2020 Guidance for Nurses and Midwives

This education programme supports nurses/midwives in providing safe, evidence-based practice in the area of medication management thus preventing medication errors and near misses.

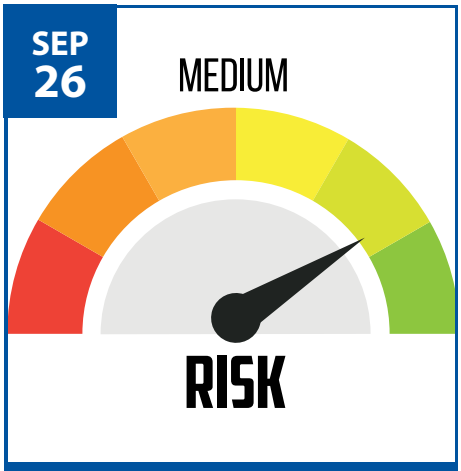
SEP 25

Introduction to

Management & Leadership Skills

This course will identify key managerial and leadership competencies for front line nursing/midwifery managers and to explore how these are applied in practice.

SEP 26



Risk Management & Incident Reporting

Outlining the core principles of best practice in managing risk, underpinned by the philosophy and care needs to improve the potential for successful change initiatives.

Book now, call us on 01 6640618/41

For more information go to www.inmoprofessional.ie/course

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

Oct 2 **Become more assertive**

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

Oct 3 **PEG feeding in the hospital/community setting**

This short online programme is aimed at nurses working within the hospital and community setting caring for adults and paediatrics who have a percutaneous endoscopic gastrostomy (PEG) tube. It will address the clinical indications and requirements for PEG feeding in the home and hospital setting. It will provide guidance on medication administration and nutrition with a focus on hospital policies and government guidance. It will also discuss the complications of PEG feeding that can occur and how these can be clinically managed.

Oct 4 **Tracheostomy care study day**

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

Oct 7 **Delegation principles and practices**

This short programme is aimed at all nurses, midwives and clinical nurse and midwife managers who work with healthcare assistants. It explores the issues surrounding delegation and decision-making, including appropriate clinical supervision for delegated functions. Participants will learn the difference between clinical and managerial delegation and how delegation differs from assignment of a task. 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 8 **Complaints management for healthcare staff (acute or residential healthcare setting)**

This short online programme is aimed at senior nurse managers within the acute or residential healthcare settings to provide them with the key communication tools to minimize the negative impact complaints can have in their workplace. Therefore, effective management of complaints is central to improve services and prioritise an open, honest and transparent health service.

Oct 9 **Change management** *(in person)*

This programme is an introduction to key concepts related to change management. The programme aims to enhance the understanding of participants of change management and strategies to improve the potential for successful change initiatives. The programme will include the following topics: the nature of change, initiating change, understanding and managing resistance, change models, the importance of communication and the role of stakeholders. €110 INMO members; €185 non-members.

Oct 10 **Paediatric asthma**

This online educational session will introduce the nurse to: epidemiology, pathophysiology, diagnosis and management of asthma in children. The Global Initiative for the Diagnosis and Management of Asthma will underpin the session providing the nurse with evidence-based material which will enable him/her to provide care to children with asthma and their families.

Oct 15 **Master your communication skills**

This online training will help you develop your interpersonal and communication skills at all levels of the organisation. The course focuses on your key competencies for face-to-face and written communications to ensure you can understand what is being communicated to you; how to respond and how to communicate clearly and with purpose. Learn these practical skills to ensure more effective and impactful communications.

Oct 15 **Improve your academic writing and research skills**

This short online course is designed for nurses and midwives who are undertaking third-level academic programmes. This course 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.

Inclusion health

This month the INMO Library looks at resources in the area of inclusion health

INCLUSION HEALTH is an approach to health services, research and policy which aims to prevent and redress health and social inequities through interventions and integrated healthcare responses that meet the needs of socially excluded groups. The main target groups for inclusion health services are people experiencing homelessness, Travellers and Roma, migrants, refugees, beneficiaries of temporary protection and international protection applicants, victims/survivors of domestic, sexual and gender-based violence and people who use drugs and alcohol.

What is inclusion health and why is it important?

- *Waterall Jamie, Newland R, Campos-Matos I, Stannard J. What is inclusion health and why is it important for all nurses and midwives? British Journal of Nursing 2021; 30(14):866-7*

Inclusion health is a catch-all term used to describe people who are socially excluded and those who typically experience multiple overlapping risk factors for poor health, including poverty, violence and complex trauma. People in these population groups are also more likely to experience poor health because healthcare is not made as easily accessible to them, despite the fact they are more likely to have several concurrent health conditions that put them at greater risk of dying young.

Inclusion health service for homeless in Dublin

- *Siersbaek R. (2020) An Integrated Inclusion Health Service for Homeless Adults in Dublin: An Observational, Descriptive Study. https://doi.org/10.21203/rs.2.21411/v1*

The pilot Inclusion Health Service was a multi-component intervention designed to improve the outcomes of adults experiencing homelessness who are accessing hospital care. The shift towards delivering more clinical care in the community not only supports the healthcare system by avoiding unnecessary hospital admissions, but can also improve outcomes, particularly for older people with complex healthcare needs. This article details a project that involved the design and development of a replicable 'Ageing Well' programme of learning to increase knowledge, skills and confidence, underpinned by a 'skills not roles' strategy.

Nurse-led projects in inclusion health

- *Abbott S, Bryor R. Nurse-led projects for people experiencing homelessness and other inclusion health groups: a realist evaluation. British Journal of Nursing 2022; 27(1):33-9*

Nursing service development or innovation projects can be difficult to deliver and evaluate due to a lack of resources and support. Results can also be difficult to disseminate, limiting transfer of learning. This paper presents findings from a realist evaluation of 10 small projects supported by the Queen's Nursing Institute Homeless and Inclusion Health Programme to deliver innovation in healthcare for people experiencing homelessness and other marginalised groups. This realist evaluation explores the factors that contributed to the delivery of positive outcomes.

Trauma-informed care

- *Dowdell EB, Speck PM. Trauma-Informed Care in Nursing Practice. American Journal of Nursing 2022; 122(4):30-8*

Trauma in childhood often leads to mental health problems, skeletal fractures and early death from conditions such as heart disease, cancer, lung disease, and liver disease. There is evidence that traumatic events are more frequently experienced by people in low socio-economic groups and from Black, Asian and minority ethnic communities. Additionally, people who are homeless are more likely to have experienced trauma than the general population. Trauma-informed care is a skill underutilised by healthcare providers and organisations. This article presents the six foundational principles of trauma-informed care.

INMO Inclusion Health Section

The Inclusion Health Section invites you to attend a conference on September 13, 10am-4pm at the Richmond Building. See **inmoprofessional.ie** for further details.

INMO library access

The Nurse2Nurse website is no longer available. The INMO Library is now only available through OpenAthens and the INMO website (**inmo.ie**). Please contact the library for further information regarding access or library services by email at library@inmo.ie or at Tel: 01-6640614/25. Please also contact us if you require any articles in full text or if you would like to make an appointment to visit in person.

Online – Introduction to Effective Library Search Skills

Next course date: Monday, September 23

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

Midwifery library update

THIS month's library update looks at a range of topics in midwifery. Taking a slightly different approach to highlighting new articles, we hope that including the abstracts will be more useful to you. If you would like to obtain the full text of any of the articles here, or if you would like to highlight research or tools that might be of interest to your colleagues, please contact the library and let us know.

Music in perinatal care

- *Cheung PS et al. Healthcare practitioners' experiences and perspectives of music in perinatal care in Ireland: An exploratory survey. Midwifery 2024; 132.* Evidence shows that music can promote the wellbeing of women and infants in the perinatal period. Ireland's National Maternity Strategy (2016-2026) suggests a holistic approach to women's healthcare needs and music interventions are an ideal non-pharmacological and cost-effective intervention to improve the quality of care offered to women and infants. This cross-sectional survey aimed to explore healthcare practitioners' personal and professional experiences of using music therapeutically and its impact and barriers in practice. The survey also investigated practitioners' knowledge and attitudes towards the use of music as a therapeutic tool in perinatal care.

