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WIN

Journal of the
Irish Nurses and
Midwives Organisation

World of Irish Nursing & Midwifery

Latest INMO CPD education programme
See page 33

Oireachtas called on to tackle overcrowding
page 9

Menopause at work – survey results
page 22

Advanced midwifery practice
page 26

Genetic testing in cancer
page 53

Justice and recognition

INMO memorials for Stardust and Covid unveiled

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Retirement Planning Webinar

Thursday, 24 March 2022

Online from 2.00pm - 3.30pm

Unfortunately due to Covid-19 and the need for social distancing all retirement seminars have been cancelled. INMO Professional in partnership with Cornmarket Financial Services have developed an online webinar to help support members planning for retirement.

Places must be booked in advance to join this webinar. Following registration you will then receive instructions on how to join so you can save the date and time in your diary and join us on the day. These sessions will briefly cover the following:

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

Following the training you will then be given an opportunity to make an appointment with one of the financial experts where you can discuss with them your own situation in more details.

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Breastfeeding: The best start

Health benefits for infants

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

Long-term benefits for children

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

Benefits for mothers

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

Support for mothers is essential

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

Work and breastfeeding

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

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The Irish Nurses and Midwives Organisation supports breastfeeding

For more information log onto www.breastfeeding.ie

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Fitting tributes to remember

THE past month has seen the unveiling of two memorials at the INMO's Richmond Education and Event Centre. The first of these is in remembrance of those who lost their lives during Covid-19 and particularly the brave healthcare workers worldwide who met the challenge head on and paid the ultimate sacrifice. It was fitting that the Taoiseach unveiled this memorial and paid tribute to the victims of Covid-19 and the professions of nursing and midwifery for their extraordinary contribution to the care of the nation at this terrifying time.

A second memorial to mark the 41st anniversary of the Stardust tragedy was also unveiled and the INMO Executive Council was delighted to host the families and some survivors of the night at the Richmond. Nurses on the frontline were shaped by the tragic events of that night as was the generation of nurses and midwives who started their working lives during the Covid-19 pandemic.

I invite all members to come to see the memorial benches at the Richmond Centre whenever nearby. It was a privilege to work with all involved to ensure these fitting tributes reflected what members of the INMO envisaged when the Richmond was purchased as a testimony to our members' values of caring and social consciousness. In the run up to the event, family members of the Stardust victims and survivors again and again expressed the gratitude they hold for members of our profession, for the dignity and respect shown to them at the time and in the subsequent years of follow-on medical care and attention.

As set out in last month's *WIN* the pandemic is not over, despite the relaxation of public restrictions. We urge caution about the relaxation of mask-wearing. We all remember the battle the INMO had to get agreement for mask-wearing in healthcare settings in March/April 2020 and the resultant decrease in the number of infections. As we go to print, despite requests from many trade unions, including the INMO, the government is set to remove the compulsory requirement for mask-wearing in all public settings (though it will continue to apply in healthcare settings). Unfortunately, this will inevitably lead to greater spread and contagion and more hospital admissions.

As everyone working in this system knows, the current occupancy, overcrowding and inhumane conditions that have existed for patients and staff working in these environments have not been caused by Covid-19, but they have worsened due to it. It is extraordinary that the HSE tries to argue that Covid-19 delays in care have caused the current overcrowding. On March 26, 2006, the then Minister for Health Mary Harney declared overcrowding in our hospitals a national emergency; it is clear that successive governments have not learned any lessons on how to tackle this crisis. Hospital overcrowding is now a common part of Irish winters, with 2021/2022 being no different. The management of this ongoing problem is again reflected in the lack of urgency in convening the national emergency department taskforce or implementing regionalisation of the health service as set out in Sláintecare to ease this problem. This complacency reflects an acceptance of this endemic disgrace.

Patient groups and those working in overcrowded environments must present the government with the reality of these avoidable events. Thus we have called for an Oireachtas Health Committee examination. This union does not accept that the 'cause' of the overcrowding since November 2021 is increased patient numbers attending hospitals due to delayed care during the pandemic. That is simply an excuse trotted out to cover up lengthy inaction and disregard for the right to expect safe care in a timely fashion, and a safe working environment for those trying their best to provide it against the odds. We will continue to highlight the issue daily and look forward to an invitation to appear before the Oireachtas Health Committee.

Phil Ní Sheaghdha
General Secretary, INMO

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A positive focus with the president

Karen McGowan, INMO president

Fight for rights rages on

INTERNATIONAL Women's Day is always a favourite day of mine and one that we need to use to promote and support each other. It is a time to appreciate the advances we have made but acknowledge the distance we still have to go. The INMO has been fighting for gender equality for years and the fight continues, whether in relation to period poverty, menopause awareness or gender-based violence. As nurses and midwives, we are uniquely positioned to be a support to ourselves and our patients. We know that women were disproportionately affected during this pandemic, and we will continue to advocate for members and defend the rights of female workers. The Executive Council and officers would like to wish you all a very happy International Women's Day 2022.

Advanced practice in midwifery-led care

THIS month I spoke with Roisín Lennon, who is one of 17 registered advanced midwife practitioners in Ireland. She is based in Sligo University Hospital, where she is the only AMP. Ms Lennon told *WIN* that her role evolved through addressing the needs of women who didn't suit the original midwifery-led care pathway.

There are distinct criteria for women who are deemed high risk in pregnancy. Ms Lennon explained that advanced practice is expanding the midwifery philosophy to a group that would not have traditionally met the criteria for midwifery-led care. The results are that women are happy with and fully embrace this accessible service.

"Midwifery-led care is very safe and gives us the opportunity to better explain and answer questions that women in our care might have. They are accompanied on their journey and are given that safety net," she said.

Since 2016, Ms Lennon has seen changes in midwifery-led care and has watched the service expand. She told *WIN* that her original nurse training has led her to be the motivated practitioner she is today. The clinics are extremely busy but she loves being in the middle of it all. The joy the role gives her is being able to assist women on their journey and making a difference to them during difficult times.

She said: "The women never forget the support they get. I've often been stopped while shopping and shown the babies that I helped along their journey.

"It is wonderful to see that the career pathway has expanded to advanced practice where there is the clinical focus. It is not just in the management route where career progression happens now.

"Seeing midwifery catch up with nursing in advanced practice roles is exciting. There are 12 candidate midwife practitioners and 17 registered midwife practitioners currently. This is so positive and encouraging for junior midwives."

The upcoming International Council of Nurses/Advanced Practice Network conference will be a wonderful opportunity to showcase what midwifery is doing in the Irish setting.

• *See 'Midwives embracing advanced practice roles', page 26*

Executive Council update

THE Executive Council met via a hybrid model this month. The Council previously sanctioned the formation of two memorial seats and we had the unveiling to commemorate those who lost their lives at the 1981 Stardust tragedy and to Covid-19. It is important to the Executive to create a space that families can come and remember those who have passed.

The diary, as far as conferences are concerned, is filling up. Some will be delivered online, such as the European Federation of Nurses Associations (EFN) assembly and International Council of Nurses (ICN) conference. In the Irish context we have the All-Ireland Midwifery Conference later this month.

A number of national issues were considered and discussed by the Executive Council, such as the hours report. This now needs to be brought to cabinet formally by Minister for Public Expenditure and Reform Michael McGrath. The expert review group has issued its report and the recommendations were also considered, while further engagement has been sought with the HSE.

It has been indicated that the pandemic bonus will be paid by March 31. The Executive Council will continue to advocate for members and ensure your voices are heard.

Nationally the trolley crisis continues, and this was debated by the Executive Council. INMO ED reps will be convened with a view to reviving the ED agreement and highlighting the non-adherence to its terms and conditions. The feedback from members is clear – this is a national crisis and workers are beyond stretched to capacity.

The next meeting of the Executive Council is scheduled for March 14 and 15.

If you would like to showcase your nurse-led initiative or role, please get in touch with me via the email address below.

Get in touch

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

"We can't go back to pre-pandemic levels of hospital overcrowding"

ON THE publication of its first monthly TrolleyWatch report of 2022, the INMO said that chronic overcrowding cannot be allowed to become the norm once again in our hospitals.

This came as 8,636 patients were on trolleys in the month of January, 132% higher than January 2021, which saw 3,715.

University Hospital Limerick was once again top of the list of overcrowded hospitals with 1,300 admitted patients on trolleys during the month. The hospitals with the next highest number on trolleys were: Letterkenny University Hospital (817); Cork University Hospital (750); University Hospital Galway (738); and Sligo University Hospital (526).

Commenting on the figures, INMO general secretary Phil Ní Sheaghdha said: "We cannot allow a return to pre-2020 business as usual in our hospitals where chronic overcrowding is allowed to continue. In the first month of the year we had overcrowding records broken in our hospitals, with University Hospital Limerick logging record overcrowding two days in a row.

"We saw the highest levels of January overcrowding since the INMO began TrolleyWatch in 2006 in University Hospital Limerick, Letterkenny University Hospital, Mercy University Hospital, Portunicula Hospital, Sligo University Hospital and University Hospital Galway.

"It is not acceptable to us that chronic overcrowding is allowed to continue while Covid-19 is still rampant in many of our hospitals. Our members are frankly embarrassed and tired of apologising to patients for the poor standard of care environments," said Ms Ní Sheaghdha.

"The HSE must take steps to ensure that this chronic overcrowding isn't allowed to continue.

"Bespoke plans should be produced for hospitals where chronic overcrowding is a persistent feature of the hospital environment."

Table 1. INMO Trolley and Ward Watch (January figures 2006 – 2021)

Hospital	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
Beaumont Hospital	414	543	661	769	794	574	634	602	710	692	710	386	355	334	435	n/a	n/a
Connolly Hospital, Blanchardstown	259	280	250	286	216	456	378	279	635	595	372	225	363	286	307	n/a	5
Mater Hospital	482	433	568	538	531	345	324	356	292	410	481	505	542	537	607	137	375
Naas General Hospital	441	45	216	355	367	491	194	239	221	369	437	240	516	310	287	65	208
St Colmcille's Hospital	300	119	76	276	293	235	186	190	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
St James's Hospital	351	200	211	319	215	150	148	142	101	236	222	229	284	238	274	91	167
St Vincent's University Hospital	372	351	535	474	509	466	310	470	334	438	598	276	559	476	479	102	420
Tallaght Hospital	812	219	805	632	528	635	238	181	348	394	337	546	494	408	507	107	327
Children's Health Ireland, Tallaght	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	9	17	1	1	9
Children's Health Ireland, Crumlin	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	87	80	62	11	52
Children's Health Ireland, Temple Street	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	98	82	33	9	73
Eastern total	**3,431**	**2,190**	**3,322**	**3,649**	**3,453**	**3,352**	**2,412**	**2,459**	**2,641**	**3,134**	**3,157**	**2,407**	**3,307**	**2,768**	**2,992**	**523**	**1,636**
Bantry General Hospital	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	47	52	11	123	77	154	n/a	28
Cavan General Hospital	408	361	287	196	277	516	316	220	91	71	183	33	63	101	340	82	91
Cork University Hospital	293	273	413	446	726	695	574	443	361	366	600	667	832	947	1,107	522	750
Letterkenny General Hospital	320	428	57	57	43	64	118	42	247	437	110	522	671	587	392	111	817
Louth County Hospital	41	14	52	62	4	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Mayo University Hospital	158	253	168	271	261	144	91	165	256	311	159	70	321	257	422	83	337
Mercy University Hospital, Cork	197	165	200	155	169	272	117	316	211	170	228	290	355	291	431	105	472
Midland Regional Hospital, Mullingar	38	23	36	54	284	214	295	171	447	374	426	540	635	265	361	156	297
Midland Regional Hospital, Portlaoise	70	15	60	53	48	111	209	43	140	210	308	477	258	288	113	42	85
Midland Regional Hospital, Tullamore	40	n/a	4	32	55	205	186	77	249	219	319	503	556	337	203	144	220
Mid Western Regional Hospital, Ennis	157	197	28	29	35	127	21	79	n/a	7	92	46	40	24	45	27	56
Monaghan General Hospital	n/a	50	52	29	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Nenagh General Hospital	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	28	18	29	6	26	n/a	n/a
Our Lady of Lourdes Hospital, Drogheda	349	313	290	399	476	455	589	410	462	735	601	469	491	160	198	36	73
Our Lady's Hospital, Navan	21	164	131	107	31	178	117	85	421	189	69	259	153	95	382	13	26
Portiuncula Hospital	82	71	115	46	148	79	60	169	119	208	63	379	191	109	223	198	226
Roscommon County Hospital	79	91	162	165	146	191	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Sligo University Hospital	94	72	124	143	197	245	108	96	142	191	302	279	439	499	346	244	526
South Tipperary General Hospital	n/a	n/a	n/a	n/a	n/a	38	130	96	204	239	313	536	615	369	355	193	334
St Luke's Hospital, Kilkenny	155	27	134	54	158	52	126	245	294	158	302	556	511	629	824	2	187
University Hospital Galway	155	170	286	319	365	523	558	378	602	519	526	618	681	534	872	122	738
University Hospital Kerry	131	97	133	93	91	93	64	88	93	75	199	187	382	297	418	125	227
University Hospital Limerick	304	225	118	213	453	404	304	437	564	631	682	793	1,003	970	1,215	949	1,300
University Hospital Waterford	n/a	n/a	n/a	68	95	88	100	138	296	125	430	480	550	547	397	n/a	58
Wexford General Hospital	546	162	129	50	226	283	111	106	102	268	196	125	189	193	208	38	152
Country total	**3,638**	**3,171**	**2,979**	**3,041**	**4,288**	**4,977**	**4,194**	**3,804**	**5,301**	**5,550**	**6,188**	**7,958**	**9,088**	**7,582**	**9,032**	**3,192**	**7,000**
NATIONAL TOTAL	**7,069**	**5,361**	**6,301**	**6,690**	**7,741**	**8,329**	**6,606**	**6,263**	**7,942**	**8,684**	**9,345**	**10,365**	**12,395**	**10,350**	**12,024**	**3,715**	**8,636**
Of which under age of 16 years													211	190	104	23	144

Percentage increase/decrease:

2021 compared to 2022: 132%
2020 compared to 2022: -28%
2019 compared to 2022: -17%
2018 compared to 2022: -30%
2017 compared to 2022: -17%
2016 compared to 2022: -8%
2015 compared to 2019: -1%
2014 compared to 2022: 9%
2013 compared to 2022: 38%
2012 compared to 2022: 31%
2011 compared to 2019: 4%
2010 compared to 2022: 12%
2009 compared to 2022: 29%
2008 compared to 2022: 37%
2007 compared to 2019: 61%
2006 compared to 2022: 22%

INMO calls on Oireachtas to step in on out-of-control overcrowding

Department of Health, HSE and HIQA fail to take meaningful action

RESPONDING to spiralling increases in the number of patients on trolleys, the INMO has called on the Oireachtas to investigate hospital overcrowding.

This call came as INMO figures showed that 12,859 patients have been on trolleys in the first six weeks of the year with over 4,224 patients on trolleys in the first 10 days of February.

INMO general secretary Phil Ní Sheaghdha said: "The INMO is calling for the Oireachtas Health Committee to urgently investigate out-of-control hospital overcrowding. After months of a hands-off approach from the HSE, HIQA and the Minister for Health when it comes to dealing with hospital overcrowding, it is time for serious political intervention from members of the Oireachtas.

"By allowing hospital overcrowding to continue at this level, we are slowly creeping back to the bad habits that plagued our health service pre-pandemic."

In the first 10 days of February this year, the number of patients on trolleys has already surpassed the total for February last year. The count reached a shocking 603 on trolleys on February 8, which prompted the INMO to call for urgent action as the situation was out of control.

"Since the INMO first sounded the alarm on the creeping return of hospital overcrowding in July 2021, we have been very discouraged by the response by the arms of the State with the Minister for Health, the HSE and HIQA all reluctant to take action when we sought intervention.

"We now need to see political intervention to solve this endemic situation. We have requested that the Oireachtas Health Committee urgently reports on this issue and investigates why this out-of-control overcrowding is being allowed to continue in our hospitals and make recommendations to the Minister for Health and the Houses of the Oireachtas.

INMO president Karen McGowan said: *"It is not good enough that overcrowding is seen as an acceptable feature of our health service. Nothing substantial has been done to alleviate the pressure that our members are under"*

"This issue is not just of concern to nurses and midwives; people are afraid to fall ill because they do not want to face excessive overcrowding in their local hospital. This is no longer an issue that the arms of the State can ignore."

INMO president Karen McGowan said: "This issue is now endemic within our health service. While many hospitals regularly make the headlines for their overcrowding levels such as University Hospital Limerick, Letterkenny University Hospital and Cork University Hospital, this is a problem in every hospital across the country.

"It is not good enough that overcrowding is seen as an acceptable feature of our health service, especially when Covid-19 is still very much circulating in our hospitals posing real risk of cross infection. Nothing substantial has been done to alleviate the pressure that our members are under."

Caution urged on easing of required mask-wearing

THE INMO has called on the government to urge caution when it comes to the removal of the mask-wearing requirement outside of healthcare settings. The union further stressed the need for the mask mandate to remain in place until hospital overcrowding eases.

The union has asked government to consider the implications of the easing of mask-wearing on our healthcare system.

INMO general secretary Phil Ní Sheaghdha said: "The INMO is urging government to take serious caution when it comes to implementing this advice and take on board the current ability of the public health system to cope with additional pressure that the removal of the mask requirement may have on the health system.

"There is a clear link between reduced transmission and mask wearing. Removing the mask requirement in congregated settings particularly with poor ventilation, such as public transport, could have a detrimental impact.

"Our hospitals are under severe pressure. At time of speaking, 15,705 patients have been without a bed in our hospitals so far this year. Our nurses and midwives have been dealing with overcrowding coupled with Covid-19 transmission and are burned out and exhausted. We cannot have a case of increased Covid transmission within our hospitals at this juncture.

INMO general secretary Phil Ní Sheaghdha: *"Until government makes headway into dealing with the trolley crisis, the mask mandate should remain in place"*

"The pandemic is far from over for nurses and midwives. Government needs to exercise caution when it comes to easing mask requirements. Until government makes headway into dealing with the trolley crisis, the mask mandate should remain in place."

INMO director of industrial relations Tony Fitzpatrick updates members

Right of nurses and midwives to disconnect from work secured

THE right of nurses and midwives to disconnect from work outside of their normal working hours has been set out in a recent HSE circular. HR Circular 002/2022, issued on January 26, 2022, outlines in detail the rights and obligations of employers and employees in this area.

The 'HSE right to disconnect policy for public health service employees' applies to all nurses and midwives working in the HSE and Section 38 organisations. The policy was produced in accordance with the *WRC Code of Practice for employers and employees on the right to disconnect*.

The policy highlights that employers/health service management should engage with their employees and their unions on the implementation of the policy at local level and identify actions that may be required within their area of responsibility to ensure compliance with the objectives of the policy.

As stated in the WRC code of practice, occasional legitimate situations can arise where it is necessary to contact employees outside of their normal working hours, including but not limited to, ascertaining availability for rosters to fill in at short notice, when unforeseen circumstances may arise, where an emergency may arise and/or for business and operational reasons that require contact outside of the employee's normal working hours.

However, the unions have secured that this must not be a frequent occurrence and steps should be taken by management to address the substantive issue if there are frequent occurrences.

Section 10 of the policy clearly sets out a process for raising concerns if an individual's right to disconnect is not being respected. When contact outside normal working hours for scheduling roster arrangements becomes the norm, this needs to be addressed either informally or, if necessary, under the organisation's grievance procedure.

INMO members can contact their local rep for advice and assistance where they feel their right to disconnect is not being respected. Where an employee feels their workload is such that they are unable to disconnect at the end of their normal working day or shift, the issue can be raised via the HSE's grievance procedure. Examples of such situations include:

- Being contacted regularly outside of normal working hours
- Being expected to regularly work through meal breaks
- Feeling obligated to routinely work longer hours than those agreed in the terms and conditions of employment
- Inability to leave work on time due to excessive workload
- Being subjected to less favourable treatment for not being available outside of normal working hours.

As part of the implementation plan for this policy, the HR circular will be sent to all senior managers and is being communicated to all HSE employees. Importantly, it will also be communicated with new employees as part of the induction process and will be incorporated in training programmes for line managers.

The INMO has engaged proactively with the HSE to ensure the introduction of this new circular in relation to the right to disconnect. It is a common grievance raised by nurses and midwives that they are constantly being contacted by text or WhatsApp messages to fill staffing deficits.

This policy reinforces the right of individuals to disconnect from work and if there is persistent contact, this matter can be addressed via the grievance procedure or indeed collective engagement between the INMO and management locally.

It is important that this policy is policed appropriately and that members are vigilant and highlight their concerns to management and the INMO.

on recent national issues under discussion

Arrangements agreed for additional public holiday

THE INMO has engaged with the HSE to agree a HR circular for a one-off public holiday on March 18, 2022, in accordance with Statutory Instrument No 50/2022 – Organisation of Working Time (Covid-19 Commemoration) Regulation 2022, which was signed into law on February 7, 2022.