Midwives wellbeing

- *Dent J et al. The importance of recovery and staffing on midwives' emotional wellbeing: A UK national survey. Midwifery 2024; 132.* There is a gap in the evidence on how working practices, such as the ability to take rest breaks, finish on time or inter-shift recovery influence outcomes. The aim of this study was to explore the association of individual characteristics, work-related factors and working practices on emotional wellbeing outcomes of UK midwives. An online cross-sectional survey collated data between September and October 2020. Outcomes explored were work-related stress, burnout, being pleased with standard of care, job satisfaction and thoughts about leaving midwifery. This research has demonstrated an association between impeded recovery, including a lack of formal methods to monitor this, and poorer emotional wellbeing outcomes, and that staffing levels are highly influential in determining outcomes. There is a need to re-evaluate current approaches to job design and how midwives are expected to work.

Biomechanics for Birth

- *Lennon R. Bouncing your way to labour and birth using biomechanics and fetal optimal positioning. British Journal of Midwifery 2024; 32(5).* 'Labour hopscotch' is a visual tool that encourages activity during pregnancy and childbirth. It has been used widely in Ireland since 2020. This study's aim was to ascertain if the biomechanics for birth toolkit impacted gestation of spontaneous onset of labour rates and birth outcomes. Using the biomechanics for birth toolkit alongside the labour hopscotch tool could increase spontaneous onset of labour rates, optimise physiological birth, reduce inductions and emergency Caesarean section following induction.

RCM iLearn

A new 15-minute course has been released this month on the RCM iLearn platform called Maternity Disadvantage Assessment Tool (MatDAT). The MatDAT is a new standardised tool for assessing social complexity in maternity, based on women and birthing people's broad social needs. It guides midwives to identify the appropriate care level and assists with providing personalised care and planning appropriate support. The tool supports multidisciplinary communication and helps services plan resource allocation. This course introduces this assessment tool and includes animations, case studies and reflective activities.

On completion of the course, you should:

- Recognise the diverse challenges faced by women and birthing people with social complexities, including severe disadvantage when accessing maternity services
- Reflect on how the MatDAT could improve equity of access and outcomes across services and contribute to personalised care and support planning
- Follow the pathway for adapting the MatDAT for your local service.

Contact the INMO Library

For further information on any of the resources mentioned here, or to gain access to the INMO Library resources via OpenAthens or to RCM iLearn, please contact us at email: library@inmo.ie or Tel: 01-6640614/25.

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

Royal College of Midwives

Cornmarket Mortgages

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01 1st Time Buyer/Mover – Tuesday, 1st October @ 4.30pm

02 Switch & Save - Wednesday, 2nd October @ 4.30pm

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Warning: If you do not keep up your repayments you may lose your home.
Warning: If you do not meet the repayments on your loan, your account will go into arrears. This may affect your credit rating, which may limit your ability to access credit in the future.

*Paid by cheque after drawdown of Mortgage.

20492 Mortgages Ad 08-24

Q and A Bulletin Board

With INMO director of industrial relations Albert Murphy and the staff of the Information Office

Extra parent's leave for young children

Q. I asked my employer if I could avail of the two extra weeks of parental leave that was introduced recently. However, my employer informed me I have taken my full entitlement

The Parent's Leave and Benefit Act 2019 amended by the Family Leave and Miscellaneous Provisions Act 2021 has extended the duration of Parent's Leave and Benefit from seven weeks to nine weeks from August 1, 2024. If your child was under the age of two years as of August 1, 2024 (or an adoptive child placed with you for less than two years as of that date), you are entitled to take nine weeks parent's leave.

In case of domestic violence…

Q. I am having difficulties at home and would like to know more about my options in case of domestic violence.

Domestic violence is defined under the Work Life Balance and Miscellaneous Provisions Act 2023 as violence or threat of violence, including sexual violence and acts of coercive control, committed against an employee or a relevant person in relation to an employee.

The domestic violence may have been committed by a spouse/civil partner, cohabitant or a person who is or was in an intimate relationship with the employee or relevant person, or an adult child of the employee or relevant person. A relevant person who an employee may take domestic violence leave to support includes the employee's: child, adopted child or dependent, spouse or civil partner, cohabitant, or a person with whom they are in an intimate relationship.

You are entitled to take up to five days paid domestic violence leave in any 12-month period. The leave cannot be taken in periods of less than one day. An absence for part of a day is counted as one day for the purposes of domestic violence leave. You are entitled to be paid by your employer while on statutory domestic violence leave.

You must advise your employer as soon as possible if you need to take domestic violence leave, but no notice period is required as the need to take domestic violence leave may not be foreseeable. Immediately on your return to work, you must confirm in writing to your employer the date of commencement and duration of the leave. This confirmation should be signed by the employee. No statement of facts in relation to the leave is required.

Medical care leave

Q. I am trying to find information on unpaid leave to care for my father after an operation. Can you please advise?

You can avail of medical care leave of up to five days without pay to care for someone who needs significant care or support for a serious medical reason. The leave is available to parents and carers. This leave applies for care of an employee's child (or other relevant person); spouse or civil partner; cohabitant; parent or grandparent; brother or sister; or a person who lives in the same household as you.

This leave entitlement is separate to *force majeure* leave (paid leave for urgent family reasons). You do not need to have minimum service to take the leave. You may be given up to five days leave for medical care in a year. You cannot take the leave for periods of less than one day. If you take leave for medical care purposes for part of a day, it counts as one day. You do not have to take the leave all together, it can be taken over a 12-month period.

Talk to your employer and fill in the relevant form as soon as reasonably practical. You will need to confirm the start date, length of leave and why you are entitled to the leave.

You may be asked to give information about your relationship to the person you are caring for, the nature of the care and support, and evidence showing that the person needs significant care or support. You may be asked for evidence of the medical need for the leave, such as a medical certificate for the person you are caring for. If they do not have a medical certificate, your manager may ask for other evidence showing that the person needs serious medical care.

Know your rights and entitlements

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

Contact Information Officers Catherine Hopkins and Catherine O'Connor at
Tel: 01 664 0610/19
Email: catherine.hopkins@inmo.ie, catherine.oconnor@inmo.ie
Mon to Thur 9am-5pm; Fri 8.30am-4.30pm

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

Quality & Safety

A column by Maureen Flynn

My health, my voice: patient resource to aid diagnostic safety

EVERY year for World Patient Safety Day, the World Health Organization (WHO) asks patients, healthcare providers, policy-makers and healthcare leaders to come together and see where we can improve patient safety. As nurses and midwives we are ideally placed to work with colleagues in responding to this call.

Diagnostic safety

This year the WHO is asking us what we can do to improve diagnostic safety. A diagnosis identifies a patient's health condition, and is a key to accessing the care and treatment they need. One important aspect of diagnostic safety is communication between patients and healthcare providers. It is estimated that one in three patients have difficulty understanding health-related information. Poor communication can hinder or cause a delay in getting a diagnosis.

As part of World Patient Safety Day, the HSE, in collaboration with the Department of Health and Patients for Patient Safety Ireland, have developed the 'My health, my voice' resource to help improve communication between patients and their providers. This resource was initially developed in 2023 and has been tested in community and hospital settings over the past year. Now, with feedback from both providers and patients, it has been accredited by the National Adult Literacy Association's (NALA) Plain English standards.

My health, my voice

'My health, my voice' is a leaflet for patients that encourages everyone to be involved in their own care. The leaflet outlines three key questions we encourage people to ask at their health or social care appointments. Examples of appointments may include GP, outpatient appointments, in-patient hospital stays, a visit from your public health nurse or a visit to the emergency department. *See box for questions*.

My health, my voice

What do I need to know now?
- This can help patients be more prepared and understand what they need to know about their health and care

What do I need to do next and why?
- This can help patients better understand what is happening with their care and make a healthcare plan based on options that matter to them

What can I expect?
- This can help patients be prepared for what to expect of their healthcare plan, how their health issues may affect each other and their overall wellbeing
- This also helps patients follow their care plan

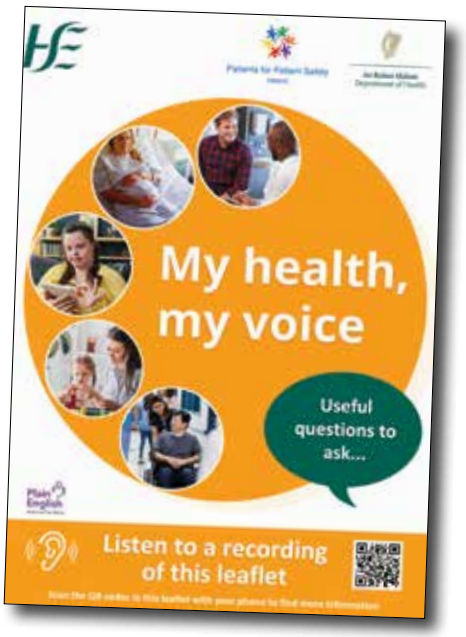
Benefits of the leaflet

We can all struggle with healthcare information and 'My health, my voice' is a simple, but effective tool to help ensure patients have key information they need on their healthcare journey. When patients get more involved in their own care, it can lead to more accurate diagnoses and better health outcomes. For example, patients can communicate more effectively with healthcare providers, accurately describing symptoms, aided by a pre-made list that is brought with them to their healthcare appointment.