These regulations provide for a one-off public holiday entitlement on Friday, March 18, 2022. In addition, the regulations provide that from 2023, the first Monday in every February will be designated as a public holiday. Where the first day of February happens to fall on a Friday, this will be the designated public holiday, in celebration of Imbolc/St Brigid's day. The first such public holiday will be Monday, February 6, 2023.

There will be two public holidays in March 2022 – Thursday March 17 (St Patrick's Day) and Friday, March 18 the one-off public holiday.

The INMO and health sector unions have secured that the additional public holiday on March 18, 2022 will be subject to the same national collective agreements and contractual public holiday entitlements that apply to public health service employees in respect of the other nine public holidays each year.

Nursing/midwifery staff who work a '5/7' roster currently have a contractual entitlement to an additional nine days leave (pro-rata for part-time employees) in lieu of their liability to be rostered on a public holiday. This will increase to an additional 10 days leave (pro-rata for part-time employees).

In addition, they will receive double pay in respect of any public holiday on which they are required to work, as per existing contractual arrangements.

Employees who work a 'Monday to Friday' attendance regime who are required to work on the public holiday, will receive an additional day's pay, incorporating public health service premium rates, including public holiday overtime rates for eligible staff as set out in HSE circular 31/2021.

In the case of employees who do not work on the public holiday, the following provisions generally apply, subject to an employee's contractual arrangements:

- Employees who normally work on the day on which the public holiday falls but have to be off by virtue of the fact that it is a public holiday, are entitled to a normal day's pay
- Employees who are not normally required to work on the day on which the public holiday falls (e.g. part-time employees who are scheduled to work on particular days only), are entitled to one-fifth of the normal weekly pay or an additional day's leave based on one-fifth of their standard working week, as the employer may decide
- Job sharers who work Monday to Friday and who are not scheduled to work on the day on which the public holiday falls are entitled to one-tenth of their normal fortnightly pay or an additional day's leave based on one-tenth of their fortnightly working hours, as the employer may decide.

Full details of the revised circular can be accessed on **www.inmo.ie**

DPER unilaterally alters Covid leave scheme

THE INMO and health sector unions have strenuously objected to revisions made by the Department of Public Expenditure and Reform (DPER) to the special leave with pay (SLWP) for Covid-19 in the public service.

These changes were communicated to the ICTU Public Service Committee at the end of January and subsequently by the HSE to the health sector at the National Joint Council.

The changes introduced by DPER are effective from February 7, 2022 with DPER setting out its rationale for using special leave with pay, stating "it continues to assist in the prevention of onward spread of Covid-19 in the work premises". The department also outlined that the changes are being made to "take account of revised isolation periods and the current public health advice".

The INMO and the health sector unions have reminded DPER that the original purpose also included that healthcare workers who had absences related to Covid-19 did not have to consume their own normal sick leave entitlements.

The DPER directive outlines that special leave with pay for Covid-19 will be applicable for a maximum of 10 consecutive calendar days for all new cases after February 7, 2022.

It is important to state that any individual who was absent due to Covid-19 prior to February 7, 2022 will be treated as per the circulars that applied prior to that date.

Within that arrangement individuals continue on special leave with pay up to 28 days and if certain conditions are met in relation to medical confirmation that the absence is related to Covid-19/long Covid, the employee should continue to receive special leave with pay. Special leave with pay includes basic salary, allowances and premium payments.

The INMO and the other health sector unions are pursuing a claim with the HSE and the Department of Health for an enhanced long Covid scheme to be utilised by healthcare workers who have contracted Covid-19.

At the time of going to print a further meeting is planned with the HSE on this matter. The INMO argues that schemes similar to the blood borne diseases scheme or MRSA scheme should apply in relation to long Covid.

For ongoing updates on all IR issues, see **www.inmo.ie**

Twilight premia in vaccination centres

THE INMO raised members' concerns with HR in CHO9 about the lack of payment of the twilight premia in North Dublin vaccination centres.

An agreement was reached to update the payroll system to accurately reflect the eligibility of relevant staff for the time and one-sixth twilight premia.

Eligible staff members will see these payments processed and back dated in the upcoming payroll cycles.

"The staff concerned would not normally work these shifts and this payment is welcomed by our members on the vaccination team in North Dublin who have gone above and beyond to provide cover for this service," said INMO IRE Noelle Hamilton.

INMO in talks as dementia unit closes

WATERMAN'S Lodge, a dementia unit in Co Tipperary that is part of the Alzheimer Society of Ireland (ASI), ceased operations on January 31, 2022.

The decision to close the facility was taken following a recommendation by a review group set up to evaluate the daycare and respite care services that were delivered at the unit. The ASI advises that it will use funding for respite beds in nursing homes throughout the Mid West area.

The INMO is currently in a consultation process on behalf of members on suitable alternative positions as their positions at Waterman's Lodge are at risk of redundancy.

– Karen Liston, IRO IRE

Health Minister declines to meet INMO reps in UHL

THE INMO called on Minister for Health Stephen Donnelly to meet with elected INMO representatives during his visit to University Hospital Limerick last month.

INMO assistant director of industrial relations Mary Fogarty said: "The INMO welcomed Minister Donnelly's visit to see the situation in UHL, first hand. We are seeing huge numbers of patients on trolleys in the hospital, with 2,264 patients on trolleys since the beginning of 2022 (and 72 on trolleys on the morning of the minister's visit).

"The INMO has been sounding the alarm on the situation in UHL for many years but even since capacity was increased, it has not improved."

The INMO requested that the Minister for Health carry out an independent inquiry into patient management at UHL last July. The union has also been calling on the HSE and the Health Information and Quality Authority (HIQA) to address the problem, and most recently has called on the Oireachtas Health Committee to investigate *(see page 9)*.

Tweet from Health Minister Stephen Donnelly who declined to meet with elected INMO representatives during his visit to UHL

Ms Fogarty said she was disappointed that the Minister for Health did not respond to the request to meet INMO officials and elected representatives as part of his visit to the hospital but she remained available on the day with elected representatives to discuss their concerns and experiences in Ireland's most overcrowded hospital.

She added that union representatives are willing and available to meet the Minister at any time. "The spiralling situation in UHL has been well flagged both locally and nationally by the INMO. The staff in the hospital have had to cope with record overcrowding coupled with dealing with Covid-19. This is simply dangerous and unacceptable as a standard for INMO members trying to provide decent safe care but finding it impossible in the conditions they are forced to work in.

"We asked the Minister to reconsider his decision to not meet with elected INMO representatives during his visit."

NiSRP roll-out delayed in CHO3

THE roll out of the HSE's new staff records and payment system, NiSRP, has been delayed for approximately two months for those working in CHO Area 3 (Clare, Limerick, North Tipperary).

The National Integrated Staff Records & Pay Program (NiSRP) was set to go live in CHO3 on February 7, 2022 and consultation with union reps on the process had begun.

However, the head of HR has advised of the need for approximately two months to address several issues.

The main issue identified by HR is the issue of carrying over of annual leave and public holidays for workers on a 5/7 roster.

Members' entitlements will not be affected but a new HR108(r) form will need to be completed by each employee with their line manager. This process should already be underway and members can expect consultation with their managers on this.

HR has begun the recruitment process for four clerical posts, with some now already appointed.

– Karen Liston, IRO IRE

Compensation for public holiday miscalculations

THE INMO raised concerns about the calculation of public holiday entitlements for part-time nursing staff at the National Orthopaedic Hospital, Cappagh. The system followed by the hospital resulted in pro rata calculation of hours for a bank holiday for part-time nurses, leading to less pay even if the public holiday fell on a day they would normally be expected to work.

INMO IRE Noelle Hamilton secured an agreement from management to implement the full entitlement of public holiday hours under the Organisation of Working Time Act 1997 to part-time nurses across the campus and payment of retrospective monies owed to affected members back to 2019.

CUH records its all-time highest number of trolleys in one day

WITH 84 admitted patients on trolleys on the morning of February 15, 2022, Cork University Hospital hit its all-time highest number of trolleys in a day since the INMO began TrolleyWatch in 2006.

INMO IRO Liam Conway said: "These figures in CUH are of no surprise to those working in this hospital. The discharge rates simply are not keeping up with the admission rates and that is one of the reasons why we are seeing such high numbers on trolleys in CUH.

"This is an extremely dangerous situation and staff cannot wait any longer for the South/Southwest Hospital Group to intervene. It is not acceptable to us that the hospital group continues to blame the problems in CUH on the national picture. For some time now, the INMO has been calling for the HSE and the hospital group to create a bespoke plan for CUH.

"Year in and year out, we see the same problems in CUH in winter. Staff feel abandoned because neither the hospital group nor the HSE are listening to their concerns.

"We need to see all non-emergency activity in the hospital curtailed and all private capacity in the region utilised where possible. Unless the hospital group takes urgent action, we are going to see many more record-breaking days in CUH."

INMO in talks with Cope Foundation over staffing levels and TOIL

THE INMO has consistently raised our members' concerns regarding ongoing inadequate nursing staff levels in Cope Foundation and subsequent inappropriate use of TOIL (time off in lieu) to fill rosters.

The union can now confirm that, until negotiations are complete, management is prepared to offer nurses the opportunity of payment for overtime hours worked, TOIL or a combination of both, operational from December 1, 2021.

The INMO is continuing to seek an agreed policy for hours worked beyond contracted hours, and the payment of meal breaks on night duty.

The Organisation has stressed that many nurses are unable to avail of the TOIL that is currently on offer due to the lack of staff to cover their time off.

– Gráinne Walsh, INMO IRE

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

Call for action on nursing workforce

A NEW international report calls for urgent global action to address the nursing workforce crisis and prevent an avoidable healthcare disaster.

The *Sustain and Retain in 2022 and Beyond* report, published by the International Centre for Nurse Migration in partnership with the Commission on Graduates of Foreign Nursing Schools and the International Council of Nurses, examines the global nursing workforce through the prism of the Covid-19 pandemic and the other global challenges for the profession and health services.

The report reveals how the pandemic has exacerbated the already fragile state of the global nursing workforce, putting the WHO's aim of universal health coverage at serious risk. It suggests up to 13 million more nurses will be required in the next decade – an increase by almost half of the world's current workforce of 28 million.

The report also provides a framework for what needs to be done, nationally and internationally, to guide nursing workforce planning. It calls on countries to commit to prioritising nurses for vaccinations, providing safe staffing levels and expanding domestic nurse education systems. Countries need to increase the attractiveness of nursing careers for women and men, adhere to ethical international recruitment standards, and aim to be self-sufficient in meeting nursing workforce requirements.

The report also says a long-term plan is needed to stem the tide of those leaving nursing because of the additional stresses resulting from Covid-19 and to create a new generation of nurses to grow the profession to meet increased future demands of an ageing population.

The European aspects of the report were informed in part by the survey of INMO members, and the effect of working through the pandemic on their personal and professional lives – the report tells your story as well as the world's story.

To mitigate the damaging effects of Covid-19, particularly on the global shortfall of nurses and to improve longer-term nurse workforce sustainability, the report identifies an urgent need for co-ordinated policy responses, both at national level and internationally *(see Table)*. It calls for immediate action to meet the urgent challenges, and the development of a shared longer-term vision and plan for the global nursing workforce, to ensure that the world is better placed in the future to meet major health shocks.

Recognising that the Covid-19 pandemic has caused unprecedented damage to the global nursing workforce and is already creating additional harm in 2022, without sufficient well motivated and supported nurses, the global health system cannot function.

This report is a timely reminder that health services and policy makers, domestically and internationally, must act now to redress the harm of Covid-19 on the profession and develop a longer-term plan to improve nurse retention and give hope for the future sustainability of the profession which in turn gives hope for the future of our health services.

A co-ordinated policy response at national and international level is urgently needed to meet the 2022 Action Agenda and to develop a longer-term plan: to improve nurse retention for the future sustainability of the profession.

Key recommendations of Sustain and Retain Report

AT COUNTRY LEVEL
Act: *Commitment to support for safe staffing levels* – based on consistent application of staffing methods, necessary resource allocation and health system good governance
Act: *Commitment to support for early access to full vaccination programmes for all nurses*
Act: *Nurse workforce impact assessments, conducted regularly* – in order to generate evidence and develop a better understanding of pandemic impact on individual nurses and the overall nursing workforce
Plan: *Reviewing/expanding the capacity of the domestic nurse education system* – based on data generated from impact assessments and from a regular and systematic national nurse labour market analysis
Plan: *Assessing/improving retention of nurses and the attractiveness of nursing as a career* – by ensuring that the damaging effect of Covid-19 burnout on nurses is addressed, and by the provision of fair pay and conditions of employment, structured career opportunities and access to continuing education
Plan: *Implementing policies to enable the nursing workforce contribution to pandemic response to be optimised* – through supporting advanced practice and specialist roles, effective skill mix and working patterns, teamworking, and provision of appropriate technology and equipment, as well as training in its use
Plan: *Monitoring and tracking nurse self-sufficiency* – by using the self-sufficiency indicator of level of percentage reliance on foreign-born or foreign-trained nurses
AT INTERNATIONAL LEVEL
Act: *Supporting an immediate update of the State of the World's Nursing (SOWN) analysis.* As we enter the third year of the pandemic, there is an urgent need for an updated global profile of the nursing workforce to assess the damage done and the scope for targeted action on sustainability and renewal
Plan: *Commitment to support for early access to full vaccinations programmes for all nurses, in all countries* – international co-operation is required to protect the nursing workforce in all countries
Plan: *Commitment to implementing and evaluating effective and ethical approaches to managed international supply of nurses, through a collective approach framed within a fuller implementation of the WHO 'Global Code of Practice on the International Recruitment of Health Personnel'.* This must focus on improved monitoring of international flows of nurses, independent monitoring of the use of bilateral agreements between countries and recruitment agencies to ensure compliance, and with fair, transparent recruitment and employment practices
Plan: *Commitment to supporting regular and systematic nurse workforce impact assessments*, particularly in resource constrained countries, by the provision of technical advice, data improvement, independent analysis, and multi-stakeholder policy dialogues to agree priority policy actions on domestic nurse supply and retention
Plan: *Commitment to investing in nurse workforce sustainability in small, lower income and fragile states, most vulnerable to nurse outflow, and impacted by the pandemic,* by building on the lessons of the UN High Level Commission on Health Employment and Economic Growth, and of the WHO Strategic Directions on Nursing and Midwifery which demonstrate the long-term economic, social and population health benefits of investing in the nursing workforce

global news affecting nursing and midwifery

ICM reflects on origins of the midwifery profession

AS THE International Confederation of Midwives (ICM) begins the year-long celebration of its 100th anniversary, it is encouraging midwives from its member organisations to look back on the origins of their profession.

Today, a midwife is a person who has graduated from an approved programme that meets the essential competencies of the ICM, as in Ireland. However, the ICM points out that midwifery is an ancient profession that is as natural and critical to humanity as birth itself, upholding and reflecting the cultural practices of women and their families.

In the run up to this year's International Day of the Midwife (IDM) on May 5, 2022, the ICM is focusing on the theme of *'100 Years of Progress'* and has provided an inspiring glimpse into the history of midwifery, which reminds us of the importance of midwives, midwifery-led care, and the requirement to do more to facilitate genuine choice for women in Ireland.

Pointing out that midwifery has come a long way since its early origins, the ICM encourages midwives to learn more about its history, and to reflect on the 100 years of progress midwifery has made for women, birthing people, newborns and families all over the world.

The ICM has provided a brief history of midwifery practices, which can be traced back to the palaeolithic era (40,000 BC), where pregnancy and childbirth required women to give birth in challenging and often life-threatening environments. Women supported themselves during birth based on knowledge and skills they learned from observing other mammals.

Indigenous cultures all over the world practised various traditions around birth, many of them spiritual and rooted in nature and herbal medicine. The Māori people of New Zealand, for example, used supplejack and flax root for contraception, and would typically burn the designated birthing spot after labour.

From 3500 BC to 300 BC, the Egyptian and Greco-Roman eras saw much progress in the development and acknowledgement of midwifery as an autonomous, scientific and paid profession. But in late 300 BC, social attitudes about female midwives changed, and midwifery became a profession under the hierarchy of male-supervised medicine.

In Europe and the Mediterranean, the biblical era (2,200 BC – 1,700 BC) saw the empowerment of women play a large role in building professionalism in midwifery. However, by the arrival of the High Middle Ages (1,000-1,250 AD), female midwives or healers were considered heretics/witches and would be hung or burned to death.

In China, female midwives practised midwifery by means of traditional Chinese medicine for thousands of years. These women were often illiterate, and most of these practices were confined within small communities and performed in the home. These practices remained the same until the 13th century, when male medical practitioners began to formalise and control medicine and obstetrics.

In both Thailand and Chile, centuries-old practices of midwifery were historically services reserved for the poor and underprivileged, although today, women and birthing people of all socioeconomic backgrounds access midwives.

All over Africa, traditional midwives and other healers have been an integral part of medicine for centuries. But when Europeans brought African people to the US and enslaved them in the 17th century, some African women were enslaved to train and serve as midwives. Midwives were still the main healthcare providers in birth on the colonies, and they continued to serve African and white women in birth until the turn of the 19th century. Then the male physician replaced midwives with the introduction of male-supervised obstetrics.

Each region, country and community has its own history of midwifery, unique to its respective belief systems and political context. These journeys are still unfolding and the ICM encourages midwives to learn more about the roots of midwifery in their own area. Several further resources are recommended on ICM website **internationalmidwives.org**

World news

Nurses and midwives in action around the world

Australia

- Aged care workers are facing a "crisis level of exhaustion" as Covid-19 pandemic continues
- Doctors push to clear elective surgery backlog but "exhausted" nurses want pause to continue

Canada

- Ontario's nursing shortage is worse than ever. How did we get here?
- "We are seeing violence almost every shift": Healthcare workers seeing uptick in abuse from patients
- Alberta nurses agree to 4.25% wage increase

Dominican Republic

- Nurses strike, demand payment of incentives

Italy

- "1,500 nurses have resigned, the profession is dying", says union
- Nurses strike: "Citizens understand, now it's up to politicians"

New Zealand

- Covid "icing on pretty horrible cake" for health worker shortages

UK

- Pandemic pressure: Six in 10 nurses in Scotland on the verge of quitting
- Nursing union raises alarm over Nationality and Borders Bill

US

- Healthcare leaders speak out as workers endure "pandemic of violence"
- Strained US hospitals seek foreign nurses amid visa windfall
- "We're at a crisis level": nurses take on union-busting bosses over short staffing

Remembrance and reco

Memorials honouring those who died in the Stardust fire and marking the contribution of healthcare workers in the pandemic have been unveiled by the INMO. **Freda Hughes** reports

ON FEBRUARY 14, 2022 the INMO unveiled two memorials – one in honour of the victims of the Stardust tragedy and another for those who died of Covid-19. They are situated on the grounds of the Richmond Education and Event Centre.

The unveiling was attended by the Stardust families, Taoiseach Micheál Martin, health minister Stephen Donnelly, Justice Mary Laffoy, HSE chief Paul Reid, veteran broadcaster Charlie Bird, social activist Sr Stan Kennedy, ICTU general secretary Patricia King and ICTU president Kevin Callinan, among many others.

The first memorial commemorates the Stardust tragedy in which 48 people tragically lost their lives and over 200 were injured when a fire broke out in a nightclub in Artane on Dublin's northside on February 14, 1981. The Richmond Hospital treated many of the victims that night and the memorial acknowledges that connection and gives the families affected by the fire a place to attend in remembrance.

The second memorial commemorates the lives lost during the pandemic – in particular those of the brave healthcare workers who died from Covid-19 – and also honours the extraordinary contribution made by nurses and midwives over the past two years.

Both memorial pieces were designed by Irish artist Robert Ballagh. In his address to those gathered at the launch, he remembered the care given to him and his wife over the years at the Richmond Hospital and commended the healthcare professions. He thanked Darren Twyford who constructed the benches based on his design and said that he hoped that they would provide a place for people to sit, reflect and remember. He added that he was honoured to help mark these tragedies in our history and to honour the remarkable dedication of frontline workers.

Also speaking at the launch, INMO president Karen McGowan said that it was poignant that the memorials were in the grounds of the old Richmond Hospital where many victims were treated. "When remembering those who tragically died that night, we think of the many families who never got a chance to say goodbye and who are still fighting for justice."

On the pandemic memorial she said: "Whenever a nurse or midwife dies in the line of duty it affects our members deeply, but during Covid-19 especially it has been so tough. As a nation we are known for how we come together when we mourn the loss of members of our community. This was impossible at the height of the pandemic. We will analyse for many years to come the profound impact the pandemic has had on us as a people, but by being here today and unveiling this memorial, we can remember the incredible role nurses and midwives played."

Taoiseach Micheál Martin acknowledged the immense trauma the Stardust fire had on the families and community of those who died. He also acknowledged the effect that the Covid-19 pandemic has had on first responders and frontline workers.

"Nurses, midwives and health professionals cannot be thanked enough for their personal and professional diligence in the face of disaster. Their efforts have kept us safe and has given Ireland one of the highest vaccine uptake figures in Europe. We must remember those who lost their lives protecting others. They will not be forgotten."

Mr Martin also committed to insuring the relevant supports and resources were in place to allow the planned Stardust inquest to go ahead this year. He met with the families after the launch.

Antoinette Keegan is one of the leading campaigners for justice for the Stardust victims. She is a survivor of the fire and lost two of her sisters, Mary and Martina, that night. Her resilience in the face of such loss has been immense. Along with her family, some of whom have since died, she has campaigned tirelessly for answers.

Ms Keegan said that her meeting with the Taoiseach had been positive. "He took my number and said to get in touch. We discussed a couple of issues that are outstanding, we have the venue but we can't proceed because of the jury selection and the jury payment," she explained.

Speaking of the fire she said: "It's still a memory imprinted in my head and I can still remember every detail. My sisters and 46 others died horrendously. We want to know how they died and why they died. We've waited 41 years for justice. Hopefully this is our year."

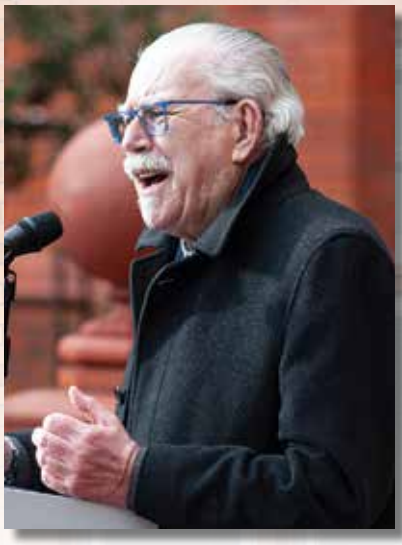
Veteran broadcaster and journalist Charlie Bird spoke on behalf of the Stardust families and thanked the nursing and midwifery workforce for the lives they saved and the care they gave that night. "The families of Bloody Sunday and Hillsborough have finally got some justice, but the Stardust families are still fighting for answers 41 years after this terrible tragedy. A tragedy of this magnitude affected us as a nation but as time moved on, the families were forgotten. If this had happened in a middle class community they would not still be fighting for justice. They want answers. They want to know why this was allowed to happen. They want to know why their loved ones died," he said.

The Stardust families presented the Taoiseach and INMO general secretary Phil Ní Sheaghdha with a framed image displaying the names of those who lost their lives and a candle bearing the campaign's logo which honours those who died.

"The INMO is pleased to offer a space for families of those that lost their lives tragically in both the Stardust fire and during Covid-19 to mourn and remember their loved ones. For many families the heartache of losing someone under such unforeseen circumstances is still very real. The Stardust tragedy has shaped so many of us in the nursing profession and made us so much more conscious of loss and grief. The nursing workforce played unprecedented roles during both the Stardust tragedy and the Covid-19 pandemic. They must not be forgotten as we write the history of both events," said Ms Ni Sheaghdha.

gnition at the Richmond

Taoiseach Micheál Martin, broadcaster Charlie Bird and INMO president Karen McGowan at the unveiling of the two memorials at the INMO's Richmond Education and Event Centre last month



Artist and designer of the two memorial benches Robert Ballagh

Antoinette Keegan, justice campaigner for the Stardust victims and survivor of the fire

The memorial plaque in remembrance of the victims of the tragic Stardust fire of 1981. The plaque from the Covid memorial is pictured on the page opposite

Susan Colgan, sister of the late John Colgan who died in the Stardust fire

Members of the INMO Executive Council who were at the unveiling of the memorials (back row, l-r): Elizabeth Allauigan; Caroline Gourley; Colette Lyng; Maeve Gaynor; and Audrey Horan; (front row, l-r): Mary Tully; Eilish Fitzgerald, INMO first-vice president; Karen McGowan, INMO president; Oliver Allen; Phil Ní Sheaghdha, INMO general secretary; Ann Noonan; and Grace Oduwole

INMO general secretary Phil Ní Sheaghdha addressing those assembled at the unveiling of the memorials at the Richmond last month

Photos by Lisa Moyles

Stardust: "A night I will never forget"

As night manager at the only burns specialist hospital in Dublin at the time, Mary Flynn remembers the early morning of February 14, 1981 like it was yesterday. Interview by **Freda Hughes**

THE memory of the Stardust disaster, in which 48 people tragically lost their lives and over 200 were injured when a fire broke out in a nightclub in Artane on Dublin's northside, lives on in the hearts and minds of so many people in Ireland.

On the night of February 13-14, 1981 more than 800 people, predominantly from the local area, were packed into the venue for a Valentine's Day disco and dance contest. The venue was popular with the younger generation but on that night it would be the site of one of the worst fires in the history of the state. Now 41 years on, survivors and the families of the deceased are still looking for answers about what went wrong that night as they continue to fight for justice on behalf of their lost loved ones.

Mary Flynn was the nursing night manager in Dr Steevens' Hospital in 1981 and was on duty on the night of the Stardust tragedy. This meant she was responsible for all nursing duties across the entire hospital. On that night the hospital was off-call which meant its emergency department was open to walk-ins but closed to ambulances. At the time the Dublin hospitals used to do two nights on and one night off and February 13 happened to be a night off. That all changed however when Ms Flynn received a phone call from Dublin Fire Brigade at 1.45am.

Multiple casualties

She recalls: "There was no switchboard operator after 1am when we were off-call so all calls were rerouted to ED. The porter working that night put the call through to me. I spoke with Dublin Fire Brigade who said there had been a major fire in the Stardust. At the time the Stardust meant nothing to me. I had no idea where it was or what that meant. They explained to me that it was a huge building with lots of people in it at the time of the fire and that there were multiple casualties. They said that we'd have to open up our ED and start accepting patients who were already on their way to us in ambulances."

Ms Flynn quickly got the keys and went down to open the ambulance gates. She met a member of the Garda Síochana in the ED and started phoning the hospital's managers and consultants to get as many hands on deck as possible. By the time she got to open up the gates the ambulances were already starting to arrive. As nurse manager she had to decide where to allocate the casualties and how to treat them while waiting for more senior staff to arrive.

The assistant matron lived on site but had no phone in her apartment. Ms Flynn remembers running across the hospital campus to wake her up. The junior doctors living on site were also woken and brought in, along with some of the registrars and any other staff they could muster.

She was aware that patients were sent to other Dublin hospitals including Jervis Street, the Richmond, St Vincent's, St James's and the Mater. As Dr Steevens' was the only burn specialist hospital in the city, she knew they would have the largest influx of patients.

"I was working on autopilot. I always carried a notebook stating where we had vacant beds so I knew we had 21 vacant beds as we were off-call. We filled all 21 beds very quickly that night.

"There was no such thing as a major incident plan at that time so we had to think on our feet. I had never experienced anything of that magnitude in my nursing career prior to that. Commonsense kept me going.

"We had to make sure we had tracheostomy kits available in case anyone had difficulty breathing. The majority of patients presented with horrific burns. We watched for swelling in the hands and difficulty breathing. We had to assess them, set up drips and dress their wounds. I had treated burn victims before but never on this scale.

"All the paperwork had to be done too. We worried that if more people presented we would have nowhere to put them. The pressure was continuous," she recalls.

Specialist burns treatment

From 1.45am to 8am the team in Dr Steevens' did not stop. Most of the patients had been admitted by around 5am, but over the coming days many more Stardust victims were transferred from other hospitals for specialist burns treatment.

"The hospital chaplain was called in to provide support to patients and the Gardaí maintained a presence in the hospital to help identify people being brought in. Family members started to arrive around 5am in search of their loved ones.

"The victims were predominantly very young people aged between 16 and 28. Half of those who died were under 18. There were couples and siblings among the deceased. So many families from a small locality lost loved ones that night," she adds.

Ms Flynn recalls: "A family came in looking for their daughter. We looked through our lists and confirmed that she wasn't here. They said we were the last hospital they had visited so at that point we knew she had not made it. It was heartbreaking."

Ms Flynn recounted that patients, staff and visitors were all traumatised but they had to keep going. The whole team did whatever was needed that night and no one cared about what their role usually involved.

"Everybody worked unbelievably hard on the night. We kept going, then I had to go and check all the other patients and do the ward rounds before writing up the report and getting ready for the handover at the end of shift. We were back on-call the following two nights so there was no rest or break.

"It was so hard to sit down and write about all the people who presented to us that night. I had so much to write up and so little time to do it. The trauma and stress really impacted on my handwriting that night too.

"There was no counselling for staff back then. We just had to go back to work the next night. We were exhausted and traumatised but we had to get on with it.

"I distinctly remember eventually getting home the next morning and turning on the TV. News of the Stardust tragedy was on every channel. It really hit me hard and all I could do was cry. I was devastated," she explains.

In the coming days the Archbishop of Dublin, the Taoiseach, the Lord Mayor and other politicians visited the hospitals to talk to the survivors. In November 1981 a Tribunal of Inquiry concluded that the fire was probably caused by arson. It criticised some of the venue's safety standards but the conclusion exonerated the owners of the Stardust from legal responsibility for the blaze. The victims' families were understandably angry and felt that the blame was being placed on those who had been inside the club that night.

In 2009 the Dáil voted to acknowledge that none of those present at the Stardust nightclub could be held responsible for the blaze. Families of the victims have continued to fight for over 40 years for a proper inquest. In 2019 the attorney general confirmed that fresh inquests would begin in 2021.

At time of going to print, pre-inquest hearings have taken place but the inquest itself has been subject to further delays. Some 41 years after the tragedy, the families and friends of the victims continue to campaign for justice.

As a result of the Stardust tragedy, Dr Steevens' Hospital later opened a new specialised burns unit. However, the hospital closed in 1987 and Ms Flynn moved to nearby St James's Hospital as night superintendent.

She says the horrors of that night have stayed with her throughout her life.

"I kept my nerve that night and made sure everything ran smoothly, but it is a night I have never forgotten. It's not easy to relive it. Families who lost loved ones are stilling fighting to establish why this disaster happened. The tragedy is still fresh in our collective memory as a country. I still feel deeply sorry for the families of the victims of the tragedy."

NMBI Q&A

The Nursing and Midwifery Board of Ireland is expanding and with several new directors in place, they addressed some questions put to them by the INMO

THE Nursing and Midwifery Board of Ireland (NMBI) is expanding and changing for 2022 with several new directors in place and additional staff being recruited in its Registration Department.

Under the leadership of chief executive Sheila McClelland, a number of recent senior appointments and key initiatives have been aimed at improving the work of the NMBI as the regulator for the nursing and midwifery professions in Ireland.

On behalf of members, the INMO asked a number of questions to Carolyn Donohoe, director of education, policy and standards, Colm O'Leary, director of fitness to practise, Ray Healy, director of registration, and Kathyann Barrett, head of operations.

INMO: *How do you see the NMBI ensuring that the education environment for undergraduate students is maintained at an appropriate standard, and in so doing safeguarding the standards associated with the professions, the standing of the professions, and the protection of the public?*

Carolyn Donohoe: "We are an evidence-based profession, so education is fundamental to how we practise now and how our practice will evolve into the future. Healthcare will never stand still, so therefore neither will nursing or midwifery, and the only way to keep up is by engaging with further education along the continuum of our careers.

"As a regulator of education, we ensure that the programmes available at undergraduate and postgraduate level are in keeping with our two briefs – to protect the public and the integrity of our profession. Engagement with students is important to the NMBI. We meet with them and listen to them during site inspections and we have held meetings with students to discuss their education pathway through Covid-19. We are in a time of great change and the design and content of the programmes need to move with the needs of the public and the professions. What we have learned from Covid-19 is that change is essential, and agility is key to survival."

INMO: *In terms of maintenance of professional competence – how will the NMBI advance this important part of the Nurses and Midwives Act in a way which ensures a user-friendly process that recognises the role not only of nurses and midwives, but also of employers, in facilitating the maintenance of professional competence?*

Carolyn Donohoe: "Continuing professional development and maintaining competence is vitally important for nurses and midwives and for the majority it is already something they do on a regular basis. Under section 11 of the Nurse and Midwives Act 2011 the NMBI is tasked with the introduction of a scheme to monitor this for every nurse and midwife who is on the Register.

"A project is underway to establish the foundations for this scheme and how it will work. The NMBI is committed to both ensuring that the new scheme will be as user friendly as possible and to working with nurses and midwives to ensure this happens. A cross section of nurses and midwives from the Register, including representatives of the INMO, were recently consulted through focus groups and we are currently analysing the feedback.

"I am confident that by working with nurses and midwives, as well as learning from other regulators internationally, we can develop a successful format. As we shape this core patient safety initiative, we are committed to keeping nurses and midwives, as well as other stakeholders, informed."

INMO: *International applicants for registration have raised serious concerns regarding delays in the registration process. It is without doubt that potential registrants are facing delays in Ireland which they are not experiencing in other jurisdictions. This affects them as individuals who have invested significantly in a personal and economic way to progress their career in Ireland. Recognising that registration is an important gatekeeper in maintaining standards, how will the NMBI ensure a more timely process of registration that is in keeping with competing jurisdictions where international nurses and midwives are also considering migrating?*

Ray Healy: "The NMBI is working hard to address the current backlog of applications from nurses and midwives who want to join the Register in Ireland.

"We fully recognise the urgent need to address delays for individual applicants and support all efforts to ensure that the widest pool of adequately trained nurses and midwives are available to meet the demand in the health service for additional capacity. We are also aware that we need to do all we can to ensure that the Irish health service remains a competitive and attractive option for nurses and midwives from overseas.

"A number of measures have been taken in recent weeks to address the delays, including recruiting additional staff to our registration department and improving our processes. We have also worked with nurses and midwives from overseas, as well as other key stakeholders, and revised and redrafted guidance documents to support those preparing their applications. In the past more than 90% of applications for recognition were incomplete when submitted, which led to delays, however this is now improving thanks to our engagement with stakeholders, including the INMO and Migrant Nurses Ireland.

"When an application is complete at the point of submission, with all the required documents correctly verified and certified, the process is much quicker. We will continue to work to reduce the delays in the weeks and months ahead, and are very appreciative to those who are engaging with us on this, including the INMO and Migrant Nurses Ireland.

"Despite the processing delays currently being experienced by overseas applicants in the recognition element of the process, the 2021 monthly average number of registrations of overseas applicants was 292, which is 105 (or 56%) above the 2020 monthly average of 187. A total of 3,093 overseas applicants joined the Register last year."

INMO: *The fitness to practise processes of the NMBI are essential for the maintenance of public safety and the standing of the professions. Recognising this, it must be acknowledged that the process places an incredible psychological burden on registrants. What is the NMBI doing to ensure that as well as accelerating fitness to practise cases, it also takes an appropriately compassionate and supportive approach to registrants involved in the process? What is the NMBI proposing in terms of the management of cases involving medical disability, noting the very different approach adopted by the Medical Council in addressing such cases?*

Colm O'Leary: "The NMBI is very aware that an inquiry might have a significant psychological impact on a nurse or midwife who is the subject of a complaint and that the reduction of waiting time for a decision to progress a complaint is in the best interests of all parties in the process. That is why we are working hard to reduce waiting times and the NMBI concluded more inquiries in 2021 than in previous years with older complaints prioritised.

"Throughout the pandemic we used hybrid and remote inquiries to continue to progress cases and this method of inquiry will be suitable for up to half of the inquiries that currently remain to be heard. We are working hard to bring inquiries to a conclusion as quickly as possible, particularly the longest running inquiries. While we acknowledge that the wait time remains unacceptably long, we are committed to further reducing it in 2022.

"As well as reducing waiting times we are also working to take a more compassionate and supportive approach to registrants involved in the process. An important part of this will be a new telephone support service for registrants subject to an inquiry. This will give them the opportunity to speak in confidence to a person who is familiar with the process and who can help to answer their questions. We plan to introduce this service in the second half of 2022. We are also working to improve the guidance material available and will be producing helpful video content in 2022.

"In relation to the management of cases involving medical disability, we are very open to examining all options in relation to how this can be done better. Taking into account the fact that the Medical Council has different legislation to the NMBI we plan to work with it to learn from the systems and procedures it has in place in this area."

INMO: *In terms of facilitating members of the INMO's understanding of the value of the NMBI, what more will the Board do to ensure that registrants can be confident that it – as the independent regulator of our professions – is delivering on its mandate, operating in a manner that delivers value for money and will, when required, advocate independently on relevant issues? In terms of independent advocacy – we note independent reports issued by other regulators relating to the training environment and practice environment for its registrants, is this something being contemplated by the NMBI?*

Kathyann Barrett and Sheila McClelland: "Active engagement with stakeholders, including the INMO, is a key priority for the NMBI and an area we plan to grow in the months ahead. It is through working together and increasing the understanding of the work of the NMBI that we can all achieve our aims of protecting the public and the integrity of our professions.

"The NMBI is committed to effectively delivering on our mandate by supporting registered midwives and nurses to provide patient care to the highest standards and doing this in a manner which delivers value for money. This commitment is overseen by our Board and committees, which include representation from nurses and midwives. An example of this support is NMBI's site visits to the training environments for registrants and the subsequent independent reports, which we intend to publish in the months ahead.

"Later this year we will begin our most comprehensive public consultation to date on the future direction and priorities of the NMBI. We will be seeking submissions on what stakeholders and others wish to see in our next three-year Statement of Strategy which will run from 2023 to 2025."

Newly appointed and current department leaders at the Nursing and Midwifery Board of Ireland

Carolyn Donohoe, NMBI director of education and policy standards

Ray Healy, NMBI director of registration (interim)

Colm O'Leary, NMBI director of fitness to practise

Kathyann Barrett, NMBI head of operations

Dawn Johnson, NMBI director of midwifery

Sheila McClelland, NMBI chief executive officer

Menopause in the workplace and you

With women representing 90% of active NMBI registrants, menopause in the workplace is an important issue for the INMO. **Steve Pitman** and **Niamh Adams** report on a recent membership survey

MENOPAUSE is a topic that is gaining increasing attention and there is growing evidence that the 'silence' has now been broken.[1] According to the Central Statistics Office there are almost 350,000 women employed in Ireland aged 45-64. The average age of a woman's menopause is 51 years,[2] so a significant number of women will be working throughout their menopause transition. Nursing and midwifery are predominately female professions, with women representing 90% of all active NMBI registrants spanning the entire working-age range. This is the reason why menopause in the workplace is such an important issue for the INMO.

Menopause has traditionally been a hidden topic that some have considered a 'taboo', particularly in the workplace.[3] It is often not taken seriously or can even be a source of ridicule. The Irish Congress of Trade Unions in Northern Ireland[4] found that almost half of respondents reported that menopause had been treated as a 'joke' in their workplace and 28% said that menopause was treated negatively in the workplace. This culture needs to be challenged and menopause must be recognised as an important issue at work.

The INMO has taken the lead and was one of the first organisations to raise menopause as a significant occupational health issue affecting women. As an initial step, the INMO published a position statement on 'Menopause at Work' in October 2019 (available on **www.inmo.ie**). The pandemic has limited the opportunity to campaign on this issue. However, it is expected that this will be an issue of increasing importance in 2022.

Table 1: Demographic breakdown of survey respondents

Registration type	(%)
RGN	927 (89.2)
RM	193 (18.6)
RPN	29 (2.8)
RCN	90 (8.7)
RNID	59 (5.7)
RPHN	55 (5.3)
RNT	14 (1.35)
RNP	43 (4.1)
RAN/MP	33 (3.2)

Age	(%)
Under 26	3 (0.3)
26-30	4 (0.4)
31-35	3 (0.3)
36-40	12 (1.2)
41-45	98 (9.4)
46-50	289 (27.7)
51-55	366 (35.0)
56-60	221 (21.2)
61-65	44 (4.2)
66+	2 (0.2)
Missing	1 (0.1)
Total	**1,043 (100)**

Sex	(%)
Female:	1,036 (99.3)
Male:	4 (0.40)
Prefer not to say:	2 (0.2)
Not listed:	1 (0.1)

Methodology and methods

An online survey was conducted to gain an understanding of nurses and midwives' experience of menopause in the workplace. The information will be used to inform the INMO strategy for raising awareness and to campaign for greater support for women in the workplace. This survey was conducted with the support of the Menopause Hub.

This cross-sectional online survey was conducted during September to October 2021 using Survey Monkey. The survey was conducted over 10 days and was open to all nurses and midwives in Ireland. INMO members were contacted via the membership database and the survey was promoted in the weekly INMO update to members and via social media.