Sharing of information reduces the likelihood of misdiagnosis and ensures timely interventions. Patients are more likely to stick to their prescribed healthcare plan when they better understand their conditions, and the decision making and rationale behind their healthcare plan.

Get involved

At your next ward, team or department meeting you might like to talk about how the leaflet might be used within your service. If you know patients who are interested in getting involved in the design, delivery and evaluation of healthcare services, ask them to contact the National Patient Forum and Patients for Patient Safety Ireland. We can all make a positive difference to health and social care services.



Where to access

The 'My health, my voice' leaflet is available on the HSE National Quality and Patient Safety Directorate website: **www.hse.ie/nqpsd**. We encourage healthcare providers to share this important resource with all their patient. You can also access the recorded version of the leaflet on YouTube. These resources will be formally launched on the World Patient Safety Day on September 17, 2024.

Dr Maureen Flynn is the director of nursing and QPS lead with the HSE Office of the Nursing and Midwifery Services Director

Acknowledgements :
Thank you to the World Patient Safety Day Project Team, chaired by Bernie O'Reilly, chair, Patients for Patient Safety Ireland and Joe Ryan, HSE national director, who working with representation from across the HSE, Patient Partners and the Department of Health, is preparing the resources. A special thank you to my colleagues, Sheema Lughmani, Kris Kavanagh and Juanita Guidera, HSE National QPS Directorate for assistance in writing this column

Student and new graduate update

With Jamie Murphy

Embarking on your career in Ireland

STARTING your career as a staff nurse or midwife in Ireland is not just the culmination of years of rigorous study, practice and dedication, it is also the beginning of a fulfilling journey. Whether you're stepping onto a busy hospital ward, working in a community setting or preparing to assist in childbirth, you're entering a career that presents both incredible challenges and immense rewards.

The transition from student to professional can be both exhilarating and daunting. You've spent years preparing for this moment, but as you don the uniform of a staff nurse or midwife you're preparing to take on new responsibilities, learning to navigate the complex healthcare system and making decisions that affect the lives of your patients and their families. It's a big step, but also an incredibly exciting one.

INMO support

As you begin this new chapter, it's important to remember that you are not alone. The INMO is here to support you every step of the way. The INMO isn't just another professional association; it's a community of over 40,000 nurses and midwives who are committed to standing up for your rights, ensuring you have the resources you need and providing guidance as you navigate the early stages of your career.

The INMO plays a crucial role in advocating for fair working conditions, equitable pay and professional development opportunities. By joining this community, you are ensuring that you have a voice in the ongoing discussions that shape the future of nursing and midwifery in Ireland. Moreover, the INMO offers a range of services designed to support you, including legal advice, representation and access to continued professional development courses.

From student to professional

As the student and new graduate officer for the INMO, I understand firsthand the challenges that come with transitioning from student to professional. The transition period can feel overwhelming as you adjust to the demands of the job, adapt to new environments and continue to develop your clinical skills but it's also a time of significant personal and professional growth.

I encourage you to lean on the support available to you. Whether you have questions about your contract, need advice on managing your workload or are simply looking for someone to talk to about your experiences, I'm here to help. My role is to ensure that you feel supported and empowered as you embark on your career and I'm always available to answer any questions or concerns you may have.

INMO membership

One of the many benefits available to you as a new graduate is the continuation of your INMO membership. During your time as an undergraduate, INMO membership is free. This was designed to give you access to valuable resources and support during your studies. Now that you're entering the workforce, it's crucial to update your membership to reflect your new status as a staff nurse or midwife.

If we didn't have the opportunity to meet during your final year and you haven't yet completed the necessary forms to update your membership, please don't hesitate to contact me. Maintaining your membership with the INMO ensures that you continue to receive all the benefits and protections that are so essential during these early years of your career. From access to exclusive training and development opportunities to having a strong advocate in your corner when you need it most, INMO membership is an invaluable resource for any new healthcare professional.

Support

Starting your career is a significant milestone. It's a time of new experiences, challenges and opportunities for growth. As you embark on this time in your career, it's important to remember that you are part of a larger community. The INMO is more than just a professional organisation; it's a network of individuals who share your passion, understand your challenges and are committed to supporting you throughout your career.

I want to take this opportunity to wish you the very best of luck as you begin this new chapter. You've worked incredibly hard to get to this point and now it's time to put your skills, knowledge and compassion into practice. Nursing and midwifery are professions that require resilience, dedication and a deep commitment to patient care, but they also offer unparalleled opportunities for personal and professional fulfilment.

As you move forward, remember that this is just the beginning. Your career will be filled with moments of learning, growth and countless opportunities to make a positive impact on the lives of those you care for. Throughout it all, the INMO will be here to support you, advocate for you and help you achieve your professional goals.

Welcome to the professions and welcome to the INMO community. Together, we'll ensure that your career as a nurse or midwife is as rewarding as it is impactful.

If you have any questions or if there's anything I can assist with, please don't hesitate to get in touch.

Jamie Murphy is the INMO student and new graduate officer. You can contact her with any problems, queries, questions or ideas that you might have – relating to students and new graduates – by email to: Jamie.murphy@inmo.ie

Male LUTS – prevention, attention and intervention

WIN looks at some of the research presented at the recent annual congress of the European Association of Urology held in Paris

A PLENARY session on lower urinary tract symptoms (LUTS) in men at the Annual Congress of the European Association of Urology (EAU) held in Paris recently focused on prevention, attention and intervention of this common problem in men's health. Focusing on non-prostate-related causes of LUTS, the session also examined genetic links.

During a segment on epidemiology and prevention, Prof Mauro Gacci from University Hospital, Florence, provided non-pharmacological strategies to avert the development of benign prostatic hyperplasia (BPH). He underscored the impact of diet, exercise, smoking and alcohol intake on the risk of BPH progression, and also examined its correlation to race and socioeconomic status.

Heavy smoking, increased consumption of beef, butter, margarine and starch, and intake of sodium and zinc, are associated with BPH risk. At least a modest amount of physical activity, moderate alcohol consumption, intermittent fasting, and the intake of micronutrients such as carotene, vitamin C and iron have a protective effect against developing BPH.

Genetic predisposition of BPH

"BPH is 15 years behind prostate cancer" was one of the overarching points from the presentation 'Genetic predisposition for BPH: Where do we stand?' by Prof Martin Hennenberg, from University Hospital, Munich. He stated that translational relevance is limited for BPH. He added that the druggability of most genes is restricted by imbalanced side effects, costs, unknown organ-specificity, lacking efficacy (eg. vitamin D receptor [VDR], progesterone), and inadequate innovative character (ie. steroid metabolism).

Epidemiology of male LUTS

In his presentation 'Epidemiology of male LUTS: Not only the prostate', Prof Marcus Drake from Bristol Urological Institute stated: "We need to consider multiple influences (that induce LUTS) such as the bladder, the inflammatory process, the nature of the nerve supply and anatomical aspects, how fast and how much urine is produced, psychology and the overall health of each individual."

Regarding the bladder, Prof Drake said: "We should emphasise the fundamental nature of urgency as the driving symptom for overactive bladder (OAB)." Additionally, he mentioned underactive bladder (UAB), which he referred to as "the other direct bladder pathology".

Concerning microbiome, Prof Drake said that it is a mistake to focus on the species of the bacteria without considering what enzymatic potential they might have. Furthermore, on shared innervation, LUTS should be evaluated in patients with inflammatory bowel disease (IBD) by urologic-validated questionnaires for prompt diagnosis and early treatment. He cited findings from a study which showed that sleep-related disorders were associated with LUTS, hesitancy, incomplete emptying, incontinence and nocturia in middle-aged and older males.[1] On frailty, regarding patients with urological diseases, those with LUTS were found to have a high prevalence of frailty. Additionally, neurological disease can have urinary symptoms as an early feature for some conditions.

Treating men with urinary frequency

The initial results from the Bladder Emptying Disorder Therapy (BEST) Trial were also presented at EAU Congress. It was revealed that an app-based therapy leads to significant improvements in the LUT symptoms that many millions of men experience – hesitancy, straining, frequent urges to urinate and emptying the bladder effectively. Full results of the trial are expected to be published later this year.