The survey response was anonymised to ensure privacy and confidentiality. No personal details were required as part of the survey. Consent was implied once participants made the decision to complete the survey. The overall survey took approximately eight minutes to complete.

The survey was divided into four sections (demographics, 'experience of menopause', menopause in the workplace, and quality of professional life). This report focuses on the demographics, 'experience of menopause', menopause in the workplace questions. The results from the Professional Quality of Life (ProQual) and the correlation with other menopause measures will be reported separately. In total, there were seven demographic questions, five 'experience of menopause' questions, 11 menopause in

the workplace questions and 30 ProQual questions. The majority of questions in this section were categorical (yes or no, category selection) or ordinal/ranking scales.

Results

In total, there were 1,045 respondents to the survey. The demographic breakdown is provided in *Table 1*. It is important to note that responses were not compulsory for each question, which resulted in variances between different total responses.

The majority of respondents were registered general nurses (89%) who worked in the public sector (91%). The employment grade of respondents was spread from student nurse (0.2%) to directors of nursing/midwifery (1.45%). The largest groups were senior enhanced nurses/midwives (21%), CNM/CMM2 (18%) and senior staff nurse/midwife (17%). Respondents worked in a variety of specialties. The highest numbers worked in care of the older person (13%), medical/surgical (10%) and 'other' (27%). The highest level of educational qualification of respondents was Level 8 (51%) and then Level 9 (49%).

Experience of menopause

When asked what best describes your menopause status, the highest figures were reported as 'Post-menopause – no periods for 12 months' (46%) and 'Perimenopause – still having periods and in the lead up to menopause' (35%). Almost half of respondents reported that they were 'not at all prepared' (48%) for menopause. In contrast, 45% reported being 'somewhat prepared' for menopause.

When asked if they had received any education or information about menopause, 46% received 'a little' and 29% 'a moderate amount'. Under 10% received 'a lot' or 'a great deal' of education or information. More than 87% of respondents reported that they have menopausal symptoms, while 7% did not know. A significant 59% described their menopausal symptoms as moderate, while 18% described their symptoms as 'severe (debilitating)' (see *Figure 1*).

Menopause in the workplace

Over 90% reported that their menopausal symptoms affected them while at work. Some 17% indicated that they had missed work due to their menopause symptoms, with 43% of this group reporting they had missed approximately five days due to symptoms. The majority (63%) did not tell their employer why they took time off. The overwhelming majority (82%) of respondents in this group have considered leaving their job or reducing their hours of work because of menopause symptoms.

Figure 1: If you have symptoms how would you describe them?

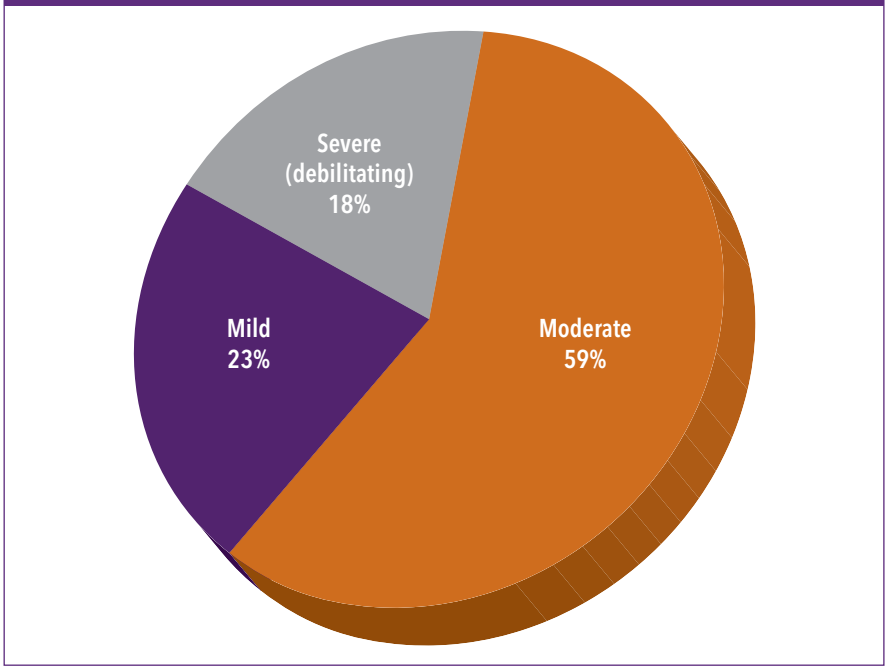


Figure 2: Do your symptoms affect you when you are working?

Just under one-third (31%) of the overall respondents were 'not very confident' about discussing menopause in the workplace. Approaching two-fifths (37%) did not feel confident discussing menopause with their line manager.

Overwhelmingly (88%), respondents would like to see their organisation introduce menopause awareness and training for staff. A similar number (87%) would like to see their workplace implement a menopause at work policy.

Discussion

The response to this survey, over such a short period, underlines the importance of menopause in the workplace as an issue for nurses and midwives. More than 80% of respondents are either perimenopausal or postmenopausal. The vast majority reported menopausal symptoms, with nearly one in five reporting their symptoms as severe and debilitating.

The need for greater education and support to prepare women for menopause was clear. While raising awareness and acknowledging menopause is a broader societal issue, employers can take the lead in creating a healthy, menopause-friendly work environment.

Menopause is an important occupational issue. Women experience menopausal symptoms at work, which can affect their work performance. Two in five nurses and midwives reported that they had taken five or more days of sick leave due to menopausal symptoms. Many women are not confident about discussing menopause at work. This may be due to embarrassment or that the topic has traditionally been considered a 'taboo', something to be ignored or should just be 'put up with'.

Beyond the individual experience of menopause, there are significant implications for the retention of nurses and midwives. In response to the global shortage of nurses and midwives, health systems must consider the factors that influence the decisions of nurses and midwives to leave the professions. One of the factors that needs to be considered is

the impact of menopause symptoms on decisions to reduce hours or leave. The recognition of menopause in the workplace as an issue and the implementation of menopause-friendly workplaces is a positive intervention that can support nurses and midwives to continue practising for longer.

The successful implementation of effective and meaningful menopause in the workplace policies needs to be underpinned by statutory recognition of menopause as an equality issue. This will require recognition and political willpower to drive an agenda of change at governmental level.

Menopause affects all women at some stage in their life. Nursing and midwifery are overwhelmingly female professions and this makes it an important issue for the INMO. The INMO was one of the first organisations in Ireland to introduce menopause at work position statement. This was a marker of the commitment of the INMO to raising the profile of menopause and to campaign for health service employers to develop and implement menopause in the workplace policies to support women at work. The INMO believes that the profile of menopause in the workplace needs to be acknowledged, recognised as an important occupational and human resource issue, and for resources to be invested in supporting women

Recommendations

The following recommendations are informed by the 2021 Global consensus recommendations on menopause in the workplace: A European Menopause and Andropause Society (EMAS) position statement.[5]

That healthcare employers should:

- Introduce menopause in the workplace health and wellbeing policies and frameworks to support women at work
- Develop inclusive workplaces that are open, inclusive and create a supportive culture regarding menopause
- Develop initiatives and training to raise the profile of menopause as a workplace issue
- Ensure that women are not discriminated against, marginalised or dismissed because of menopausal symptoms
- Develop work environments and practices that are menopause friendly. These can include improvements in airflow, access to water and the implementation of uniforms that take into consideration symptoms of menopause
- That government introduces legislation that recognises menopause at work as an equality issue that affects women. This should include provision for menopause-related leave and support for women reducing working hours or other work arrangements without implications for pension entitlements.

Steven Pitman is INMO head of education and Niamh Adams is INMO librarian

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Q and A Bulletin Board

With INMO director of industrial relations Tony Fitzpatrick

Career breaks and your pension scheme

Q. I am returning to work as a staff nurse in the public health service following a 10-year break to look after my children. As I could not get a career break at the time, I resigned from my previous post. My employer advised that I will be paying into the new Single Public Service Pension Scheme because I had a break of more than six months in employment, prior to this I was in a defined benefit scheme. Is this correct?

Yes, this is correct, the Single Public Service Pension Scheme applies to new entrants to the public health service and is effective from January 1, 2013. This will not affect people who are currently working and paying into a defined benefit pension scheme, as their pension will continue as is. The Single Public Service Scheme is different from the Defined Benefit Scheme when calculating pension and lump sum. The Defined Benefit Scheme is based on the salary of the grade on date of retirement. The Single Public Service Pension Scheme is based on what is termed a 'career average', meaning contributions made each year will be averaged over the career span and pension will be based on this sum which will be increased in line with the consumer price index, on retirement, as opposed to the salary for the grade on retirement. If you leave the service for a period in excess of 26 weeks at any time in the future, and then re-enter the public health service, you will enter on the single public service pension scheme. This will not apply if your contract is not broken, for example for a career break, secondment or maternity leave. It is therefore very important that people on the Defined Benefit Scheme take this into consideration before resigning from their post in the future.

Is parental leave an entitlement?

Q. I recently applied for parental leave but my employer has refused this request. I thought I had an entitlement to take parental leave. Where do I stand?

Parental leave is a statutory entitlement based on the provisions of the Parental Leave Act. There is a requirement on employees to advise their employer of their intention to take parental leave and also to request the manner in which that leave is sought. Some employees seek to take a block of time (26 weeks or separate blocks of a minimum of six continuous weeks), others seek to have the time taken as one day a week or a number of hours per week. However, the decision as to how the period of parental leave should be taken has to be agreed with the employer. If the employer does not agree, then the matter may require some negotiation. A confirmation document specifying the date of commencement of the leave, its duration and the manner in which it is to be taken has to be prepared and signed by both the employee and the employer, at least four weeks before the leave is due to commence. Once the confirmation document has been signed, the terms set out in it cover the agreement. The employer has the right to postpone the commencement of parental leave if the confirmation document has not been signed. Leave can be postponed for up to six months but, prior to postponing it, your employer must consult with you.

Salary scale – am I on the correct point?

Q. I qualified in September 2021 as a registered nurse and immediately began working in the HSE. I am currently on the second point of the salary scale. I'm just wondering is this correct or should I be on the next point of the salary scale?

This is not correct. When you commenced employment in September 2021 as an RGN, you should have been placed on point 1 of the nursing/midwifery salary scale. After you have completed 16 weeks of work (including time worked as a pre-reg) in approximately January 2022, you should have progressed to point 3 of salary scale – this will be your 'new increment date'. This is in line with HSE HR Circular 032/2019 which states "Nurses/midwives currently on point 1 will benefit from the revised new entrant measure and, at their next increment post March 1, 2019, skip point 2 and go to point 3". One year from this date, you should progress to point 4 and are then eligible to apply for the enhanced practice contract (I would recommend applying a few weeks before moving to point 4). I would advise that you bring the circular to the attention of your HR department and seek to be placed on the third point of salary scale with retrospection to your increment date. If you encounter any difficulties with this, do not hesitate to get in touch with your local INMO official.

Midwives embracing advanced practice roles

Two of Ireland's registered advanced midwife practitioners, **Roisin Lennon** and **Bernadette Gregg**, outline the many specialist roles played by their counterparts across the country

IN 2016 the Irish National Maternity Strategy was published as a 10-year plan to change and advance Irish maternity services. Implementation of the strategy is evolving slowly and there has been some hesitancy among midwives to embrace becoming the lead professionals for normal healthy pregnancies. This could be circumstantial, due to staffing, hospital structure, space and funding. However, this is beginning to change, with midwife-led care emerging nationally.

Advanced nursing and midwifery practice was first introduced in Ireland following the report of the Commission of Nursing in 1998. Despite this, the number of midwives becoming registered advanced midwife practitioners (RAMP) is still in its infancy compared to registered advanced nurse practitioners (RANP). The first RANP was registered in 2002, while the first RAMP was registered in 2011. By 2018 there were 550 RANPs but only 12 RAMPs.

However, maternity services are beginning to embrace these changes. In response to the National Maternity Strategy, many new services are being developed and introduced into the 19 maternity units around the country. As well as this, the National Women and Infant Health Programme has been instrumental in ensuring the Maternity Strategy will be fully implemented by 2026 and has been instrumental in funding and progressing 12 candidate advanced midwife practitioner roles to ensure there will be at least one RAMP in each maternity unit.

A contributory factor to the low numbers of RAMPs is identifying firstly where the local service need is and then scoping what the advanced practice service would look like, obtaining stake-holder agreement and then introducing this into the unit. Despite these challenges, there are 18 RAMPs currently in practice in a variety of specialties across Ireland, demonstrating the various areas in which midwives can extend their scope of practice and become specialists in their chosen area of expertise.

RAMPs are the lead clinical experts and pioneers in their chosen clinical field of expertise. They use their expertise, knowledge, leadership, clinical skills and critical decision-making abilities to provide a complete episode of care from admission to discharge for a locally agreed caseload of women. They have referring rights and prescriptive authority. They are constantly evaluating, auditing, researching and developing their practice to enhance the service they provide for their cohort of women.

Pioneering appointment

University Hospital Waterford was the first maternity unit to have a RAMP in post with a focus on clinical leadership, peer review and midwifery-led care (MLC). The RAMP service was introduced to reduce unnecessary interventions and to nurture and expand midwifery services. At an advanced practice level, the RAMP has a caseload of women with specific midwifery needs, provides clinical supervision for MLC and facilitates education to ensure care is evidence based. The RAMP in Waterford is also the designated midwifery officer (DMO) for homebirth services in the region.

Emergency assessment

Within the emergency and assessment departments of the Rotunda Hospital, the National Maternity Hospital (NMH) and St Luke's General Hospital in Kilkenny, there are four RAMPs who provide optimum midwifery-led care and individualised care to those who fall within their scope of practice. The RAMPs use advanced clinical skills, innovative thinking, experience, health promotion, knowledge and decision-making abilities to improve clinical outcomes for those who attend the service. The presence of the RAMP allows for a more immediate response to obstetric emergencies, prevents unnecessary admissions, reduces waiting times and provides a heightened assessment of foetal and maternal wellbeing.

Diabetes care

There are two RAMPs in diabetes care: one in the University of Limerick Hospital Group and one in the NMH. They provide care to women with pre-existing diabetes and gestational diabetes before, during and after pregnancy. The RAMP diabetes service develops a care plan, monitors the woman throughout the pregnancy, refers as required, admits and discharges from both the RAMP service and maternity service and has close links with the consultant endocrinologist and consultant obstetrician. This includes clinical decision/diagnosis in relation to diabetes care, initiating treatments, prescribing and titrating medication regimes based on clinical need, as well as facilitating staff education pertaining to diabetes.

There are two other RAMPs in the NMH. One is in postnatal morbidity. This is a collaborative, multidisciplinary service for women to manage and review physical and emotional complications related to childbirth. The second RAMP is in urodynamics and Women's Health. The service is for women experiencing lower urinary tract dysfunction and enables them to lead an independent life with minimum discomfort. It also provides care for women who have had an obstetric anal sphincter injury postnatally and in subsequent pregnancies.

Haematology

The Coombe Women and Infants University Hospital in Dublin has two RAMPs. One RAMP is in haematology and maternal medicine. This service cares for women with complex blood disorders that require specialist care planning, and it marries obstetric and midwifery care based on the woman's medical, emotional and social needs in pregnancy, thus normalising pregnancy and birth for women on the specialised care pathway. The other RAMP is the link between the hospital service and the community midwifery-led service as the lead clinical expert to oversee expansion of the service and the eventual midwifery-led unit for women on the supported care pathway.

St Luke's Hospital Kilkenny has two RAMPs. One in the emergency assessment as discussed previously. The other RAMP specialises in holistic midwifery care with the main focus on the physiological birth process. She is also the clinical lead and supervisor for the midwifery-led community services. Having a RAMP in this location enabled the Early Transfer Home Service, facilitating early discharge and providing care as close to home as possible in alignment with the Sláintecare Programme.

Sligo University Hospital has one RAMP who provides continuity of midwifery care to women who do not meet the criteria for midwifery-led care due to underlying medical conditions, one previous caesarean section and other complexities. The RAMP's extended scope of practice ensures the service provides a choice of care pathway that normalises pregnancy and birth for these women within the midwifery philosophy of care.

In University Hospital Galway the RAMP is responsible for the development of the supported care pathway and extending MLC to include continuity of care and early transfer home. The RAMP caseload specialises in birth after caesarean section, which involves discussing birth options with women who have had a previous section and providing them with the most up to date information to facilitate informed decision-making about their next birth.

Registered advanced midwife practitioners in Ireland

Hospital	Name	Specialty
University Hospital Waterford	Janet Murphy	MLC clinical supervision
Rotunda Hospital	Bernadette Gregg	Emergency department
	Debra England	Emergency department
	Ursula Nagle*	Perinatal mental health
National Maternity Hospital	Anitha Baby	Emergency department
	Ciara Coveney	Diabetes
	Caroline Brophy	Postnatal maternal morbidity
	Linda Kelly	Urodynamics and women's health
	Usha Daniel*	Diabetes
Coombe Women & Infants University Hospital	Catherine Manning	Haematology and maternal medicine
	Nora Vallejo	MLC link hospital and community
University of Limerick Hospital	Yvonne Maloney	Diabetes
	Yvonne Tier*	Diabetes
St Luke's Hospital, Kilkenny	Clare Kennedy	Holistic MLC, VBAC, community
	Susan Sherwood	Emergency department
Sligo University Hospital	Roisin Lennon	MLC assisted care pathway
University Hospital Galway	Jennifer Duggan	Extending MLC and VBAC
Wexford General Hospital	Orla Mongan*	Intrapartum care

** Appointments since article accepted for publication*

Since this article was accepted for publication, four further RAMPs have been appointed around the country: one in Wexford General Hospital with a vision and a plan for intrapartum, supported care; one in the Rotunda Hospital in perinatal mental health; and a RAMP in diabetes care for both NMH and University Hospital Limerick.

As midwifery care in Ireland changes to align with and implement the National Maternity Strategy, midwives and RAMPs are in an exciting and a unique position to embrace and impact the way maternity care services are structured and delivered. Midwives who provide care within their full scope of practice will become the leaders and caregivers in normal pregnancy, birth and postnatal care.

Leadership

Through the use of their extended scope of practice and advanced decision-making abilities, RAMPs will continue to provide leadership and be an expert resource for midwives, obstetricians, other specialties and the service users. The future of maternity care in the 21st century is evolving to ensure that the woman and her family have more informed choices. These alternative options have enabled a specific range of maternity caregivers based on the women's individual needs. The maternity service needs to ensure that the woman is central to the caregiving and their birth is viewed as a normal physiological event, yet remaining cognisant that some women will require obstetric input and other specialist care based on their individual needs and circumstances.

Advanced practice roles have been proven to deliver significant service user benefits. The publication of *'The Development of Graduate to Advanced Nursing and Midwifery Practice'* (2019) heralded a new model for advanced nursing and midwifery practice. The aim is to have 2% of the nursing and midwifery workforce practising at an advanced level.

The collaboration between the HSE and the Department of Health to achieve this and to implement Sláintecare is a clear indication of the importance of the contribution and impact of advanced practitioners on the health of the population. Nurses are ahead of midwives on advanced practice, but the midwifery workforce is gradually evolving and developing new services and roles to reflect the changing needs of Irish maternity services in the 21st century.

Roisin Lennon is a registered advanced midwife practitioner at Sligo University Hospital and Bernadette Gregg is a registered advanced midwife practitioner at the Rotunda Hospital, Dublin

Opioids and pain management: Lessons from the US

Elaine Clear explores the role played by the 'Pain as the Fifth Vital Sign' campaign in the deaths of thousands of people in the US during the opioid crisis

THE experience of acute pain is very individual and subjective, influenced by physiological, psychological, environmental factors, experiences in early life, coping strategies, culture, prognosis, fear, anxiety and depression.[1] The link between mood disorders and acute pain is significant since the link is bi-directional, with both acting as risk factors for each other.

While the gold standard to assess pain remains self-report, it must be recognised that it is influenced by some or all of the above factors. The most common acute pain assessment tool is the numerical rating scale (NRS), which is quick to administer but only assesses pain intensity and not the other variables that can influence pain, such as the patient's mood or their ability to function.

Pain as the Fifth Vital Sign

In the 1990s there was a campaign in the US to encourage doctors and nurses to listen to their patients and assess and manage their pain adequately. In 1996 James Campbell, president of the American Pain Society, introduced 'Pain as the Fifth Vital Sign' (P5VS), stating that if pain was assessed with the same zeal as the other vital signs, it would have a much better chance of being treated properly.

In 1998 the US Veteran Health Association (VHA) adopted P5VS and in addition advocated using the unidimensional numerical rating scale (NRS 0-10/10) to assess pain at rest and on movement. It added that a pain score of 4/10 or over should trigger a comprehensive pain assessment and prompt intervention, which invariably became an opioid.[2,3]

Opioid prescriptions

Throughout the 2000s, the zeal to assess and treat pain culminated in the number of opioid prescriptions increasing exponentially all over the US.[4] Several factors contributed towards this including the pharmaceutical industry, which used opportunistic aggressive marketing, made false claims about opioids being non-addictive, sponsored drug trials designed to demonstrate superiority and collaborated with researchers penalised for fabricating data.