Carried out in Germany, this was the world's first randomised controlled trial to look at combining pelvic floor training, behavioural therapy and bladder control techniques for mild, moderate and severe bladder emptying disorders in men, all delivered as an app-based therapeutic. Bladder emptying disorders can start to appear from the age of 30 and typically affect a large proportion of men aged over 50. While clinical guidelines recommend physiotherapy, behavioural therapy and lifestyle changes as a first-line of treatment, they are often neglected by clinicians due to a lack of available evidence.

Prof Christian Gratzke, from University Hospital Freiburg in Germany, who co-led the trial, explained that frequent urges to urinate and issues emptying the bladder were the most prevalent urinary conditions in men following UTIs.

The researchers recruited 237 men aged over 18 from across Germany into their 12-week study. Half the men were randomised to receive standard medical care, while the other half were given access to the Kranus Lutera app-based therapy alongside standard care. These participants were asked to record a urination diary and complete questionnaires about the severity of their symptoms. After 12 weeks, the trial found significant and clinically meaningful improvements in symptoms and quality of life measures from participants given the app-based therapy, who reported an average seven-point increase in symptom scores compared to those in the control group. Crucially, the study found that the app-based therapy was more effective than medical therapy. The researchers compared data from men whose symptoms were due to an overactive bladder with those whose symptoms were due to an enlarged prostate. They found that both groups benefited from the therapy.

Reference

1. Chen J, Liu Z, Yang L et al. Sleep-related disorders and lower urinary tract symptoms in middle-aged and elderly males: a cross-sectional study based on NHANES 2005-2008. Sleep Breath 2024 Mar; 28(1):359-70

Betmiga™

mirabegron 50mgs once daily

BETMIGA 25 mg prolonged-release tablets &
BETMIGA 50 mg prolonged-release tablets.

Prescribing Information: BETMIGA™ (mirabegron)
For full prescribing information, refer to the Summary of Product Characteristics (SPC). **Name:** BETMIGA 25 mg prolonged-release tablets & BETMIGA 50 mg prolonged-release tablets. **Presentation:** Prolonged-release tablets containing 25 mg or 50 mg mirabegron. **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 administration:** The recommended dose is 50 mg orally once daily in adults (including elderly patients). Mirabegron should not be used in paediatrics for OAB. A reduced dose of 25 mg once daily is recommended for special populations (please see the full SPC for information on special populations). The tablet should be taken with liquids, swallowed whole and is not to be chewed, divided, or crushed. The tablet may be taken with or without food. **Contraindications:** Hypersensitivity to the active substance or to any of the excipients listed in section 6.1 of the SPC. Severe uncontrolled hypertension defined as systolic blood pressure ≥ 180 mm Hg and/or diastolic blood pressure ≥ 110 mm Hg. **Warnings and Precautions:** Renal impairment: BETMIGA has not been studied in patients with end stage renal disease (eGFR < 15 ml/min/1.73 m^2 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 (eGFR 15 to 29 ml/min/1.73 m^2); based on a pharmacokinetic study (see section 5.2 of the SPC) a dose of 25 mg once daily is recommended in this population. This medicinal product is not recommended for use in patients with severe renal impairment (eGFR 15 to 29 ml/min/1.73 m^2) concomitantly receiving strong CYP3A inhibitors (see section 4.5 of the SPC). 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 (see section 4.5 of the SPC). 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 (see section 5.1 of the SPC). 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 antimuscarinics 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:** Caution is advised if mirabegron is co-administered with medicinal products with a narrow therapeutic index and significantly metabolised by CYP2D6. Caution is also advised if mirabegron is co-administered with CYP2D6 substrates that are individually dose titrated. In patients with mild to moderate renal impairment or mild hepatic impairment, concomitantly receiving strong CYP3A inhibitors, the recommended dose is 25 mg once daily. For patients who are initiating a combination of mirabegron and digoxin (P-gp substrate), the lowest dose for digoxin should be prescribed initially (see the SPC for full prescribing information). The potential for inhibition of P-gp by mirabegron should be considered when BETMIGA is combined with sensitive P-gp substrates. Increases in mirabegron exposure due to drug-drug interactions may be associated with increases in pulse rate. **Pregnancy and lactation:** BETMIGA is not recommended in women of childbearing potential not using contraception. This medicinal product is not recommended during pregnancy. BETMIGA should not be administered during breast-feeding. **Undesirable effects:** Summary of the safety profile: The safety of BETMIGA was evaluated in 8433 adult 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 adult 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. Adverse reactions: The following list reflects the adverse reactions observed with mirabegron in adults with OAB 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) and 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 (cannot be estimated from the available data): 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. * signifies adverse reactions observed during post-marketing experience. Prescribers should consult the SPC in relation to other adverse reactions. **Overdose:** Treatment for overdose should be symptomatic and supportive. In the event of overdose, pulse rate, blood pressure, and ECG monitoring is recommended. **Basic NHS Cost:** Great Britain (GB)/Northern Ireland(NI): BETMIGA 50 mg x 30 = £29, BETMIGA 25 mg x 30 tablets = £29. Ireland (IE): POA. **Legal classification:** POM. **Marketing Authorisation number(s):** (GB): PLGB 00166/0415-0416. NI/IE: EU/1/12/809/001-006, EU/1/12/809/008-013, EU/1/12/809/015-018. **Marketing Authorisation Holder:** GB: Astellas Pharma Ltd., 300 Dashwood Lang Road, Bourne Business Park, Addlestone, United Kingdom, KT15 2NX. NI/IE: Astellas Pharma Europe B.V. Sylviusweg 62, 2333 BE Leiden, The Netherlands. **Date of Preparation of Prescribing information:** January 2023. **Job bag number:** MAT-IE-BET-2023-00001. **Further information available from:** GB/NI: Astellas Pharma Ltd, Medical Information: 0800 783 5018. IE: Astellas Pharma Co. Ltd., Tel.: +353 1 467 1555. For full prescribing information, please see the Summary of Product Characteristics, which may be found at: GB: www.medicines.org.uk; NI: https://www.emcmedicines.com/en-GB/northernireland/; IE: www.medicines.ie.

United Kingdom (GB/NI)
Adverse events should be reported. Reporting forms and information can be found at www.mhra.gov.uk/yellowcard or search for MHRA Yellow Card in the Google Play or Apple App Store. Adverse events should also be reported to Astellas Pharma Ltd. on 0800 783 5018.

Ireland
Adverse events should be reported. Healthcare professionals are asked to report any suspected adverse reactions via: HPRA Pharmacovigilance, Website: www.hpra.ie or Astellas Pharma Co. Ltd. Tel: +353 1 467 1555, E-mail: irishdrugsafety@astellas.com.

Date of preparation: January 2023

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

MAT-IE-BET-2023-00003

Eliminating cervical cancer in Ireland

Sinéad Cleary looks at how optimal screening and vaccination uptake can help to eliminate cervical cancer in the Irish setting

IN NOVEMBER 2023, Minister for Health Stephen Donnelly announced that Ireland will eliminate cervical cancer by 2040. This was a very exciting development in Women's health – a cancer we could eliminate. The WHO defines elimination as fewer than four cases per 100,000 women* per year which would make cervical cancer rare. Ireland's incidence of cervical cancer is currently 10.4 per 100,000.[1]

Cervical cancer

Cervical cancer is the ninth leading cause of cancer in women and the fourth most common cancer in women aged 15-44 years.[2] In Ireland on average 292 women are diagnosed with cervical cancer annually and 90 women die from this disease. It is a young woman's disease and mostly affects women aged between 30 and 50.[3] Over 90% of all cases of cervical cancer are caused by the human papilloma virus (HPV) and it is treatable when detected early.

Human papilloma virus

HPV is spread through skin to skin intimate contact. It is important that women are aware that penetrative intercourse is not necessary for the spread of HPV. Some 80% of us – men and women – will be exposed to HPV across our lifetimes. Most infections are transient and will resolve within 18 months. Fewer than 20% of infections will become persistent allowing the HPV to integrate into the host DNA, causing the loss of the tumour suppressor gene E2 which allows uncontrolled cell division leading to cervical intraepithelial neoplasia (CIN).[4]

It takes 15-20 years for HPV to integrate into the host DNA and cause CIN which can then progress from mild to moderate to severe dyskarosis and, if untreated, to invasive cervical cancer.[5]

HPV is also responsible for an important fraction of other anogenital and orophyaryngeal cancers. It accounts for 90% of anal cancers, 40% of vulval and vaginal cancers, and 35% of oropharyngeal cancers. HPV is also responsible for 90% of cases of genital warts.[6]

Cervix

The cervix is made up of two types of skin: glandular cells lining the endocervix (inside the cervix) and squamous cells which line the ectocervix (outside the cervix). Where these cells meet is known as the transformation zone (TZ) and it is vulnerable to the HPV virus. When a cervical screen is done, the transformation zone is the area on the cervix where the cells are brushed off from and is the area that is looked at under magnification using dyes and fluids at colposcopy to identify abnormal cells.[2]

Screening

In Ireland cervical screening as we know it now, with a robust call and recall system 'CervicalCheck', only began in 2008. At that time cervical screening was offered freely to women every three years aged 25 to 44 years and five yearly for women aged 45 to 60.

At this time cells were brushed off the neck of the womb and looked at under a microscope. Now when the cells are brushed off the neck of the womb they are first checked for the presence of high-risk HPV and if HPV is detected then the vial is checked for abnormal cells.

Two years later we rolled out a school-based vaccination programme. The first cohort of girls vaccinated began to turn 25 years old in 2019.

HPV vaccination

In 2010 HPV vaccination with a quadrivalent vaccine (HPV subtypes 16, 18, 6 and 11) rolled out into schools for girls in first year. In 2011/2012 there was a three year catch up programme for girls up to sixth year. In September 2019 vaccination in first year in schools included boys and this coincided with the switch to the nanovalent vaccine (HPV subtypes 16, 18, 6, 11, 31, 33, 45, 52 and 58).[7]

Initially the vaccine was given as a three-dose schedule which became a two dose schedule in 2014 and moved to a one dose schedule in 2023. The National Immunisation Advisory Committee (NIAC) recommends a single dose schedule of HPV vaccine for all those aged nine to 24 years of age. A two-dose schedule of HPV vaccine at an interval of zero and six-to-12 months for those aged 25 years and older (up to the age of 45 years). A three-dose schedule at zero, two and six months is recommended for specific cohorts considered to be immunocompromised.[7]

From December 2022 to December 2023 the HSE offered a catch-up opportunity to those who were not vaccinated as part of the HSE School Immunisation Programme. This programme was called the Laura Brennan HPV catch-up vaccination programme. All unvaccinated boys who were ≤ 21 years and all unvaccinated girls who were ≤ 24 years could avail of the HP vaccine free of charge through HSE vaccination clinics.[7]

HPV primary screening

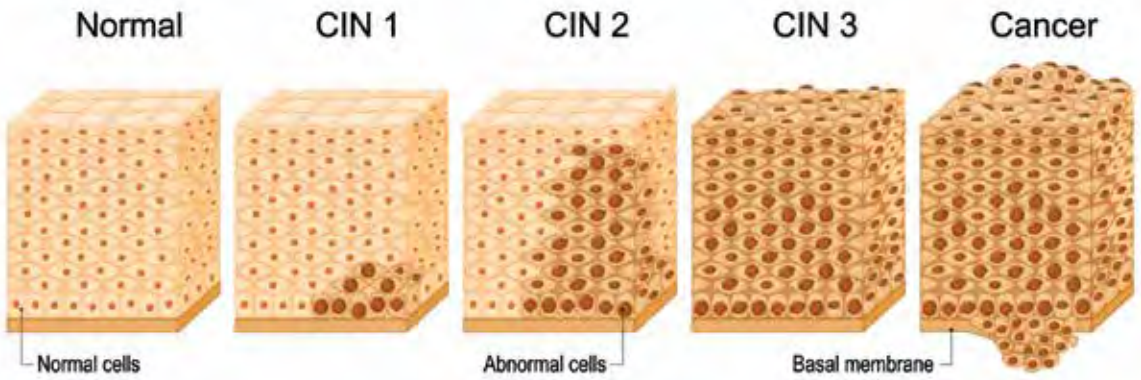
In March 2020 CervicalCheck moved to HPV primary screening. The high risk HPV subtypes looked for in the cervical screen are: 16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 66 and 68. The high risk HPV subtypes found in cancers diagnosed in Ireland are subtypes 16, 18, 31, 33, 52 and 58. The screening interval has changed now with women 25-29 years only, having three yearly screening and women 30-65 years having five-yearly screening.

When high-risk HPV subtypes are detected the cervical screen is then checked for abnormal cells. If no abnormal cells are found then a further cervical screen in 12 months' time in primary care is recommended. If abnormal cells are found then a referral for colposcopy is made.

Colposcopy

HPV vaccination and cervical screening are crucial to the cervical cancer elimination project; the third strand is diagnosis and management of CIN or the early detection of cervical cancer and the onward referral to a gynaecological cancer centre.

Close-up of a normal squamous cell and abnormal cells in cervical cancer



Colposcopy is the ability to look at the cervix under magnification using dyes and fluids to detect and, if necessary, treat pre-cancerous lesions before they become a cancer. It is important to reassure women that the vast majority of CIN will regress without treatment within two years and 60% of women diagnosed with CIN1 will regress spontaneously, as will 50% of CIN2. Treatment is always recommended to women with CIN3 or cGIN (changes in the glandular epithelium) as there is a much higher risk of progression to squamous cell cancer or adenocarcinoma respectively.

Women who are referred with low grade (LSIL, ASCUS) or negative cytology and have a normal colposcopy are returned to primary care for a repeat cervical screen in three years' time regardless of their age.

Women who are referred with low grade or negative cytology and have a low grade colposcopic impression and/or biopsy are usually conservatively managed as most resolve spontaneously and are returned to primary care for a repeat cervical screen in one year's time.

Women with CIN2 can be conservatively managed over a 24-month timeframe with interval colposcopy and cervical screening and will only be returned to primary care when two consecutive cervical screens 12 months apart do not detect high risk HPV.

Women with CIN3 and cGIN are always seen with post treatment follow up in the colposcopy screening clinic in six months for CIN and six and 18 months for cGIN.

Women with cervical cancer must have a biopsy with histological confirmation and an MRI pelvis with onward referral for management to a gynaecology cancer centre.

Signs and symptoms of cervical cancer

Screening is a very effective tool but it does not detect all women with abnormalities and while, HPV accounts for more than 90% of cervical cancers, there are non HPV types of cervical cancer. Therefore it is important that women and sample takers are aware of the signs and symptoms of cervical cancer.

For sample takers it is important to remember that cervical screening is a screening tool and is not for women with symptoms. It is important that sample takers are registered with CervicalCheck, and that they are familiar with the normal appearance of the cervix and are competent and confident to recognise deviations from the normal.[8]

If a malignancy is suspected then a cervical screen must not be taken but rather contact made with the local colposcopy service to discuss concerns for cervical cancer. Features suggestive for cervical cancer include, but are not limited to, a red granular area with an irregular surface on the cervix often with contact bleeding. There can be a frank growth or ulcer seen on the cervix. There can be a large bulging polypoid mass or an ulcerated growth that completely replaces the cervix and is very friable to touch.[8]

Cervical polyps, particularly asymptomatic ploops less than 5mm in size, do not need to be removed. Nabothian follicles or cysts are within normal parameters, as is an ectropian, and do not require colposcopy.

For women themselves, it is important they be aware of symptoms such as abnormal bleeding in-between periods (IMB), after sex (PCB), or after the menopause (PMB), abnormal vaginal discharge that may have a foul smell, pelvic pain or discomfort or pain or discomfort after sex (dyspareunia). These symptoms are common and have many causes which may not be related to cervical cancer but should be discussed and investigated.

Conclusion

Ireland is committed to the WHO's global initiative to eliminate cervical cancer. The first step towards elimination is that 90% of girls are fully vaccinated by age 15; we are currently at an 80% vaccination rate.

The second step is that 70% of women are screened with a high performance test by 35 years of age and again by 45 years of age; we currently have a 73% screening rate. The final step is that 90% of women identified with cervical disease receive treatment (90% of women with precancer treated and 90% of women with invasive cancer managed); we currently have a 97% treated rate.[1]

We must take every opportunity to increase the HPV vaccination rate in our eligible population.

Sinéad Cleary is an advanced nurse practitioner in women's health at Tallaght University Hospital, Dublin

** In using women I am also including all those born with a cervix and its use is meant in the most inclusive way*

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Menopause and a history of VTE or CVD

Recent research provides reassurance about the use of HRT in women with a history of thromboembolism, however those with established CVD need an individualised approach, write **Brenda Moran, Karen Soffe** and **Rachel Guerin**

FOLLOWING the introductory article on complex menopause in the summer issue, this month we will discuss two types of complex cases that are commonly referred to the complex menopause clinic:

- Patients with a previous thromboembolic event or a known thrombophilia disorder, such as factor V Leiden, protein S or C deficiency or antiphospholipid syndrome
- Patients with a personal history of a significant established heart disease.