The pharmaceutical company Perdue Pharma informed doctors that its opioid painkiller OxyContin and Oxynorm were non-addictive, so the number of prescriptions in the US sky-rocketed from about 76 million in 1991 to nearly 207 million in 2013.[5] In 2000, the Joint Commission, which accredits healthcare facilities in the US, published a book, sponsored by Perdue Pharma, targeting doctors as part of continuing practice education, which claimed there was no evidence that addiction was a significant issue when people are given opioids for pain control.[5] This was untrue: between 1999 and 2015 there were more than 183,000 deaths from prescription opioids reported in the US.[6]

Patients in the US were prescribed larger doses of opioids for longer periods. Many prescriptions were inappropriate opioid prescriptions for minor ailments, which put patients at greater risk of addiction. Poor knowledge of safe opioid prescribing, use of repeat prescriptions, use of long-acting opioids, doctor shopping, use of compound preparations such as Solpadol or Ixprim where opioids are mixed with other analgesics such as paracetamol, the mistaken belief that dependence on opioids was rare and lack of stewardship, all exacerbated the opioid epidemic.[7]

Patients from socioeconomically deprived backgrounds, those with alcohol or drug dependence, psychological issues such as depression and anxiety, were more vulnerable to developing opioid addiction. Unused opioids were shared and often stolen or sold. Diversion, misuse and abuse of opioids resulted in a 493% increase in the rate of opioid use disorder between 2010 and 2016.[8]

In 2017 alone, there were more than 72,000 deaths from overdoses in the US, more deaths than from gunshots (37,400), car accidents (38,000) or breast cancer (40,000).[5] These 72,000 deaths represented the tip of the iceberg, the portion

below the surface was estimated at 30 non-fatal overdoses for every opioid death.

A study by Cicero et al in 2014[9] on heroin use found there was a shift from an inner city, minority population to a wider suburban use among white men and women in their late 20s. They found that 75% of heroin users started their opioid misuse with prescribed opioids.

A report in 2015 by the US Centers for Disease Control and Prevention[10] found that those addicted to prescription opioids were 40 times more likely to become addicted to heroin. In October 2017, President Trump announced a national healthcare emergency but did not request any funding to help resolve it.[11]

In 2016 the opioid crisis culminated in the American Medical Association (AMA), the American College of Surgeons, the Joint Commission, the American Academy of Family Physicians, and the Centers for Medicare and Medicaid Services, all withdrawing their advocacy of 'Pain as the Fifth Vital Sign' campaign.[12] They argued that its reliance on the numerical rating scale had failed to improve pain management despite its positive intentions, and had directly contributed to the opioid epidemic.

Critics argued that while Pain as the Fifth Vital Sign (P5VS) campaign was well intentioned, it had unintended consequences. They claimed that unlike the four vital signs – heart rate, respiratory rate, blood pressure and temperature – self-reporting of pain is a subjective measurement and that nurses and doctors were encouraged to accept patients' pain scores and prescribe/administer opioids accordingly.

They added that P5VS relied on the numerical rating scale to titrate opioids according to patients' pain scores so that if they scored 8/10 for example, they got higher doses of opioids. As referred to above, the numerical rating scale only measures pain intensity and not the patient's level of anxiety, which can greatly influence a patient's pain score or their ability to move. These critics claimed this reliance on pain scores alone and not on their ability to function and mobilise, directly contributed to the prescribed-opioid crisis.[12,13]

Functional Activity Scale (FAS)

In 2020, the Australian & New Zealand College of Anaesthesia and Faculty of Pain Medicine (ANZCA)[14] recommended the use of the Functional Activity Scale (FAS), a simple three-level score to assess a patient's ability to undertake an appropriate activity and if unable, to trigger an intervention *(see Table 1)*.

Table 1: Functional Activity Scale (FAS) (ANZCA 2020)[15]

A: *No limitation* – the patient is able to undertake the activity without limitation due to pain (pain intensity score is typically 0-3/10)
B: *Mild limitation* – the patient is able to undertake the activity but experiences moderate to severe pain (pain intensity score is typically 4-10/10)
C: *Significant limitation* – the patient is unable to complete the activity due to pain, or pain treatment-related adverse effects, independent of pain intensity scores

The patient's ability to do the activity is measured using the FAS as either A, B or C. If the patient is unable to perform an appropriate activity, this is a trigger for intervention. Analgesia should be titrated to reduce pain intensity and promote the patient's ability to undertake appropriate functional activity.[15]

By assessing acute pain using the FAS does not necessarily mean abolishing P5VS; pain needs to be assessed and treated on a regular and ongoing basis. Not asking about pain does not make it go away, nor does it relieve healthcare professionals of their moral and ethical obligation to assess and treat pain effectively.

Functional assessment has become the universal measure of outcome success in the treatment of COPD, heart failure, diabetic neuropathy, fatigue, headache, etc. According to Lee,[16] aiming to reduce patients' suffering and improve function is more in keeping with patients' expectations. This shift towards assessing patients' ability to move reflects a change in practice so that instead of asking a patient if they have pain, the questions asked should be: "Are you able to… take a deep breath/sit up in bed/cough/get out of bed/walk?" etc.

The aim is to assess acute pain and its limitations on movement without the influence of psychological, emotional factors that make pain so subjective. It is important to address any of these psychological factors and at the very least, reassure and show kindness to the patient. In this way, dependence on opioids to manage acute pain is minimised.

Conclusion

Dependence on opioids to treat acute pain is appropriate and needed while simultaneously continuing to enhance opioid reduction initiatives to treat trauma and postoperative pain. Inadequately controlled acute pain is a risk factor for chronic pain. Local anaesthetic infusion therapies such as the paravertebral infusion for thoracotomy incisions and multiple fractured ribs; erector spinae plane infusions for major abdominal surgery, peripheral nerve block infusions for lower limb amputations, all provide very safe, effective, opioid-free pain management for five days.

Elaine Clear is an advanced nurse practitioner in acute pain management at St Vincent's University Hospital, Dublin

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Irish Nurses and Midwives Organisation

Preceptor of the Year 2022

www.inmo.ie

Nominations for the annual 'Preceptor of the Year' Award, sponsored by Cornmarket Group Financial Services, are now open.

Nominations for the 'Preceptor of the Year' must be made on the official nomination form, which can be completed on the INMO website.

The award recognises an INMO member who has inspired and motivated the student to reach their full potential.

The member chosen as 'Preceptor of the Year', together with a partner or colleague, will be invited to receive their award at the annual awards dinner, which will be held during the annual delegate conference in Sligo this year. The student member who nominated the chosen preceptor, along with a colleague, will also be invited to attend.

The deadline for nominations is the 30 March 2022.

For more information visit www.inmo.ie/Preceptor_of_the_Year

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Section focus

INMO Professional

Jean Carroll, Section Development Officer

Governments must invest in post-pandemic healthcare

TOYOSI Atoyebi, secretary of the INMO International Nurses Section, has made a call for governments to invest in post-pandemic healthcare.

She pointed out that Covid-19 continues to burden global healthcare systems and test the resolve of frontline nurses, midwives and all healthcare workers. Nurses and midwives are continuing to provide the best care possible while risking their own wellbeing, she said.

"The pandemic highlighted the critical role played by nurses in the entire healthcare ecosystem. However, the nurses publicly described as heroes during the pandemic, are now at the end of their tether. Going to work became a nightmare and was exhausting for nurses throughout this crisis. Many nurses are burned out at this stage," said Ms Atoyebi.

"With the world now entering the third year of the Covid-19 pandemic, a lot must change – governments must invest in post-pandemic healthcare," she said.

She pointed out that reflection is a major part of the nursing profession. Therefore,

Toyosi Atoyebi, secretary of the INMO International Nurses Section

she said she is looking forward with renewed hope for strategic interventions by government to help combat nurse burnout and protect patient safety.

A voice for retired nurses and midwives

THE Retired Section has a busy year planned, with plenty of social activities on the agenda along with official section business meetings.

There will be a guest speaker at most of the section meetings, the next one being on April 21, which will either be held online or in The Richmond, if public health conditions continue to improve.

Susan Shaw, CEO of the Irish Senior Citizens Parliament, will give a presentation to this meeting addressing the question 'Where is the voice of retired workers?'

The section recently had an overnight stay and dinner in the Morrison Hotel, Dublin. More than 30 people attended the dinner and 18 stayed over for the night. Restrictions had just been lifted, so thankfully that facilitated a lovely social evening for all involved.

Organiser of the evening, Myra Garahan said: "There was a great buzz among us. It gave us all such a lift and the staff were so very friendly, attentive and helpful. A lucky few were treated to some welcome gifts in their bedrooms – a bottle of bubbly or a bar of Butler's chocolate and cookies. I would really recommend coming along to these social events – they are such a great way of staying in touch with colleagues and our much loved professions."

Social activities are open to all section members – whether you have attended before or not – see below for upcoming events.

INMO Retired Nurses Section Social Outings 2022

Dublin – Tuesday, April 5: Kilmainham Jail tour at 11,40am
Contact: Ger Sweeney, 087 2794701

Killarney – Monday, May 2-Friday May 6: Four nights/5 days at the Castlerosse Hotel, Killarney, Co Kerry
11.30am Departure from Hugh Lane Gallery, Parnell Square North, Dublin 1
Accommodation rate: €370 per person sharing (+€30 single room supplement – only 15 single rooms available). Early booking advised
Contact: Annette McGinley, 074 9135960 or info@jmgtravel.ie

Galway – Wednesday, July 6: Day trip with lunch at 1pm at Park House Restaurant
Contact: Teresa Connolly, 087 6402962

In brief...

PHN Section

At its recent AGM, the PHN Section elected new officers to oversee the running of the section for the coming year. Incoming chairperson Mary Tully thanked Eilish Fitzgerald, chairperson and INMO first vice president, for her years of service to the section. Eilish has been chairperson of the PHN section for the past two years and involved with the INMO for many more.

The dates for your diary for the PHN section meetings for the year are April 2, June 11, Sept 10 and Nov 12. The next AGM will be held on Jan 21, 2023. All meetings take place from 10.30am on Zoom, as the agreed by the section, as attendance is positively influenced by being online.

Telephone Triage Section

The Telephone Triage Section is busy organising its annual conference, which it hopes can be a fully in-person event. It will take place on Wednesday, September 28 in the Midland Park Hotel, Portlaoise. Topics being covered include: catheter care in the community, children's respiratory conditions, PQ vacuum dressings, tropical health and more. Details will be finalised in the coming months and paid bookings, which are essential, can be made through **INMOProfessional.ie**

Get in touch

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

INMO Professional

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Webinars & Conferences for Nurses and Midwives

Webinars and Conferences 2022

ONLINE AND IN-PERSON EVENTS

All conferences and webinars are Category 1 approved by NMBI

Thursday 9 JUNE — Emergency Department Nurses Section Webinar

Tuesday 20 SEPTEMBER — Care of the Older Person Section Webinar

Wednesday 28 SEPTEMBER — Telephone Triage Nurses Nurses Section Webinar

Thursday 10 NOVEMBER — All Ireland Midwifery Conference

Date to be Confirmed — Operating Department Nurses Section Webinar

Date to be Confirmed — Occupational Health Nurses Section Webinar

Date to be Confirmed — RNID Section Webinar

Date to be Confirmed — Director & Asst. Directors Section Webinar

Date to be Confirmed — Public Health Nurses Section Webinar

Date to be Confirmed — International Nurses Section Culture Fest

For more Information:

Jean Carroll, Section Development Officer
jean.carroll@inmo.ie, www.inmoprofessional.ie/conference

INMO Professional

Continuing professional development for nurses and midwives

INMO EDUCATION PROGRAMMES

In the pull-out this month…

Intellectual Disability Services

Mar/Apr

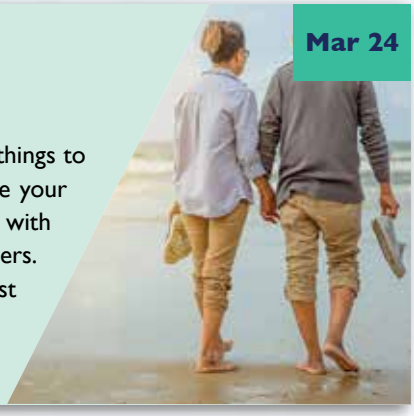
We have a series of new short online courses which will provide understanding, knowledge and skills when delivering care to individuals who may present with behaviours that challenge. These include:

- Developing Behaviour Management Strategies (March 7)
- Positive Behaviour Support – An Introduction (March 14)
- Post-incident Reviews – Operational and Peer Debriefing (March 21)
- Consent and Positive Risk Taking (March 28)
- Infection Prevention and Control in the Disability Services (April 4).

Special discounts for INMO members and group bookings.
Visit **www.inmoprofessional.ie** or Tel: 01 6640641/18 to avail of special offers.

Retirement Planning Webinar

Mar 24

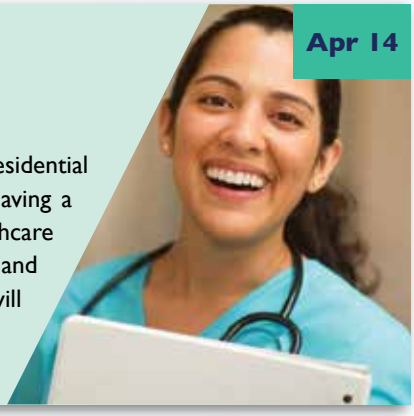


2-3pm. Free for all

Planning for retirement is even more important today than it has ever been. There are many things to consider as you approach retirement. It's good to start by reviewing your finances to ensure your future income will allow you to enjoy the lifestyle you want. INMO Professional, in partnership with Cornmarket Financial Services, have developed this online webinar to help support our members. It will briefly cover the following: superannuation, AVCs, lump sum and investments. Places must be booked in advance to join this webinar. To book, visit **www.inmoprofessional.ie** or email education@inmo.ie with your INMO number, email and the name you are registered with us.

Clinical Governance for Senior Management for Nurses and Midwives

Apr 14



This short online programme is most relevant to senior nurse managers within the acute or residential healthcare settings to help them understand and be confident in building their skills and having a keen knowledge of clinical governance. Clinical governance is the system through which healthcare organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which clinical excellence will flourish.

Steve Pitman
Head of Education and Professional Development

INMO Professional continues to adapt to the changing environment with the lifting of pandemic restrictions. We expect to be able to welcome members back to the Richmond Education and Event Centre in the near future. Clinical skills-based training courses, meetings and conferences will recommence over the coming months. Online courses will continue to be offered, and new courses will be developed. This will ensure that members across the country have a variety of options that can support their continuing professional development.

THE RICHMOND
EDUCATION AND EVENT CENTRE

Maintaining professional confidence

The NMBI has commenced the development of the Scheme for Monitoring of Maintenance of Professional Competence. The requirement for the Board to introduce a scheme is outlined in the Nurses and Midwives Act 2011. The Scheme is one of the actions included in the NMBI Statement of Strategy 2020-2022. The first phase of this process involves developing and consulting on a proof of concept. It is expected that the consultation process involving key stakeholders on the Scheme's development will continue throughout the first half of 2022.

Pure Foundation Bursary Award

INMO Professional would like to congratulate the winners of the Pure Foundation Bursary Award. INMO members Claire Fitzpatrick (clinical midwife and specialist in lactation at Midland Regional Hospital Portlaoise), Anne Buckley (neonatal nurse at Cork University Maternity Hospital) and Pauline O'Connor, (public health nurse, Claremorris) were each awarded €2,500 for their respective departments *(see page 61)*.

ICN NP/APN Network Conference 2022

The call for abstracts and registration is now open for the 12th ICN NP/APN Network Conference in Dublin. The conference will be an in-person event that will take place from August 21-24, 2022 at University College Dublin. This will be one of the largest nursing conferences to be held in Ireland. The conference is hosted by the INMO and the Irish Association of Advanced Nurse and Midwife Practitioners and is open to nurse/midwife practitioners, advanced practice nurses/midwives, clinical nurse/midwife specialists and registered nurses and midwives. The theme for the conference is 'Advanced Practice Nursing: Shaping the Future of Healthcare'. Further details can be found *page 70* and on: **www.npapndublin2022.com**

Midwifery and nursing festivals

The INMO will be collaborating with NSA in delivering the Maternity and Midwifery Festival and the Nursing Festival in 2022. These popular events will run on March 29 and 30 in the Helix, Dublin City University. More details are available on *page 6*, as well as on the INMO website. Speakers include: Michelle Acorn, ICN chief nurse; Karen McGowan, INMO president; Rita Devlin, RCN NI; Paul Gallagher, IEHG; Loretta Dignan, Menopause Hub; and many more. These events are free and places can be booked on **www.eventbrite.com**

International nurses and midwives

The second online 'orientation programme to the Irish healthcare system and culture for international nurses and midwives' took place on February 22, 2022. The event was hugely successful, with nurses from India, the Philippines and Africa attending. This initiative was designed to welcome and support migrant nurses and midwives planning to move to Ireland or who have recently made Ireland their home. The topics covered included rights and entitlements, career and professional development opportunities, an introduction to the International Nurses and Midwives Section and an introduction to Irish culture.

CJ Coleman Award 2022

The closing date for the CJ Coleman Research and Innovation Award 2022 has been extended until April 7, 2022. CJ Coleman has been generously sponsoring the INMO members research award for over a decade. A bursary of €1,000 will be awarded for a completed research/change project that promotes and improves the quality of patient care and/or staff working conditions in an innovative way. A link to the award application form is available at **www.inmo.ie** where further details can be found.

On-site Education

INMO Professional offers an extensive range of on-site programmes facilitated by expert practitioners. If you are interested in booking one, email marian.godley@inmo.ie or call 01 6640642.

Delivering courses and writing for *WIN*

INMO Professional is eager to offer members the opportunity to work with us in delivering education courses. If you are an advanced nurse or midwife practitioner, a clinical nurse/midwife specialist or a nurse/midwife with expertise in clinical or management practice, we would like to hear from you by email: education@inmo.ie or Tel: 01 6640642.

INMO Professional is also interested in hearing from members who would like to write professional and clinical articles for *WIN*. Email steve.pitman@inmo.ie

INMO Professional

Online Education Programmes

Tel: 01 6640641/18
Email: education@inmo.ie

All of the following programmes are category 1 approved by the NMBI and allocated continuous education units
Fee: €30 members; €65 non-members
Time: 10am-1pm

Book three online education programmes and get the fourth free
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Keep your CPD up to date • Extensive range of programmes • NMBI category 1 approved • Digital certification provided

Mar 7 **Developing Behaviour Management Strategies**

This workshop will focus on approaches that can be used to develop individualised proactive and reactive behaviour management strategies to support individuals that may present with behaviours that challenge. The workshop will be relevant to management and frontline staff that work in health and social care settings where there are individuals who may present with behaviours that challenge. This course is part of a series of online programmes for management and frontline nursing staff that work in health and social care settings.

Mar 8 **Training Delivery and Evaluation – new dates**

This five-day training module will now take place on the following dates 20-22 Sept and 4, 5 October 2022. For more information E: education@inmo.ie

Mar 10 **Risk Management and Incident Reporting**

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

Mar 14 **Positive Behaviour Support – An Introduction**

This short course utilises a human right based and person-centred approach as a means of identifying supportive environments for individuals in health and social care settings. The workshop will be relevant to management and frontline staff that work in health and social care settings where there may be individuals who can present with behaviours that challenge. This course is part of a series of short online programmes for management and frontline nursing staff that work in health and social care settings.

Mar 21 **Post-Incident Reviews (Operational and Peer Debriefing)**

Post-incident supports are an essential element of workforce wellbeing whilst also helping to ensure quality service delivery. This workshop provides guidance about proactive supports and reactive interventions that can be utilised to support staff wellbeing and organisational learning after incidents. The workshop will be relevant to management and frontline staff that work in health and social care settings where there may be some exposure incidents that may cause a stress reaction. This course is part of a series of short online programmes for management and frontline nursing staff that work in health and social care settings.

Mar 23 **Strategies for Managing Conflict**

The learning outcome for this course will be to help participants develop the insights and skills necessary to navigate conflict situations and reach satisfactory solutions. In many ways, workplaces are perfect breeding grounds for conflict. As well as our skills, we bring our individual needs, goals, ambitions, personalities, perspectives, backgrounds and vulnerabilities with us to work. It is hardly surprising, then, that conflict can arise from time to time as we interact with others with their own unique take on the world. While a moderate amount of conflict can be healthy, unresolved conflict can lead to many negative outcomes, with consequences for wellbeing and careers.

Mar 23 **Introduction to Treating and Preventing Pressure Ulcers**

This short online course will advise participants on pressure ulcer prevention. Topics covered on the day include; causes of pressure ulcers, risk assessment, and prevention of pressure ulcers. Learning outcomes: discuss the causes of pressure ulcers; identify the factors that place a person at risk of developing pressure ulcers; have an understanding of the key principles of preventing ulcers and be able to take action to prevent pressure ulcers in the clinical environment; have an understanding of pressure ulcer classifications and grading; have an understanding of the key principles of the SSKIN Bundle and how to implement it in the clinical environment.

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

Mar 24 **The 'Know How' of Inhaler Technique**

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

Mar 24 **Introduction to Positive Behaviour Support**

Positive Behaviour Support is an internationally recognised evidence-based approach to supporting individuals that can present with behaviours that challenge. This one-day workshop introduces participants to the model of Positive Behaviour Support and outlines the benefits and considerations in its utilisation from a practical and applied standpoint. Fee €60 INMO members; €130 non-members. Time: 9.15am-4.45pm

Mar 28 **Promoting Informed Consent and Positive Risk in Nursing Persons with an Intellectual Disability**

The aim of this programme is outline principles of practice for supporting clients' autonomy through the promotion of informed consent and positive risk taking in person centred planning. This course is part of a series of short online programmes for management and frontline nursing staff that work in health and social care settings. This course is part of a series of short online programmes for management and frontline nursing staff that work in health and social care settings.

Mar 30 **Introduction to Management and Leadership Skills for Nurses and Midwives**

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

Mar 30 **Introduction to Oncology: Terminology and Patient Pathways**

This course will give participants an increased understanding of the language of oncology in order to improve fluency with patients and colleagues, and increased insight into the oncology journey and stages. There will also be an opportunity to ask questions.

Mar 31 **Medication Management Best Practice – Guidance for Nurses and Midwives**

This programme supports 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 NMBI Guidance for Registered Nurses and Midwives Administration (2020) and HIQA requirements for medication management.

Mar 31 **Paediatric Asthma – Understanding the Basics**

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

Apr 4 **Infection Prevention and Control in Disability Services**

This training provides nurses with the knowledge and skills to implement infection prevention and control practices and procedures in the workplace, which is essential for all healthcare workers, especially those who work with vulnerable service users. The session will provide participants with a comprehensive understanding of the process of preventing infections from spreading; this includes proper hand hygiene procedures, the use of personal protective equipment, and decontamination of the environment and waste disposal. This course is part of a series of short online programmes for management and frontline nursing staff that work in health and social care settings.

Apr 5 **Tools for Safe Practice for Nurses and Midwives**

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 understand the processes involved regarding patient alerts, clinical incidents and thorough assessment, while remaining focused on the patient. This programme is free to members.

Apr 7 **Diabetes CBT and general wellbeing**

The self-management of diabetes is associated with high incidence rates of depression and anxiety. The use of different strategies, cognitive behaviour therapy (CBT) and clinical trials look at the area of wellbeing and theories and models to help clients and healthcare providers to formulate plans to look at these issues. This programme explores techniques to help clients to manage their diabetes..

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

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

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.

Apr 12 **Introduction to Chemotherapy**

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

Apr 13 **Introduction to Wound Management for Nurses and Midwives**

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

Apr 14 **Clinical Governance for Senior Nurse Managers (Acute/Residential Healthcare Settings)**

This short online programme is aimed at the most relevant to senior nurse managers within the acute or residential healthcare settings to help them understand and be confident in building their skills and having a keen knowledge of clinical governance. Clinical Governance is the system through which healthcare organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which clinical excellence will flourish.

Apr 14 **Competency-based Interview Preparation for Nurses and Midwives**

This 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 reacted to, dealt with and handled previous workplace situations. It will explore preparation, presentation and performance during the interview and briefly focus on CV preparation.

Apr 20 **PEG Feeding – Caring for Adults and Paediatrics who have a PEG Tube**

This short introductory programme is aimed at all 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.

Apr 21 **Infection Control Regulation 27: Guide to Thematic/Focused Inspections in your Facility**

This course is for staff who are interested in infection prevention and control standards. It will identify key areas relevant to the new focused HIQA infection control guidelines/inspections (October 2021). This programme will provide information and outline the actions required by registered providers to ensure that procedures, consistent with the National Standards for infection prevention and control in community services, published by HIQA, are implemented by staff.

Apr 26 **Restrictive Practices in Residential Care Settings for Older People**

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

Apr 27 **Improve Your Academic Writing and Research Skills**

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

Apr 28 **Chronic Obstructive Pulmonary Disease (COPD) – Getting the Basics Right**

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

Apr 28 **Recognition and Management of Sepsis**

This online session will focus on early recognition and management of Sepsis. Case studies will be included to create an interactive learning platform to engage participants throughout the session. Outcomes: discuss and provide background for development of sepsis; identify the early recognition of signs of sepsis; discuss implementations of sepsis guidelines through fluid and antimicrobial stewardship; apply and integrate evidence based guidelines into patient care planning.

May 5 **Adult Asthma – Getting the Basics Right**

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

May 10 **Risk Management and Incident Reporting**

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

May 11 **Introduction to Treating and Preventing Pressure Ulcers**

This short online course will advise participants on pressure ulcer prevention. Topics covered on the day include; causes of pressure ulcers, risk assessment, and prevention of pressure ulcers. Learning outcomes: discuss the causes of pressure ulcers; identify the factors that place a person at risk of developing pressure ulcers; have an understanding of the key principles of preventing ulcers and be able to take action to prevent pressure ulcers in the clinical environment; have an understanding of pressure ulcer classifications and grading; have an understanding of the key principles of the SSKIN Bundle and how to implement it in the clinical environment.

May 12 **Telephone Assessment and Advice Skills**

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

May 12 **Best Practice for Clinical Audit for Nurses and Midwives**

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

May 18 **End of Life Care in Residential Care Settings for Older Persons**

This online programme outlines information specific to the care and support of residents and their families in end of life care. The course aims to recognise signs and symptoms of deterioration, and will assess, monitor and review physical, psychological, social and spiritual areas of care at the end of a person's life. Participants will be able to identify and apply effective interpersonal communication with families of a loved one at end of life during this difficult period. Furthermore, the outline of debriefing of staff and bereavement care for residents and relatives is addressed.

May 25 **Introduction to Wound Management for Nurses and Midwives**

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

Jun 9 **Tracheostomy Care Study Day**

This programme introduces a holistic and interdisciplinary 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. The programme will cover the anatomy, the different types of tracheostomy tubes, complications communication and swallowing in a patient with a tracheostomy, how to manage emergencies safely, the purpose of humidification, managing safe suctioning of a patient and how to be aware of nursing care of a tracheostomy.

INMO Professional

INMO
Irish Nurses and Midwives Organisation
Working Together

LIVE ONLINE EVENTS

SERIES OF ONLINE COURSES

Intellectual Disability Services

We have a series of short online programmes designed specifically for nurse management and frontline nursing staff that work in health and social care settings. These programmes will provide an understanding, knowledge and skills when delivering care to individuals who may present with behaviours that challenge.
They take place on Mondays, online 10.00am – 1.00pm.

Monday **07 March**

Developing behaviour management strategies

This workshop will focus on approaches that can be used to develop individualised proactive and reactive behaviour management strategies to support individuals that may present with behaviours that challenge.

Monday **14 March**

Introduction to positive behaviour support

This short course utilises a human right based and person-centred approach as a means of identifying supportive environments for individuals in health and social care settings.

Monday **21 March**

Post-incident reviews (operational and peer debriefing)

Post-incident supports are an essential element of workforce wellbeing whilst also helping to ensure quality service delivery. This workshop provides guidance about proactive supports and reactive interventions that can be utilised to support staff wellbeing and organisational learning after incidents.

Monday **28 March**

Promoting informed consent and positive risk in nursing persons with an intellectual disability

The aim of this programme is to outline principles of practice for supporting clients' autonomy through the promotion of informed consent and positive risk taking in person centred planning.

Monday **04 April**

Infection prevention and control in the disability services

This training provides nurses with the knowledge and skills to implement infection prevention and control practices and procedures in the workplace, which is essential for all healthcare workers, especially those who work with vulnerable service users.

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Taking a look at the latest journals

This month the staff in the library highlight some newly published Irish and international research from the journals

Nursing

- Wall O, O'Sullivan E. Teaching acute hospital staff and students about patient flow. British Journal of Nursing. 2021;30(13):812–9
- Cheung M, Fitzpatrick M. The impact of the CervicalCheck controversy on provision of colposcopy services in Ireland: A cohort study. European Journal of Obstetrics & Gynecology & Reproductive Biology. 2021;262:228–31
- Walpole G, Kelly M, Lewis J, Gleeson A, Cullen A-M, Wochal P. Living with myeloproliferative neoplasms (MPN) in Ireland: patients' and caregivers' perspectives. British Journal of Nursing. 2021 Sep 23:S24–30
- Pierse T, O'Neill S, Dinneen SF, O'Neill C. A simulation study of the economic and health impact of a diabetes prevention programme in Ireland. Diabetic Medicine. 2021;38(6):1–8
- O'Connell S, McCarthy VJC, Queally M, Savage E. The preferences of people with asthma or chronic obstructive pulmonary disease for self-management support: A qualitative descriptive study. Journal of Clinical Nursing. 2021;30(19/20):2832–41
- Murphy L, Moore S, Swan J, Hehir D, Ryan J. Examining the impact of video-based outpatient education on patient demand for a rheumatology CNS service. British Journal of Nursing. 2021;30(18):1056–64
- Freaney S. More planning and slower discharge: a qualitative study of the facilitators of and barriers to a smooth discharge for stroke patients. British Journal of Neuroscience Nursing. 2021;17(Sup5): S8–14.

Midwifery

- Hayes-Ryan D, Meaney S, Byrne S, Ramphul M, O'Dwyer V, Cooley S. Women's experience of Manual Vacuum Aspiration: An Irish perspective. European Journal of Obstetrics & Gynecology & Reproductive Biology. 2021;266:114–8
- Doherty J, Brosnan M, Sheehy L. Changes in care in the fourth trimester in Ireland: 2010–2020. British Journal of Midwifery. 2021;29(12):683–91
- Leahy-Warren P, Mulcahy H, Corcoran P, Bradley R, O'Connor M, O'Connell R. Factors influencing women's perceptions of choice and control during pregnancy and birth: a cross-sectional study. BMC Pregnancy & Childbirth. 2021;21(1):1–12.
- O'Riordan N, Robson M, McAuliffe FM. Management of poor progress in labour. Obstetrics, Gynaecology & Reproductive Medicine. 2021 ;31(12):342–50.

Emergency Department

- Bernard P, Corcoran G, Kenna L, O'Brien C, Ward P, Howard W, et al. Is Pathfinder a safe alternative to the emergency department for older patients? An observational analysis. Age & Ageing. 2021;50(5):1854–8
- Mulhearne P, Cotter P, O'Shea M, Leahy-Warren P. Experiences of registered general nurses who care for patients presenting with self-harm to the emergency department in Ireland. International Emergency Nursing. 2021; 58:101047. doi: 10.1016/j.ienj.2021.101047

Nursing Education

- Veigh CM, Reid J, Carswell C, Ace L, Walsh I, Graham-Wisener L, et al. Mindfulness as a well-being initiative for future nurses: a survey with undergraduate nursing students. BMC Nursing. 2021 Dec 20 ;20(1):1–9
- Kaihlanen A, Gluschkoff K, Koskinen S, Salminen L, Strandell LC, Fuster Linares P, et al. Final clinical practicum shapes the transition experience and occupational commitment of newly graduated nurses in Europe—A longitudinal study. Journal of Advanced Nursing. 2021;77(12):4782–92
- Saab MM, Hegarty J, Murphy D, Landers M. Incorporating virtual reality in nurse education: A qualitative study of nursing students' perspectives. Nurse Education Today. 2021;105.

Wound Care

- Meagher H, Keane N, Egan S, Sheikhi A, Moloney MA, Kavanagh E. Wound prevalence survey in a regional integrated care organisation in the midwest of Ireland. Nursing & Residential Care. 2021;23(6):1–11
- Reilly A, Sorensen J, Strapp H, Patton D, Blair A, Avsar P, et al. Costing pressure ulcer care in an Irish acute care setting: a feasibility study. Journal of Wound Care. 2021;30(11):940–4.

Mental Health

- O'Sullivan K, Brady AM, Downes C, Higgins A, Doyle L, McCann T, et al. The role and activities of the Traveller mental health liaison nurse: Findings from a multi-stakeholder evaluation. International Journal of Mental Health Nursing. 2021 Dec ;30(6):1664–73
- Casey B, Webb M. Experiences of mental health support workers in mental healthcare practice: Three visual arts narratives. Journal of Psychiatric & Mental Health Nursing (John Wiley & Sons, Inc). 2021 Dec ;28(6):1018–28.
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Library services

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Online – Introduction to Effective Library Search Skills

Next course date: Monday, April 11, 2022

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

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

INMO Professional

RCM i-learn

THE ROYAL COLLEGE OF MIDWIVES

Cancer in pregnancy

This i-learn module aims to enable maternity staff to feel more confident and informed when supporting women with cancer

CANCER in pregnancy remains uncommon, however, changes in lifestyle and a maturing maternity population is likely to increase the incidence. Receiving a diagnosis of cancer in pregnancy or soon after birth is difficult and challenging for the woman and her family. It is important that maternity practitioners are aware of some of the issues and impact to ensure that the woman receives the most appropriate and timely information and support.

This i-learn module has been developed to support midwives, student midwives and maternity support workers in caring for women diagnosed with cancer during pregnancy and postnatally. The aim of this module is to enable maternity staff to feel more confident and informed when supporting women in this unusual and challenging situation.

This module will take approximately 45 minutes to complete.

Why this topic important

There is a lack of national data concerning the number of women diagnosed with cancer during pregnancy and beyond. In the UK, Public Health England published a report in 2018 stating the occurrence of cancer during pregnancy is uncommon with an incidence rate of approximately one in 1,000 pregnancies. The rate of pregnancy associated cancer is increasing and is partly caused by a trend in delaying childbearing to an older age.

While the number is relatively small, the impact on the women and their families, during the pregnancy and beyond is significant. From a public health perspective, the effects on both mother and baby can be far-reaching and detrimental.

For the majority of women with a medical complication such as cancer, care is primarily with obstetricians and the relevant medical specialists. This often means that the woman has little continuity with the maternity team.

By equipping midwives and support workers with the confidence to provide care alongside crucial medical treatment, women, their partners and their families are likely to have a better overall experience during the maternity continuum, helping to keep the woman and her baby at the centre of care.

Role of the midwife

Midwives may have little education and training around cancer in pregnancy and many midwives may never have previously cared for a woman with cancer. In addition to trying to appreciate the specific needs of the woman and her family related to the cancer care, the midwife's primary responsibility is to continue to provide her usual care to support normality in the pregnancy and birth experience.

Although the woman has a diagnosis of cancer in pregnancy, midwives and staff need to continue to focus on the pregnancy and aim to support her just as they would a healthy pregnant woman – in the most appropriate and positive way while always being honest. This is key to the woman and her partner's experience of maternity care particularly and will be more successful when using a continuity of carer model.

Listening is an important skill for midwives as they are not professional cancer experts and must ensure always to be careful about how they speak and what they say.

Learning outcomes

Having completed this module you will:

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

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

Spotlight on Leadership

Shared and distributed leadership

THIS month, our sixth in a series of articles exploring the topic of leadership focuses on shared and distributed leadership. What follows is an overview of shared leadership, key concepts as well as further investigation into distributed leadership and its relation to the healthcare setting.

The theory of shared leadership has been around for some time and as a concept can come under various names, including collective leadership, horizontal leadership, democratic leadership and emergent leadership. Although academics have pointed to the differences with each of these leadership approaches, they also cover some common ground. They all point to the notion that leadership is not "the monopoly or responsibility of just one person, with each suggesting a similar need for a more collective and systemic understanding of leadership as a social process".[1]

According to Bolden, out of these styles of leadership, distributed leadership has emerged over several years to be influential in shaping how contemporary leadership has been perceived and explored.[1]

There are varying definitions of distributed leadership. At its core, this leadership style focuses on team members and broadly distributes the responsibility of power and influence throughout the team. It is categorised as a 'post-heroic' approach to leadership. In practice, what this means is a move away from a formal leadership position, driving an organisation to success. According to the King's Fund,[2] the evidence suggests that heroic leadership does not always bring improved outcomes to teams or organisations.

Distributed leadership "reflects a situation where multiple team members engage in leadership and is characterised by collaborative decision-making and shared responsibility for outcomes".[3]

This style of leadership is seen to take a holistic view of leadership. According to Bennett et al:[4] "Distributed leadership is not something 'done' by an individual 'to' others, or a set of individual actions through which people contribute to a group or organisation... [it] is a group activity that works through and within relationships, rather than individual action."

In exploring the various concepts and theories around distributed leadership, Bennett et al identified three components that seem to be shared by most authors:[4]

- *"Leadership is an emergent property of a group or network of interacting individuals"* – this contrasts with more traditional forms of leadership that emerge and are driven by the individual
- *"There is openness to the boundaries of leadership"* – this points to a broader view of the pool of leaders who can contribute and as such raises the issue of who or what groups will be brought into the leadership role
- *"Varieties of expertise are distributed across the many, not the few"* – arising from the bigger pool of potential leaders, an emergence of varying specialties, talents and views can converge to forge a *"concertive dynamic which represents more than the sum of the individual contributors"*.

The distributed leadership model has been identified as an appropriate model within the healthcare setting. Given the complexities of delivering healthcare in a modern world with varying specialisms and the importance of multidisciplinary teams, devolving leadership to the frontline has been identified as a key model within the healthcare setting.

Several studies identify the potential benefits of distributed and shared leadership approaches. In the UK, one study found that distributed leadership was beneficial to increasing employee engagement, reducing staff turnover and increasing job satisfaction.[5] Sammut et al[6] point to the importance of nurturing the aspects of distributed leadership, which lead to increased job satisfaction.

However, other studies have identified the disadvantages of distributed leadership. One systematic review determined that the use of distributed leadership could be constrained and often subject to two differing perspectives from different professions within healthcare.[7] A study undertaken of Irish nursing leadership experiences[8] found that leadership was mainly routed in a more traditional style, with distributed leadership seen as aspirational. The authors point to the importance of embedding this style of leadership into education and formal programmes to progress its use within nursing.

The time appears to be right for shared and distributed leadership within nursing, midwifery and healthcare. In often challenging environments where problems can often appear intractable the importance of a collective approach has never been more important. It allows for the leadership qualities of the whole team to be used through shared responsibility and decision making.

Niamh Adams is INMO head of library services and Steve Pitman is INMO head of professional development

Launched in 2021, the Nursing Now Challenge brings forward the Nightingale Challenge mandate, which focuses on developing leadership opportunities for nurses and midwives globally. Visit ***www.nursingnowireland.ie***

If you are interested in writing or contributing to this series of leadership articles, please get contact Steve Pitman by email to: steve.pitman@inmo.ie.

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A column by Maureen Flynn

Quality & Safety

All-Ireland Nursing and Midwifery Digital Health Capability Framework

THE nursing and midwifery professions collectively represent Ireland and Northern Ireland's largest professionally registered health workforce, with direct responsibility for collection, entry and use of clinical information. In this month's column we introduce the 'All-Ireland Nursing and Midwifery Digital Health Capability Framework'.

Recognising the changes in healthcare due to the Covid-19 pandemic, the growing adoption of digital technologies, and taking into account all aspects of professional practice, the Digital Health Capability Framework (the Framework) has been created to:

- Define the digital health knowledge, skills and attitudes required for professional practice
- Complement existing individual knowledge, skill and attitudinal frameworks
- Provide a solid basis for tailored learning.

Digital health when implemented appropriately can improve the quality, safety and efficiency of healthcare. A digital health capable workforce is key to ensuring safe, quality healthcare in the future. This Framework was initially developed for Australian nurses and midwives with a central theme of safety and quality in healthcare within the digital healthcare environment and there is a similar central theme for Ireland.

Why digital healthcare?

As healthcare systems increase the use of digital technologies to deliver patient care, digital health related roles and capabilities will become commonplace. This Framework seeks to recognise those roles and the unique digital health capabilities of nurses and midwives.

People's expectations are changing in line with the increased availability and use of affordable digital health technologies. People who use our services are more informed; they expect to be actively involved in managing their health and in decision making, and be provided with prompt, individualised care.

Role of nurses and midwives

The evolving role for nurses and midwives, which has been brought to the fore during the Covid-19 pandemic, has enabled opportunities for nurses and midwives to provide care via digital health technologies such as telehealth. It is expected that for many people telehealth consultations will become the preferred model of care due to its convenience and timeliness.

While many nurses and midwives are familiar with competencies or competency statements, the Framework provides capability statements. The Framework outlines the capabilities required to support individuals and organisations in extending their digital health development rather than providing a rigid set of competencies.