Previous thromboembolic event (VTE) or known thrombophilia disorder

Historically a thrombophilia disorder or a previous venous thromboembolism (VTE) were considered a relative contraindication to hormone replacement therapy (HRT).

However, the current 2019 update of the NICE guidelines on the management of menopause states: "The risk of VTE is increased by oral HRT compared with baseline population risk, however the risk associated with transdermal HRT given at standard therapeutic doses is no greater than baseline population risk. Consider transdermal rather than oral HRT for menopausal women who are at increased risk of VTE, including those with a BMI over 30kg/m^2. Consider referring menopausal women at high risk of VTE (eg. those with a strong family history of VTE or a hereditary thrombophilia) to a haematologist for assessment before considering HRT".[1]

In addition, since that publication, there has been a wealth of international research and now most guidelines are at last in agreement, that topical oestrogen at low or standards doses (ie. ≤ 50mcg patch oestradiol or equivocal), does not increase the incidence of VTEs. Micronised progestogens or local progestogen such as levonorgestrel delivered in an intrauterine system (IUS) device do not significantly increase the risk of VTE. However, these studies were in healthy women; data in women with a history of thrombophilia or VTE is limited. In simple terms, these patients are at high risk of a VTE whether they use low dose topical HRT or not.

When we see these patients at the complex menopause clinic in Cork University Maternity Hospital, we use the opportunity to discuss their baseline risk of VTE, which is higher than that of the general population. We revise everything that may further increase their risk and discuss ways to reduce their impact.

This includes advice such as the benefit of exercise, avoiding weight gain, and advice on things that may increase their risk further such as a hospital admission, dehydration and long-haul flights. It is often several years since these women had their original diagnosis and these issues may not been discussed for a long time.

Special consideration must be given to women on anticoagulants in terms of the risk of excessive bleeding when prescribing HRT. Patient information leaflets such as 'Menopause and clots' produced by Thrombosis Ireland (thrombosis.ie) are useful. We discuss all forms of treatments including lifestyle modification, non-pharmaceutical treatment such as cognitive behavioural therapy (CBT), and prescribable alternatives. If after a risk-benefit analysis we are prescribing HRT, we would use the lowest effective dose, and a micronised progestogen or a levonorgestrel IUS.

Patients are still frequently asked to stop their HRT in advance of a planned hospital admission or procedure. In the case of oral

Role of the clinical nurse manager in managing menopause in women with a history of VTE or CVD

DISCUSSING a patient's lifestyle is of key importance in helping to reduce cardiovascular or VTE risk factors. A visit to the clinic can be overwhelming for some patients, with a lot of information to take in and decisions to be made.

Taking a patient's history to see where they are currently in their exercise and diet journey is important. Many women struggle with weight management during the perimenopause and menopause and can be disheartened. Reassuring women that they are not alone in this experience and journey helps women gain back some power to make changes to their lifestyle. Where to start can be overwhelming for many, but looking at the overall picture of the health gains rather than the weight loss is often more motivational.

Each woman has a different experience, health concerns, work and family life which may limit their ability to optimise their lifestyle, so it is important to make specific and measurable goals for each individual patient. Encouraging small starts and changes can lead to long-term benefits for their cardiovascular, bone and mental health.

As a nurse, it is my job to help alleviate the anxiety of starting a new health journey and help motivate a change. For each patient I create a pack specific to their complex health and menopause, with local resources or initiatives for exercise and diet. I also source placebo samples of different types of HRT that women can see in the clinic to indicate which would suit them and their lifestyle best. I often refer on to other services such as physio, CBT workshops etc.

– Rachel Guerin, CNM2

preparations this may be appropriate, but they should be advised to discuss changing to a topical preparation with their menopause care provider to reduce their VTE risk. In the case of a patient on a topical oestrogen, there is no evidence that stopping their treatment will reduce their VTE risk and in fact this tends to cause troublesome rebound menopausal symptoms which may impede their recovery.

History of cardiovascular disease

Cardiovascular disease (CVD) is the leading cause of death in women and, according to the World Heart Federation, is responsible for one in three deaths globally.[2] Over the past decade, the prevalence of CVD risk factors and CVD events has increased in women, particularly in younger women. Cardiovascular disease in women remains understudied, under-recognised, underdiagnosed and undertreated.[3] It appears that there are physiological differences between cardiovascular disease in men and that experienced by women.

Most scoring systems for cardiovascular risk are believed to underestimate the risk in women; some additional risk factors in women such as pre-eclampsia, migraine with aura, polycystic ovary syndrome (PCOS) and gestational diabetes are not included in these scoring systems despite the fact they are shown to increase the risk of subsequent CV events.[4] Women with hypertension or diabetes also have a significantly higher rate of cardiovascular events than their male counterparts with the same risk profile.[3] Women frequently do not present with classic symptoms such as typical angina, further contributing to their increased incidence of late presentation and poor outcomes.[5]

Oestrogens have long been known to contribute to multiple cardiac and vascular functions, including blood pressure, endothelial function, cardiac remodelling and vascular reactivity.[6] A cardioprotective effect of oestrogen was hypothesised and it was suggested that the lower levels of oestrogen after menopause cause the increase of cardiovascular risk for women in midlife. We know that women who have premature ovarian failure have a higher incidence of cardiovascular events and this is even more pronounced following a surgical menopause.[7] Adverse alterations in body composition and lipids/lipoproteins have also been observed in the menopause transition.[6]

The type of menopause transition a woman experiences also appears to have an effect on her cardiovascular risk. Several large longitudinal studies, such as the Study of Women's Health Across the Nation (SWAN), have shown that the frequency and severity of vasomotor symptoms especially in younger women is associated with a higher risk of CV events and potentially cerebral vascular disease.[8,9]

The history of HRT use and cardiovascular disease has been somewhat of a roller-coaster ride. Two large scale studies, the Heart and Estrogen-progestin Replacement Study (HERS)[10] and the Women's Health Initiative (WHI) study[11] were specifically designed to see the effect of HRT on cardiovascular outcomes. Both reported an increase in CV events, mainly in the first 12 months and in older women who commenced HRT > 10 years post menopause.

Subsequently analysis of the WHI results by age group,[12] and more recent randomised control studies, including the Kronos Early Estrogen and Prevention Study (KEEPS)[13] and Early Versus Late Intervention Trial (ELITE),[14] demonstrate that the risk of adverse cardiovascular events for hormone therapy are low for women < 60 years of age or within 10 year from menopause. This finding and some animal studies have led to the 'timing hypothesis', which postulates that HRT effects are determined by timing of initiation according to age and/or time-since-menopause plus the underlying health of target tissue and duration of therapy.

While the all-cause mortality in women aged 50-59 years taking HRT on the two WHI randomised trials during the intervention phase was significantly reduced, and this reduction in mortality was still present at an 18-year follow up, HRT has not been shown to be of enough benefit to use as primary prevention for cardiovascular disease. Smoking cessation, blood pressure control, treating hyperlipidaemia and control of diabetes all have better results in terms of reducing the incidence of further events.

When a patient presents to our clinic with already established cardiovascular disease, we take an individualised approach to help them manage their menopause transition. This process has a number of

Table 1. Step by step approach to menopause management in women with a history of CVD (CUMH)

Step 1: • Evaluate the patient's menopausal symptoms and the degree to which they are affecting their quality of life
Step 2: • Endeavour to establish patient's current cardiovascular health, often with input of their cardiologist • Establish their individual CV risk factors and ensure that these are being managed in an optimal way • Spend time discussing lifestyle factors such as reducing stress, improving sleep, regular exercise and weight management. These will all have a positive impact on their CV health as well as their menopause symptoms
Step 3: • Discuss non-hormonal treatments where possible including CBT, acupuncture and non-hormonal options to manage menopausal symptoms • Offer vaginal oestrogen to treat genito-urinary syndrome of menopause (if present), as it has no effect on CV risk
Step 4: • Discuss the potential risks (often unknown) versus the benefits of a trial of HRT • If necessary, liaise with their cardiologist to see whether further investigations are required prior to considering HRT or to arrange a plan for review to evaluate if disease progression has occurred after commencing
Step 5: • Always recommend non-hormonal options initially but if symptoms persist in spite of our interventions and are significantly debilitating, we can initiate HRT • Use ultra-low dose topical oestrogen and a micronised progestogen. We aim to use the lowest dose possible and for the shortest duration • Close monitoring is required as the biggest risk of a further CV event appears to be in the first 12 months • Aim to use HRT for the shortest duration possible, however it should be weaned slowly as it is postulated that acute withdrawal of oestrogen may predispose to cardiac events

steps and may take place over multiple visits *(see Table 1)*.