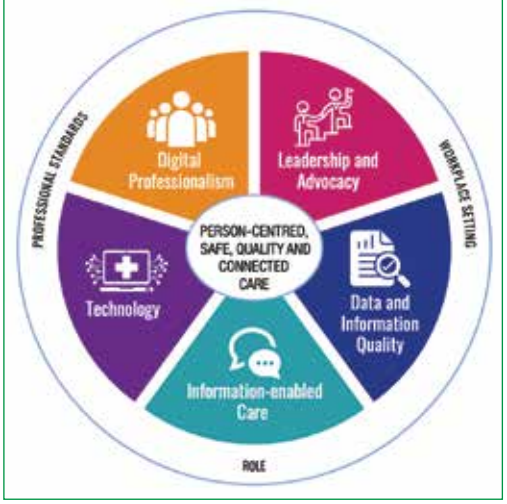
It is intended to enable and inform and is not intended to be adopted as a professional standard but to be used as a resource to guide individuals, employers and educators in their workforce and professional development planning and delivery. Most importantly, the Framework intends to promote and encourage positive attitudes in relation to the increasing introduction and adoption of technology and innovation.

The Framework consists of five domains (see *Figure*). The five domains sit within the context of nurses and midwives' roles, workplace settings and the professional standards that apply to their practice. It recognises the breadth of the disciplines of nursing and midwifery and the fact that we operate within existing professional structures and rules.

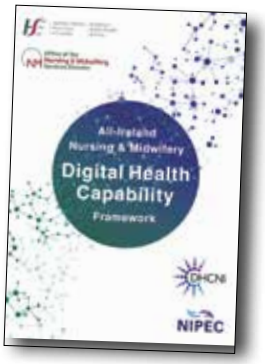
Get involved

At your next team, ward or unit meeting why not talk about your digital health capabilities. You can use the Framework to assess your digital health capabilities and identify learning and developmental needs, inform personal and professional development plans and provide direction for career advancement planning in digital health or other nursing and midwifery specialties.

Figure: Framework domains



Further Information



You can access the Framework at: **https://healthservice.hse.ie** and entering 'All-Ireland Nursing and Midwifery Digital Health Capability Framework' in the search box, or you can contact Loretto Grogan by email for more information: loretto.grogan1@hse.ie

Maureen Flynn is the director of nursing ONMSD, QPS Connect lead, HSE National Quality and Patient Safety Directorate

Acknowledgements: Thank you to my colleague Loretto Grogan, director of nursing, national clinical information officer with the ONMSD, for providing information and assistance in writing this column

Are you dealing with the stress?

Work-related stress is an occupational hazard for nursing and midwifery students, writes **Róisín O'Connell**

OVER the past two years, student nurses and midwives have worked tirelessly in the fight against Covid-19. This has left many students feeling tired, low on energy, lacking motivation and experiencing irregular sleeping habits or disrupted sleep. Combined, these are signs of burnout and stress. Long hours, working in difficult conditions, being overworked and being underpaid naturally leads to stress, never mind adding a global pandemic to the mix. Work-related stress is an occupational hazard.

There are many definitions of stress. According to the Health and Safety Authority (HSA): "Stress is a negative experience/feeling, associated with new physical symptoms. These include increased heartbeat, swiftness of breath, dry mouth, upset stomach and sweaty palms, and over the longer term, more serious digestive upset, cramp and raised blood pressure/cardiovascular disease. Psychological symptoms range from racing thoughts and speech, lack of impulse control, and feelings of being overpowered, losing control and fearfulness generally."

The HSA says other characteristics can include fatigue, proneness to upset, withdrawal, self neglect and depression.

Having too much work to do or having insufficient time to do it, bullying and harassment, being subject to violence and aggression in the workplace, understaffing and overcrowding and dealing with life-threatening illness and injuries, along with patient deaths all contribute to stress. Most of us will experience work-related stress at some point, but it is important to have the correct tools to cope with these stresses and not allow them to overcome you.

Ways to counteract stress

There are many different ways to help counteract your feelings of stress and anxiety. Some suggestions are outlined above. It is important for nursing/midwifery students to start implementing these practices into their daily lives. As you are still at the beginning of your career you still have time to ensure that you manage your stress in a way that is safe for you. Before you take care of someone else it is important that you also look after yourself. Always ensure that you show yourself the same compassion that you share with your patients.

For information on available support visit: **www.aware.ie** and **www.yourmentalhealth.ie** The INMO has a free counselling helpline available 24 hours a day for members and their immediate families; it is a totally confidential service and can be reached at **1850 6704077**. Counselling services are available to all students in college or university and all workers within the HSE can avail of the employee assistance programme through occupational health.

Preceptor of the Year Award 2022

The INMO is delighted to announce that the annual preceptor of the year award has once again opened for nominations. The Organisation would like to thank Cornmarket for its continued sponsorship of this prize. The award will be presented to an INMO member who has inspired, encouraged and motivated a nursing or midwifery student to reach their potential.

This award aims to give recognition to the essential work of our nurse and midwife preceptors who are a fundamental component of nursing and midwifery education.

Students can nominate their preceptor before March 30, 2022 online via the form available at **www.inmo.ie/Preceptor_of_the_Year**. If you want to nominate your preceptor, please don't hesitate and let's show recognition to the amazing nurses and midwives working within our health service. (See *page 30* for further details).

If you have any queries, please do get in touch with me by email to: roisin.oconnell@inmo.ie

Róisín O'Connell is the INMO's student and new graduate officer

Tips for dealing with stress

A positive start: Try to start your day off in a positive way by having your favourite breakfast cereal or listening to a podcast you like; these are great ways to get yourself in a positive mindset to take on the day

Try to stay organised: If you are a naturally disorganised person, planning ahead can greatly decrease your stress at work. It's always a good idea to ask your preceptor for tips on how to plan out your day as they will have a greater understanding of the different tasks that you will need to complete throughout the day

Be comfortable: This can be a surprising factor relating to stress that many people don't consider. We spend much of our time on our feet. We must have the correct fitting shoes to ensure that we feel comfortable throughout the day. A uniform that fits correctly will give added confidence and comfort as we go about our day

Take a break: This is something we often take for granted. Breaks are an integral part of our working day so it is important that we take them. They allow us to slow down and allow our minds to rest. It is also time that your body uses to rest and recover. In our professions this is an area we need to improve on as, in the long-term, missing breaks has been linked with developing serious health implications

A detailed assessment of mother and baby will inform the treatment required to support continued breastfeeding in cases of tongue tie, write **Anna O'Donoghue**, **Fiona Coffey** and **Tadhg-Iarla Curran**

Managing tongue tie

THE lingual frenulum is a mucous membrane connecting the underside of the tongue with the floor of the mouth. Tongue tie or ankyloglossia is when the lingual frenulum is short, fibrous, tight, or positioned too far forward, limiting the range of motion of the tongue and affecting oral function.[1]

It can affect infants' breastfeeding skills in different ways, and can affect other activities such as feeding, dental and speech. Tongue tie is a congenital condition, and runs in families. It occurs in 2-10% of infants. Research evidence demonstrates that tongue tie sometimes negatively affects breastfeeding for mothers and babies.

The infant's tongue is a vital component of the suckling process during breastfeeding. The tongue plays a vital role in the peristaltic action of milk been removed from the breast. Tongue tie may prevent the infant from taking in enough breast tissue into its mouth to form a teat, which may affect breastfeeding. Some infants are unable to attach to the breast; some can attach but are less efficient at breastfeeding due to reduced tongue mobility.[1] As a result of restricted tongue movement the mother may experience nipple tenderness and/or nipple damage.

The role of the practice nurse includes antenatal and postnatal care. General practices are often the first 'port of call' when a mother experiences breastfeeding problems. The two-week and six-week checks are an opportunity for the mother to discuss any concerns she may have about breastfeeding. Weight issues, sore nipples, feeding all day, the baby won't settle, the baby is very windy, are some of the common issues presented.

The Growing up in Ireland Survey and the National Infant Feeding Survey 2012 showed that insufficient milk, difficulty in latching, painful breasts and the baby 'feeding too often' were the reasons breastfeeding was ended earlier than planned.[2] Tongue tie in breastfeeding infants can cause some, or all, of these obstacles. Early diagnosis and intervention, with lactation support and advice, will assist the mother and infant achieve their breastfeeding goals.

Common symptoms of tongue tie

The breastfed baby

- Frequent and prolonged feeds, but inefficient feeding resulting in baby unsatisfied
- Falling asleep at the breast
- Difficulty latching onto the breast or unable to maintain a latch, slipping off the breast
- Disorganised suck, fussiness at the breast, 'bopping' on and off the breast
- Clicking sound while feeding
- Symptoms of wind and reflux
- Slow weight gain.

The mother

- Nipple soreness and pain while feeding
- Nipple damage, bleeding nipples, nipple changing shape post feeds
- Incomplete breast drainage
- Blocked ducts, mastitis
- Low milk supply.

The bottle-fed baby

- Slow feeding, may only be able to take a small amount of milk at each feed
- Baby may dribble a lot

Classification of Tongue Tie

Tongue Tie is categorised into four types.

Type 1 – Anterior tongue tie
(75-100% restriction)
Frenulum extends to tip of tongue and in front of alveolar ridge

Type 2 – Anterior tongue tie
(50-75% restriction)
Type 2 is 2-4mm behind the tongue tip and attaches on or just behind the alveolar ridge

Type 3 – Posterior tongue tie
(25-50% restriction)
Attachment is to the mid tongue and the middle of the floor of the mouth and usually tight and elastic.

Type 4 – Posterior tongue tie
Usually thick, shiny and inelastic, and essentially against the base of the tongue

- Baby is windy and unsettled between feeds
- Difficulty keeping bottle teat in mouth.

Assessing the infant for tongue tie

Tongue tie affects babies to varying degrees[3]

Key movements of the tongue include:

- Lift – the infant should be able to lift the tongue to the upper gum ridge when the mouth is wide open
- Extension – rubbing chin just below lower jaw, or a light tap to the tongue with your finger. The tongue should extend over the lower gum ridge and ideally beyond the lower lip
- Cupping – assessing infant's suck ability by assessing how well the sides of the tongue hug your finger
- Lateralisation – rubbing your finger along the outside of the lower gum, the tongue should move from side to side.[4]

Tongue tie affects babies to varying degrees, and often a tongue tie doesn't have any impact on feeding.[3] However, tongue tie can cause many issues due to restricted tongue movement, such as the infant is unable to take enough breast tissue into the mouth, some babies are unable to attach to the breast, while others attach but are less efficient at breastfeeding due to reduced tongue mobility. Due to restricted tongue movement, the mother may experience painful, bleeding nipples from the friction of inadequate latch or frequent feeding.[1] This in turn leads to painful feeding, which sometimes becomes unbearable, resulting in early cessation of breastfeeding.[5]

If a mother is experiencing difficulties during breastfeeding it is advisable for a professional to assess the baby's sucking and feeding skills for tongue tie restriction. There are tools available for clinicians to improve the assessment of breastfeeding difficulties associated with tongue tie such as the Bristol Tongue Assessment Tool (BTAT), the Hazelbaker assessment tool and, most recent, the Tongue Tie and Breastfed Babies (TABBY) assessment tool.[6]

Using such tools will give the clinician more accurate assessment for further intervention regarding tongue tie.[5] A study in New Zealand showed assessing the infant using BTAT was associated with a reduction in frenotomy rated from 11.3% to 3.5% over a two-year period. [6]

Treatment options

The focus should be firstly on lactation support if the mother presents with feeding issues. A detailed history is important to establish feeding history, birth history and also maternal health history. A feeding assessment should be carried out to identify the source of breastfeeding problems encountered. An oral examination may also be carried out by a lactation consultant, assessing the suck and movement of the tongue.

Breastfeeding positions that pull the infant's chin very close to the breast can help. Laid back positioning also can help the baby achieve a deeper latch. Skin to skin contact is so beneficial in encouraging a baby to latch. Breast compression while the baby is feeding will also increase intake of breast milk. An abundant milk supply is the single most important factor in getting the baby to latch.[7]

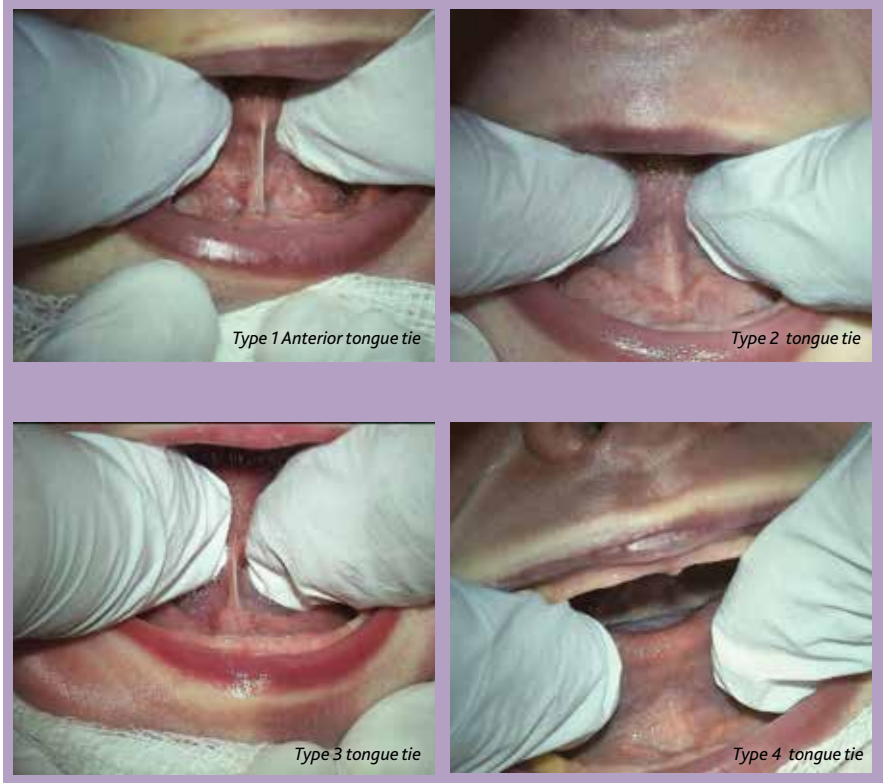
Protecting and increasing milk supply will help the baby latch on. Supplemental feeding techniques at the breast may also improve latch and suck. Avoiding bottles and pacifiers is also encouraged.

Nipple shields also can play a part short-term if the infant is unable to sustain a latch or has a dysfunctional suck.

Parents also can play a role in observing the infant's tongue actions, such as elevation of the tongue when crying or yawning, how far does the tongue stretch out and the shape of the tip of the tongue.

There are simple suck training exercises parents can carry out to improve the strength of the suck.

Figure: Types of tongue tie



Photos courtesy of Dr Justin Roche, National Tongue Tie Clinic , Clonmel, Co Tipperary

Difficulty latching baby on the breast, followed by nipple pain and trauma are the most common reasons for seeking support and intervention regarding tongue tie. A shallow latch and prolonged feeding are causes of nipple pain and trauma. Education on nipple care, use of healing creams and dressings and resting the nipple if necessary by feeding the infant expressed breastmilk.

If tongue tie still interferes with breastfeeding, a frenotomy should be considered. A frenotomy is a surgical procedure in which the lingual frenulum is cut using scissors or laser. The procedure is performed while the baby is awake, using topical anaesthetic gel for pain control. Minimal side effects have been experienced. It carries a one in 10,000 risk of infection. Pain relief is prescribed; the baby is encouraged to breastfeed as soon as the procedure is complete. Reattachment has been experienced in 2-3% in type 1 and 2, and up to 10% in type 3 and 4.

Post frenotomy.

Some practitioners recommend frequent exercises, while other practitioners view it as unnecessary and painful for babies. There is lack of evidence and published controlled trials regarding wound massage and exercises. A small Irish-based cohort study found 91% of women reported an

overall improvement in breastfeeding after a frenotomy procedure. Some 45% experienced immediate improvement and 29% experienced improvement within two weeks of the procedure. Rates of breastfeeding remained the same pre and post frenotomy.[8]

A larger study published in England in 2009 showed that post frenotomy, most of the mothers reported that breastfeeding was less painful, that babies latched better and remained latched for a full feed.[9]

Optimising breastfeeding continuation

Following a frenotomy, lactation support is so important. A feeding plan is established, as common issues initially can include poor weight gain and the mother's milk supply. Studies have shown that antenatal and postnatal support from professionals lengthens breastfeeding time for families.[10] The role of the practice nurse to inform and educate breastfeeding families on available lactation support and resources to protect breastfeeding will increase breastfeeding success. Lactation consultants are International Board Certified (IBCLC) healthcare professionals who have made an in-depth study of breastfeeding and lactation and passed an exam at masters degree level of difficulty.

Some IBCLCs work in private practice or in designated positions, and many work in their existing roles for example practice nurses, midwives, GPs and public health nurses. There are a wide range of breastfeeding support offered through voluntary groups such as La Leche League, Cuidiú and Friends of Breastfeeding. The Association of Lactation Consultants in Ireland (ALCI) website contains listings of lactation consultants around the country – **www.alcireland.ie** The HSE website resource **www.breastfeeding.ie** is practical and informative on all aspects breastfeeding.

Conclusion

Tongue tie diagnosis and the rates of frenotomy being performed have increased worldwide over the past 10-15 years. Lactation support, breastfeeding positioning and increasing milk supply are measures that may assist a baby with tongue tie to latch efficiently. A detailed medical history of mother and baby, including a detailed feeding assessment by an appropriately trained healthcare professional to assess feeding challenges and the severity of the tongue tie, will allow the professional and the mother make an informed decision about which pathway is required to protect and continue the breastfeeding journey.

Anna O'Donoghue is a practice nurse and lactation consultant, and Fiona Coffey and Tadhg-Iarla Curran are GPs in Ross Medical Practice, Killarney, Co Kerry

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Psoriatic arthritis: Management and treatment

Advances in drug therapies and treat-to-target approaches to disease management reflect increasingly positive outcomes for our patients, writes **Alexia Kelly**

PSORIATIC arthritis (PsA) is an autoimmune inflammatory musculoskeletal disorder associated with psoriasis. It was first identified by Moll and Wright in 1973.[1] It is a chronic and progressive condition which has extra articular features including uveitis, enthesitis, spondylitis, dactylitis, nail disease and cardiac and metabolic manifestations.[2] Left untreated the joint disease associated with PsA can result in permanent joint damage and deformity.

In their original description of PsA, Moll and Wright described a mild arthritis, however, over the past two decades there is increasing evidence to show that PsA is more aggressive than previously thought. About 20% of patients develop a destructive disabling form of arthritis.[3,4,5]

Epidemiology

PsA affects between 0.05% and 0.25% of the population with equal distribution between males and females. It is often seen in a younger cohort than with other types of arthritis, with peak incidence between 35 and 45 years of age.

In about 60% of cases, psoriasis has its onset prior to joint symptoms. It is estimated that between 5% and 40% of those with psoriasis will develop PsA.

Classification

PsA is classified as a spondyloarthopathy (SpA), which is a family of disorders that includes:

- Ankylosing spondylitis (AS)
- Non-radiographic axial spondyloarthritis (nr-axSpA)
- Arthritis associated with psoriasis (PsA)
- Arthritis associated with inflammatory bowel diseases
- Reactive arthritis
- Juvenile-onset SpA.

PsA is classified with the spondyloarthropathies because of the presence of spondylitis (inflammation in the joints between the vertebrae) in up to 40% of people affected and association with HLA-B27 (human leukocyte antigen).

There are five types of psoriatic arthritis:

- *Symmetric psoriatic arthritis* – 50% of PsA cases
- *Asymmetric psoriatic arthritis* – 35% of PsA cases
- *Distal psoriatic arthritis* – affects distal joints predominantly, with changes in toenails and fingernails such as pitting, white spots and lifting from the nail bed
- *Spondylitis* – pain and stiffness in the spine and neck
- *Arthritis mutilans* – considered to be the most severe form of PsA, but affects only 5% of people who have PsA. It causes deformities in the distal joints of fingers and toes, and can destroy them almost completely.[6]

The original classification of psoriatic arthritis by Moll and Wright was problematic in that there was a lot of variability in case definition, which was inconsistent for research purposes. The establishment of the CASPAR criteria (classification criteria for psoriatic arthritis)[7] was developed specifically for clinical research but has helped researchers to more accurately define clinical disease. The CASPAR criteria are relatively simple to apply and have considerably advanced the study of PsA.

Causes

While there is no distinct cause of PsA, there is known to be a familial predisposition, with up to 40% of patients citing a family history of psoriasis. There is a 55-fold risk of developing PsA if a first degree relative is affected.[2,3,6]

There is some evidence also that environmental factors like trauma, infection – specifically streptococcal infection, obesity and smoking may play a part in triggering the onset of the disease.