There is a dearth of research regarding the effect of HRT on other cardiac conditions such as cardiomyopathy, atrial fibrillation and valvular heart disease. Women tend to be under-represented in studies and in clinical trials across the cardiology field in general, and therefore there is little or no quality studies on the effect of HRT on disease progression in patients with these conditions. Frequently these cases need close collaboration with their cardiologist and we also have to consider their stroke risk, whether they are on anticoagulants and other co-morbidities.

Conclusion

In recent years, research and the use and availability of topical preparations of HRT has provided some reassurance around the use of low/standard dose HRT in women with a previous VTE or those with a thrombophilia disorder. However, more research is required regarding the use of newer topical forms of HRT in those with established cardiovascular disease. Until this is available care can only be provided using a highly individualised, patient-centred, shared decision-making approach. This is one of the values of having the regional complex menopause clinics throughout the country.

Next month: Managing menopause in patients with a history of breast cancer

Dr Brenda Moran and Dr Karen Soffe are joint clinical leads and Rachel Guerin is the clinical nurse manager of the Complex Menopause Service at Cork University Maternity Hospital

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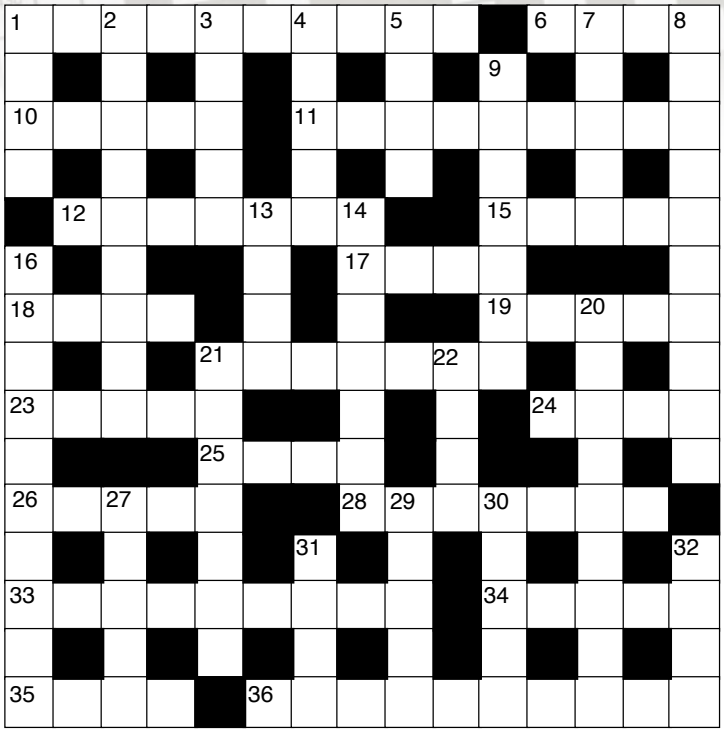
Across

1 Intestinal illness that might make a rustic flag? (7,3)
6 American Midwestern state, capital Columbus (4)
10 Scour, brush thoroughly (5)
11 Opponent (9)
12 It's a strange golf map that helps motorists in poor visibility! (3,4)
15 Large South American water rodent (5)
17 Medieval instrument of torture (4)
18 Extremely dry (4)
19 & 21d Spirit served up in the holy local (5,7)
21 Put one's name forward for a job (7)
23 Purloin (5)
24 Mimics (4)
25 Piece of money (4)
26 Fleeting film-piece or piece of jewellery (5)
28 Is it prescribed in order to make your lug lower? (7)
33 Space traveller (9)
34 Versatile Mediterranean fruit (5)
35 Birds' home (4)
36 Might the tiniest nod cause this painful inflammation? (10)

Down

1 Flow copiously (4)
2 Preach (9)
3 Insurrectionist (5)
4 Amulet (5)
5 Molten rock from a volcano (4)
7 Of considerable weight (5)
8 & 32d Completely fatigued - having used all your other lower limbs? (2,4,4,4)
9 Hoodwinked (7)
13 In as quick a time as can be achieved (1111)
14 How sweet, to upset an Alpiner (7)
16 Children make it by using small meadow plants (5,5)
20 Mesmerist (9)
21 See 19 across
22 Middle-Eastern potentate (4)
27 Butterfly-like creatures (5)
29 Performed a role in a play or film (5)
30 Perish in water (5)
31 Inland body of water (4)
32 See 8 down



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Summer crossword solution

Across: 1 High jumper 6 Aged 10 Tweed 11 Stem cells 12 Attends 15 Outdo 17 Tomb 18 Idea 19 Amman 21 Vagrant 23 Horse 24 Zinc 25 Race 26 Shoot 28 Deserts 33 Integrity 34 Venus 35 Turn 36 Footbridge

Down: 1 Hate 2 Great Bear 3 Judge 4 Mused 5 Ewer 7 Gilet 8 Disconnect 9 Acrobat 13 NASA 14 Started 16 Night shift 20 Moistened 21 Vertigo 22 News 27 Otter 28 Egypt 29 Elver 31 Lido 32 Isle

The winner of the Summer crossword sponsored by MedMedia is Regina McDonagh, Ennis, Co Clare

New mothers safe to spend first 24 hours of induced labour at home

FIRST-TIME mothers are safe to spend the first 24 hours of induced low-risk labour in the comfort of their own homes, a study conducted by researchers from the Royal College of Surgeons in Ireland and the Rotunda Hospital has suggested.

The RCSI-Rotunda HOME INDUCTION study examined what happens when first-time mothers choose to have labour induced as an outpatient at 39 weeks and then return home to wait for labour to start.

The findings, published in *The Lancet*, showed that the mothers' experiences were generally positive and that there were no additional risks for the birth.

The study comprised a randomised trial which compared methods of induction at 39 weeks in the outpatient setting for 271 normal-risk first-time mothers. Each mother had labour induced as an outpatient, either with a prostaglandin gel or a device that dilates the cervix, then went home for 12-24 hours before returning to the hospital to give birth.

The study showed that both induction approaches were safe and effective in the outpatient setting. Three-quarters of the mothers in the study successfully delivered their babies vaginally, which meant there was no increased risk of Caesarean delivery compared to women who did not choose induction at 39 weeks. Patient surveys demonstrated high levels of patient satisfaction on the study.

Fergal Malone, professor of obstetrics and gynaecology, RCSI, and consultant in obstetrics and gynaecology, Rotunda Hospital, said: "Induction of labour at 39 weeks' gestation has been shown to be safe and effective for first-time mothers and it minimises the chances of Caesarean section while maximising safety for mother and baby and if mothers would like to start the process of induction in an outpatient setting, it could help to alleviate the pressure on busy maternity hospitals."

Prof Malone, who was the lead author of the study, continued: "But until now, there has been minimal data available to guide mothers, midwives and obstetricians on how safe and effective it is to start the induction of labour as an outpatient.

"Given that more patients are now choosing induction of labour, this is causing challenges for busy maternity hospitals which struggle to manage these large patient numbers while trying to optimise patient comfort and safety. Outpatient induction of labour is an emerging system that might enable larger numbers of patients to choose induction if that is their preference, while remaining in the comfort of their own home."

Anti-nausea drug approved for reimbursement

DOXYLAMINE/PYRIDOXINE, indicated for the management of hyperemesis gravidarum, has been added to the reimbursement list for the community drug scheme as of August 1, 2024.

This move will support greater access to the drug, sold under the brand name Cariban, for the women who require it.

Cariban will now be available with a prescription from a GP and women will no longer have to attend a consultant to access the medicine.

Cariban has been in high demand since it was made available under an exceptional arrangement in early 2023 and this latest step removes barriers to women accessing this treatment.

Under the Drugs Payment Scheme, the total cost of prescription medicines, including Cariban is €80 per month per family.

Hyperemesis gravidarum is characterised by persistent nausea and vomiting during pregnancy and is typically treated through lifestyle and dietary changes as well as anti-nausea medication.

Podcast series dispels epidural myths

EPIDURALS have no impact on breastfeeding success, according to consultant neonatologist Dr Afif El-Khuffash.

"We've done two studies in the Rotunda Hospital with hundreds and hundreds of women and we found no association between getting an epidural and the success of breastfeeding, when you account for other potential confounders," he said.

"So it's a very important message to send out that an epidural, when everything else is taken into consideration, has no impact on breastfeeding".

Speaking alongside Dr El-Khuffash on 'The Baby Tribe' podcast, Dr Anne Doherty, consultant anaesthesiologist, said while no procedure was without risk, cases of serious complications were "exceedingly rare".

On the risk of meningitis or epidural abscess, Dr Doherty said the risk is around one in 100,000 for an incidence of meningitis related to an epidural placement. For an epidural abscess (infection), the risk is around one in 50,000.

She added that cases of paralysis or severe nerve injury are thought to occur in about one out of every 250,000 procedures.

"Regarding paralysis or severe nerve injury, I have never seen it. It is exceedingly rare," she said.

On the less serious but more common side effects, such as bruising at the injection site or a reduction in blood pressure, Dr Doherty said these are normal and are rarely worth worrying about.

"About one in 1,000 people can get a little numb patch that takes a few weeks or a few months to completely go away. That's just related to how the nerve itself regenerates a numb patch. It's just a little compression nerve injury because you're not moving around the bed as you normally would be.

"A fall in blood pressure can happen to one in 50. That's 2%. And that is just because the blood vessels dilate a little after you get an epidural. And you just need a little more fluid to fill it up a little bit," she added.

The Baby Tribe is co-hosted by Katie Mugan a paediatric and public health nurse and lactation consultant with over 20 years' experience and is available on most podcast platforms.

First-ever national diabetes strategy mandated by Minister for Health

Strategy review group due to report back within six months

MINISTER for Health Stephen Donnelly welcomed the first meeting of the Diabetes Policy and Services Review Group, which was established recently.

Welcoming the review group members who gathered at the Department of Health in July, Minister Donnelly said: "Diabetes is a major health challenge for our population and managing diabetes is a major challenge for our health services."

"I have mandated the establishment of the Diabetes Policy and Services Review, so we can improve patient outcomes, minimise the health complications associated with diabetes and ensure that our health services are best organised to provide the patient care and support needed by people living with diabetes."

Prof Derek O'Keeffe, HSE national clinical lead for diabetes, provided an overview of current diabetes care systems.

"I am delighted to chair this Diabetes Strategy 2030, which has a wonderful multidisciplinary group of stakeholders including people with diabetes, diabetes advocates, clinicians and management professionals, all of whom will work collaboratively to build a better tomorrow for diabetes care in Ireland."

Kieran O'Leary, chief executive of Diabetes Ireland, outlined the importance of this review : "We have never had a national diabetes strategy providing us with the vision, leadership and a forward-looking plan that provides optimum care for every person living with diabetes in Ireland.

"Our goal has to be to develop a strategy that will fully meet their needs, is resourced to do so and is fundable."

Approximately 300,000 people in Ireland are estimated to be living with diabetes and it is the most prevalent chronic condition in those aged 45-75 years. The Diabetes Policy and Services Review is charged with providing a report to the Minister within six months, identifying gaps and weaknesses in current diabetes services and a set of actions and a plan to improve service delivery and patient outcomes.

The steering group leading the review, which includes representatives of the Department of Health, the HSE and Diabetes Ireland, has already met several times and the final document will be published once the review is concluded.

September

Monday 9
Inclusion Health Section meeting. 11am In person and online

Tuesday 10
PHN Section meeting online

Thursday 12
RNID Section meeting. 2.30pm online

Friday 13
Inclusion Health Section conference. Richmond Education and Event Centre. 9am

Monday 16
Nurse/Midwife Education Section meeting. 9am online

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

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

Thursday 26
Assistant Directors Section meeting. 2.30 online

October

Saturday 5
Operating Department Nurses Section conference. Slieve Russell Hotel, Co Cavan. 9am

Tuesday 8
Clinical Placement Co-ordinators Section seminar. Richmond Education and Event Centre

November

Thursday 21
All-Ireland Midwifery Conference Fairways Hotel, Dundalk, Co Louth. See *page 18*

December

Friday 6
Occupational Health Nurses Section conference. Richmond Education and Event Centre

INMO Membership Fees 2024

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

Condolences

- The management, staff and residents in the Dean Maxwell Community Nursing Unit, Roscrea offer their deepest sympathies to the family of senior staff nurse Mary Doughan on her sudden passing recently. Mary was due to retire after many years of service and also worked with the palliative care services in the community. Our thoughts are with her family, friends and colleagues. May she rest in peace.
- We were shocked and saddened to hear that Lizy Abraham Saju, who worked in the Meath Community Unit in Dublin 8, recently lost her life in a tragic car accident. She will be dearly missed by all of her colleagues and peers at the INMO and in her workplace. We extend our heartfelt condolences to her husband and children, her mother, her grandchildren and extended family.
- The INMO extends its most sincere condolences to Aiveen Ahern from the communications department on the recent passing of her mother Maeve Cleary in the care of the staff in the Mater Private Hospital. Maeve is lovingly remembered by her husband Michael, children Aiveen, Anne-Marie and Eoin, grandchildren and extended family. May your fond memories sustain you during this difficult time.
- The Mullingar Branch extends its sincerest condolences to branch member Jenny Tobin on the death of her husband Terry, who passed away recently. Our thoughts are with Jenny, her daughter Laura, her son Philip, daughter-in-law Áine and the extended Tobin and McCourt families. May Terry rest in peace.
- We share the sadness of INMO industrial relations officer Gráinne Walsh on the recent passing of her sister Aoife. Aoife will be missed by her son Ruaidrí, her partner PJ, her mother Anne, siblings Gráinne, Céara, Róisín, Enda and John and extended family. May she rest in everlasting peace.

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

Exciting changes coming to Nurse2Nurse

As part of our commitment to providing you with an enhanced online experience, the library is changing how members will access our online resources, including databases and journals.

What does this mean?
- The Nurse2Nurse website will cease to exist
- All library resources will be accessible via the INMO website: **inmo.ie/library**
- Access to library resources will be via OpenAthens

This change will occur over the coming months, so to ensure uninterrupted access, register for OpenAthens by emailing niamh.adams@inmo.ie or call 01 6640625

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Occupational Health Nurse Office of the CMO, Civil Service Occupational Health Department

The Civil Service Occupational Health Department (CSOHD) operates within the Office of the Civil Service Chief Medical Officer (CMO). The CMO's Office is part of the Department of Public Expenditure NDP Delivery and Reform.

The Occupational Health Nurse will have day-to-day responsibility for nurse lead pre-employment medicals, health surveillance, immunisations and health promotion initiatives. They also work collaboratively with Occupational Physicians on first line case management, including conducting both telephone and face to face consultations.

The Occupational Health Department is based in purpose built premises in Smithfield, Dublin. In addition, the service conducts regular nurse lead immunisation programmes in clinics in Greater Dublin/Leinster area.

A panel will be formed from this competition to fill current and any future vacancies that may arise.

Further information about the CSOHD is available on www.cmo.gov.ie

Full details of the role, including specific eligibility requirements is available on www.publicjobs.ie

The role can be discussed informally with Monica Donnelly OHN or Sinéad Brady OHN by phoning 01-6045341.

Closing Date: 3pm on Thursday 19th September 2024.

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Web: **www.clarecastledaycare.com**

Night nurses needed

The Irish Cancer Society are seeking Registered Nurses, qualified in General or Paediatric Nursing, who have some palliative care experience to deliver end-of-life care to seriously ill patients in their home.
We require 4-6 nights per month availability.
Training will be provided. Job description on **www.cancer.ie**
Email CV to **recruitment@irishcancer.ie**
Informal queries to Amanda on 01 231 0532 or **awalsh@irishcancer.ie**

Irish Cancer Society

Read a good book recently? Write a review for *WIN*

Every month we publish a book review written by one of the *WIN* team or by an INMO member. It doesn't have to be nursing/midwifery related, but if you have read something that you found helpful to your practice, please consider writing a review for an upcoming issue of *WIN*.

Submit your review to nursing@medmedia.ie

Word count: 400

CALL FOR ABSTRACTS

The 30th International Council of Nurses'(ICN) Congress will take place 9-13 June 2025 in Helsinki.

With the theme, ***Nursing Power to Change the World,*** we invite abstract submissions that align with this theme and address the diverse challenges and opportunities facing nursing professionals today.

Abstract submission is open to all INMO members.

ICN also encourages undergraduate student nurses to participate by submitting their abstracts.

ICN International Council of Nurses

Helsinki 2025
ICN Congress

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9-13 **JUNE**

Abstracts for an oral or e-poster presentation can be submitted from:
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https://icncongress.org/220/page/abstract

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