Clinical presentation

The arthritis that evolves in PsA tends to present with an asymmetrical joint distribution rather than symmetrical, which is more typical in rheumatoid arthritis (RA). There is common involvement of the distal joints. In PsA, where one digit is involved, all joints in that digit may be affected.[3]

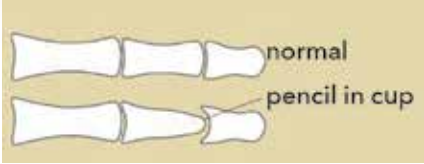


Figure 1: Pencil-in-cup deformity

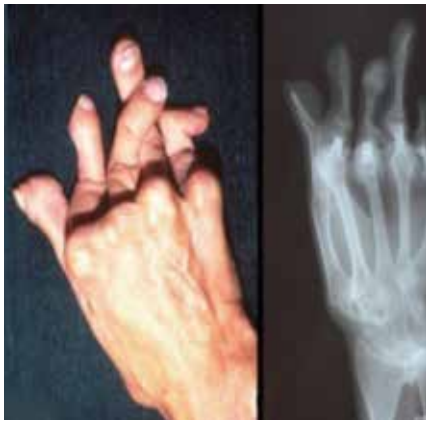


Figure 2: Arthritis mutilans

PsA often presents as an oligoarticular mild disease, however disease progression with polyarticular joint involvement is typical. About 20% of those affected will have a severe disease.[3]

The deformities that result from PsA may lead to shortening of digits, with bony fusion of the joints. These are seen on x-ray as a 'pencil in cup' deformity, with the most severe form being the telescoping of digits and total destruction of the joint – arthritis mutilans *(see Figures 1 & 2)*.

There are a number of clinical features of PsA that help distinguish it from RA *(see Table 1)*.

Extra articular features of PsA

The extra articular features of PsA include:

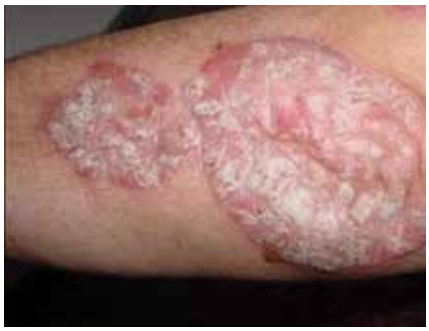
- Psoriasis – an autoimmune inflammatory skin condition characterised by erythematous, scaly patches of affected skin *(see Figures 3&4)*
- Nail lesions – nail lesions are very common and help distinguish between patients

who have PsA and those who have RA. They occur in about 40-45% of patients with psoriasis uncomplicated by arthritis and about 87% of patients with PsA. There is some correlation between severity of joint and skin involvement and nail lesions. The nail changes include nail pitting, onycholysis (where there is partial or entire separation of the nail from the nail bed), oil drop discolouration, white spots, flaking and hyperkeratosis[6] *(see Figure 5)*

- Dactylitis – this is a typical clinical feature of PsA. There is inflammation of an entire digit, likely from inflammation affecting both the joints and the tendons. These inflamed digits are colloquially termed 'sausage digits' *(see Figure 6)*
- Enthesitis – inflammation at the site of a tendon or ligament. Common sites for PsA related enthesitis include the Achilles insertion and plantar fascia
- Tenosynovitis – inflammation of a tendon and its synovial sheath
- Fatigue – a profound lack of energy, muscle weakness and slow reaction time. Fatigue is often reported as more problematic than joint pain
- Low mood, anxiety and depression[8]
- Pitting oedema – reported in 21% of those with PsA. It usually affects hands and feet in an asymmetrical pattern and may pre-date the onset of arthritis
- Uveitis – a form of eye inflammation. Warning signs often come on suddenly and get worse quickly. They include eye redness, pain and blurred vision. Anterior uveitis is a feature of PsA
- Cardiovascular disease and the metabolic syndrome – there is an increased prevalence of cardiovascular-related morbidity and mortality including myocardial infarction, angina, hypertension and metabolic syndrome. There is often concomitant diabetes, dyslipidaemia, active psoriasis, subclinical atherosclerosis, renal impairment, hyperuricaemia and the use of non-steroidal anti-inflammatory drugs (NSAIDs).[7,9]

Treatments

There is evidence that a delay in diagnosis of more than six months, followed by delayed treatment initiation is associated with a worse outcome, with increased prevalence of joint damage progression and poor quality of life.[5,10,11] It is clear that early identification and timely diagnosis and treatments lead to better outcomes. Using a treat-to-target approach[2] and both conventional and biological disease modifying drugs, it is possible to prevent long-term structural damage and disability.



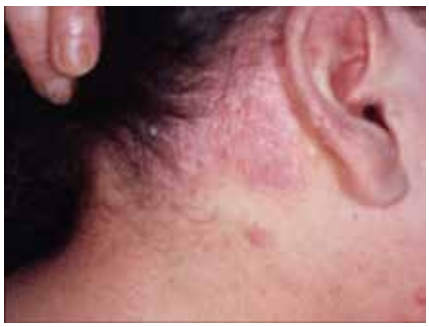


Figure 3 & 4 (above): Erythematous, scaly patches of skin characteristic of psoriasis

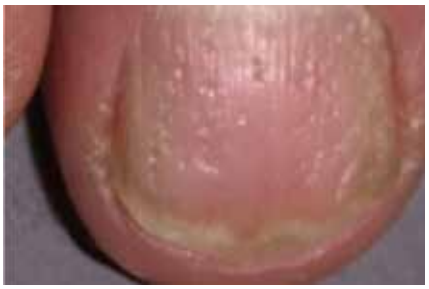


Figure 5: Nail lesions help distinguish between patients who have PsA and those who have RA

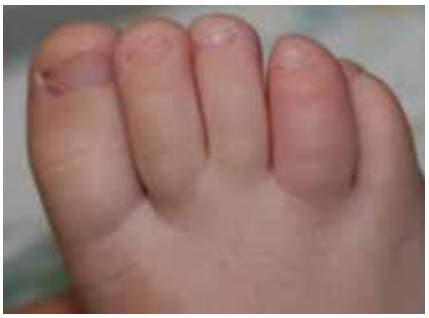


Figure 6: Dactylitis is a typical clinical feature of PsA, where there is inflammation of an entire digit

Table 1: Comparison between RA and PsA[6]

Clinical features	Psoriatic arthritis	Rheumatoid arthritis
Pattern of joint involvement	Asymmetrical	Symmetrical
Small Joint distribution	Proximal and distal interphalangeal joints	Metacarpophalangeal and proximal interphalangeal joints
Nail lesions	common	rare
Psoriatic skin lesions	common	rare
Enthesitis	common	rare
Dactylitis	common	rare
Spondylitis	common	rare
Rheumatoid Nodules	absent	common
Erythema over affected joints	common	rare

Treat to target approach

In recent years the development of treat-to-target strategies in the management of PsA have helped ensure timely and appropriate medication and therapy interventions. The increased focus on the treat-to-target regime gives increasing recognition to the high burden and impact of PsA and the growing number of therapeutic options available.

Advanced nurse practitioners and clinical nurse specialists in rheumatology conduct treat-to-target clinics with tight appointment schedules to assess and monitor the success of treatments. The use of this approach has been shown to be clinically beneficial in achieving timely low disease activity or remission.[12]

The European League Against Rheumatism (EULAR) treatment algorithm[4] *(see Figure 7)* is a useful guide.

NSAIDs and conventional disease-modifying anti-rheumatic drugs (DMARDs) are commonly used as first-line therapies in PsA. The most commonly prescribed DMARD is methotrexate. The safety and efficacy of methotrexate in treating patients with PsA is documented in the literature.[8] Alternative conventional DMARDs include sulfazalazine and leflunomide.

When these medications alone are not effective in halting disease progression and controlling symptoms, biologic medications may be considered.

The advent of biologic therapies in the late 1990s and more recently small molecule agents targeting specific cytokines has had a dramatic effect on the successful management of PsA, both halting disease progression and improving quality of life.[6,11] We know that TNF-α plays an important role in the chronic inflammation seen in PsA. Biologic agents which inhibit TNF-α

have efficacy in reducing inflammation and inhibiting radiographic progression. These agents are therefore widely used in conjunction with methotrexate. They include adalimumab, etanercept, infliximab and golimumab.

Anti-IL 12/23 monoclonal antibodies, ustekinumab, IL-17 agents secukinumab and ixekizumab; PDE4 inhibition with apremilast and JAK kinase inhibitor tofacitinib are all licensed for PsA and have shown efficacy in addressing both skin and joint manifestations.

Nursing management

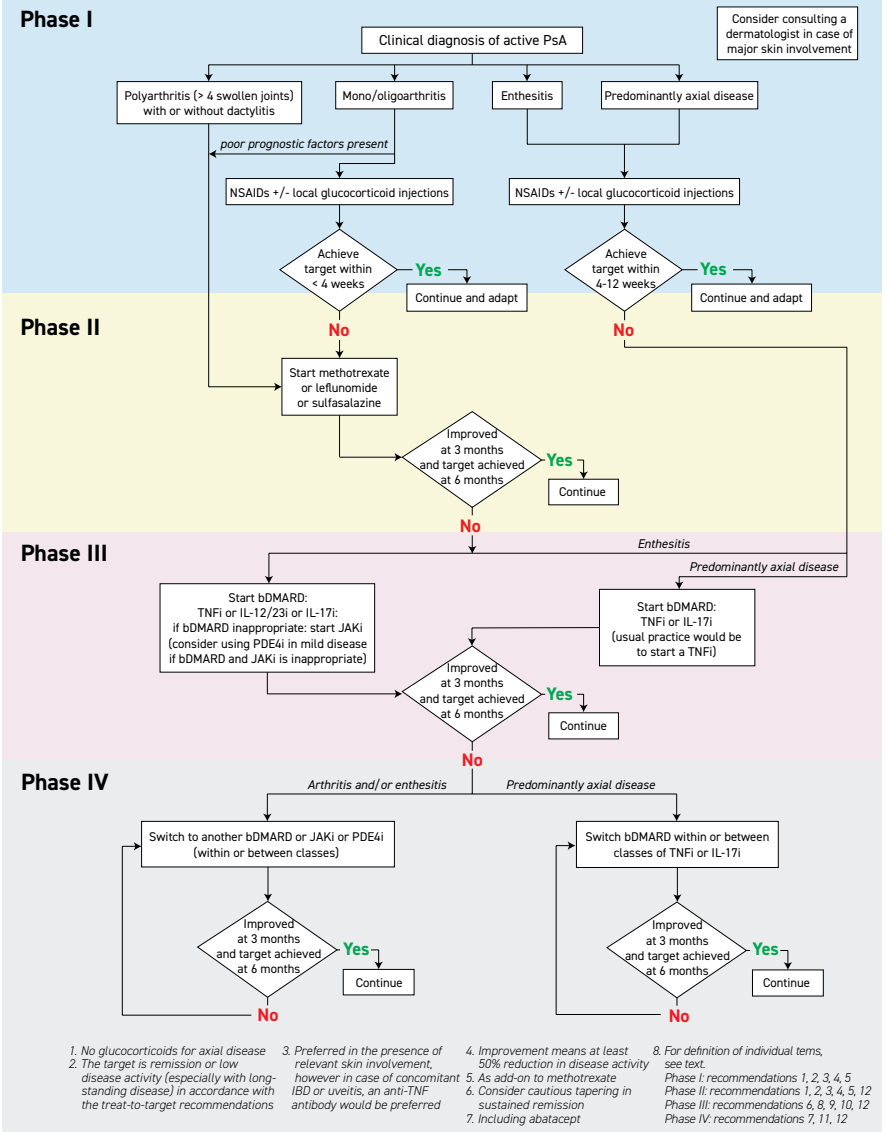
It is clear that the impact of PsA extends beyond the physical signs and symptoms. Ineffectively treated, the condition can significantly impair quality of life.[7] Patients may attend a rheumatology clinic for the first time with longstanding joint symptoms. This can happen for a number of reasons; patients may be unaware of mild joint symptoms and may not think of mentioning them to their GP or dermatologist. Many people attribute their symptoms of pain and fatigue to environmental or life stressors not associated with their psoriasis. There is evidence also that those with PsA appear to have higher thresholds for joint pain than patients with rheumatoid arthritis despite a similar level of joint inflammation.[3]

Achieving optimal quality of life is a key measurable objective for patients with PsA as we know that those with PsA often have reduced quality of life and functional capacity compared with those with psoriasis alone or healthy controls.[7,8]

Empowering patients to self-manage their PsA is key to achieving a positive outcome. Often patients are unclear about what an autoimmune condition is and this confusion and lack of understanding can be detrimental to their progress. Improving a patient's knowledge of the disease can improve treatment adherence.[9,10] Nurses are uniquely positioned to build the foundations for successful self-management.

When a patient first attends the rheumatology clinic with a diagnosis of PsA, it is essential to ascertain their level of knowledge about PsA is and to tailor education appropriately. A clear management plan using shared decision making techniques,[7] tailored to the individual's needs, defining treatment goals, with planned follow up appointments using a treat-to-target[12] approach is crucial. Referral to allied therapists in physiotherapy, occupational therapy, dietetics and orthotics are part of an holistic approach to management of PsA.

Figure 1: Treatment algorithm[4]



1. No glucocorticoids for axial disease
2. The target is remission or low disease activity (especially with long-standing disease) in accordance with the treat-to-target recommendations
3. Preferred in the presence of relevant skin involvement, however in case of concomitant IBD or uveitis, an anti-TNF antibody would be preferred
4. Improvement means at least 50% reduction in disease activity
5. As add-on to methotrexate
6. Consider cautious tapering in sustained remission
7. Including abatacept
8. For definition of individual tems, see text.
Phase I: recommendations 1, 2, 3, 4, 5
Phase II: recommendations 1, 2, 3, 4, 5, 12
Phase III: recommendations 6, 8, 9, 10, 12
Phase IV: recommendations 7, 11, 12

Conclusion

PsA is a chronic disabling condition that is associated with extra-articular features and comorbidities. Advances in drug therapies and treat-to-target approaches to disease management reflect increasingly positive outcomes for our patients. Nurses play a key role and are a core component in the management of this patient group, ensuring optimal outcomes in PsA.

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OTEZLA® (apremilast) 10mg, 20mg and 30mg film coated-tablets Brief Prescribing Information. Refer to the Summary of Product Characteristics (SPC) before prescribing. Further information is available upon request. Presentation: 10mg, 20mg and 30mg film coated-tablets. **Indications:** Psoriatic arthritis: OTEZLA, alone or in combination with Disease Modifying Antirheumatic Drugs (DMARDs), is indicated for the treatment of active psoriatic arthritis (PsA) in adult patients who have had an inadequate response or who have been intolerant to a prior DMARD therapy. Psoriasis: OTEZLA is indicated for the treatment of moderate to severe chronic plaque psoriasis in adult patients who failed to respond to or who have a contraindication to, or are intolerant to other systemic therapy including ciclosporine, methotrexate or psoralen and ultraviolet-A light (PUVA). **Dosage and administration:** Treatment with OTEZLA should be initiated by specialists experienced in the diagnosis and treatment of psoriasis or psoriatic arthritis. The recommended dose of OTEZLA is 30mg twice daily taken orally in the AM and PM, approximately 12 hours apart, with no food restrictions. The film-coated tablets should be swallowed whole. An initial dose titration is required per the following schedule: Day 1: 10mg in the AM; Day 2: 10mg in the AM and 10 mg in the PM; Day 3: 10mg in the AM and 20mg in the PM; Day 4: 20mg in the AM and 20mg in the PM; Day 5: 20mg in the AM and 30mg in the PM; Day 6 and thereafter: 30mg twice daily in the AM and PM. No re-titration is required after initial titration. If patients miss a dose, the next dose should be taken as soon as possible. If it is close to the time for their next dose, the missed dose should not be taken and the next dose should be taken at the regular time. Patients with severe renal impairment: The dose of OTEZLA should be reduced to 30mg once daily in patients with severe renal impairment (creatinine clearance of less than 30mL per minute estimated by the Cockcroft-Gault equation). For initial dose titration in this group, it is recommended that OTEZLA is titrated using only the AM doses and the PM doses be skipped. Paediatric population: The safety and efficacy of OTEZLA in children aged 0 to 17 years have not been established. No data is available. **Contraindications:** Hypersensitivity to the active substance(s) or to any of the excipients. OTEZLA is contraindicated in pregnancy. Pregnancy should be excluded before treatment can be initiated. **Special warnings and precautions:** Diarrhoea, nausea and vomiting: Severe diarrhoea, nausea, and vomiting associated with the use of OTEZLA have been reported. Most events occurred within the first few weeks of treatment. In some cases, patients were hospitalized. Patients 65 years of age or older may be at a higher risk of complications. Discontinuation of treatment may be necessary. Psychiatric disorders: OTEZLA is associated with an increased risk of psychiatric disorders such as insomnia and depression. Instances of suicidal ideation and behaviour, including suicide, have been observed in patients with or without history of depression. The risks and benefits of starting or continuing treatment with OTEZLA should be carefully assessed if patients report previous or existing psychiatric symptoms or if concomitant treatment with other medicinal products likely to cause psychiatric events is intended. Patients and caregivers should be instructed to notify the prescriber of any changes in behaviour or mood and of any suicidal ideation. If patients suffered from new or worsening psychiatric symptoms, or suicidal ideation or suicidal attempt is identified, it is recommended to discontinue treatment with OTEZLA. Severe renal impairment: See dosage and administration section. Underweight patients: OTEZLA may cause weight loss. Patients who are underweight at the start of treatment should have their body weight monitored regularly. In the event of unexplained and clinically significant weight loss, these patients should be evaluated by a medical practitioner and discontinuation of treatment should be considered. Lactose content: Patients with rare hereditary problems of galactose intolerance, total lactase deficiency or glucose-galactose malabsorption should not take this medicinal product. **Interactions:** Co-administration of strong cytochrome P450 3A4 (CYP3A4) enzyme inducer, rifampicin, resulted in a reduction of systemic exposure of OTEZLA, which may result in a loss of efficacy of OTEZLA. Therefore, the use of strong CYP3A4 enzyme inducers (e.g. rifampicin, phenobarbital, carbamazepine, phenytoin and St. John's Wort) with OTEZLA is not recommended. In clinical studies, OTEZLA has been administered concomitantly with topical therapy (including corticosteroids, coal tar shampoo and salicylic acid scalp preparations) and UVB phototherapy. OTEZLA can be co-administered with a potent CYP3A4 inhibitor such as ketoconazole, as well as with methotrexate in psoriatic arthritis patients and with oral contraceptives. **Pregnancy, lactation and fertility:** Women of childbearing potential should use an effective method of contraception to prevent pregnancy during treatment. OTEZLA should not be used during breast-feeding. No fertility data is available in humans. **Undesirable effects:** Psychiatric disorders: In clinical studies and post-marketing experience, uncommon cases of suicidal ideation and behaviour, were reported, while completed suicide was reported post-marketing. The most commonly reported adverse reactions with OTEZLA in these indications are gastrointestinal (GI) disorders including diarrhoea (15.7%) and nausea (13.9%). These GI adverse reactions generally occurred within the first 2 weeks of treatment and usually resolved within 4 weeks. Adverse reactions reported in the psoriatic arthritis and/or psoriasis clinical trial programme and post marketing experience include: very common (≥ 1/10) diarrhoea*, nausea*; common (≥1/100 to <1/10) bronchitis, upper respiratory tract infection, nasopharyngitis*, decreased appetite*, insomnia, depression, migraine*, tension headache*, headache*, cough, vomiting*, dyspepsia, frequent bowel movements, upper abdominal pain*, gastroesophageal reflux disease, back pain*, fatigue; uncommon (≥1/1,000 to <1/100) hypersensitivity, suicidal ideation and behaviour, gastrointestinal haemorrhage, rash, urticaria, weight loss; not known (cannot be estimated from the available data) angioedema. *At least one of these adverse reactions was reported as serious. Please consult the SPC for a full description of undesirable events. **Pharmaceutical Precautions:** Do not store above 30°C. **Legal category:** POM. **Presentation and Marketing Authorisation Numbers:** Initiation pack containing 27 film coated tablets (4 x 10mg, 4 x 20mg, 19 x 30mg) - EU/1/14/981/001; 30mg film coated tablets in a pack size of 56 tablets - EU/1/14/981/002. **Marketing Authorisation Holder:** Amgen Europe B.V. Minervum 7061, 4817 ZK Breda, The Netherlands. Further information is available from Amgen Ireland Limited, 21 Northwood Court, Santry, Dublin D09 TX31. OTEZLA is a trademark owned or licensed by Amgen Inc., its subsidiaries, or affiliates. **Date of preparation:** April 2020 (Ref: IE-OTZ-2000019).

Adverse reactions/events should be reported to the Health Products Regulatory Authority (HPRA) using the available methods via www.hpra.ie. Adverse events should also be reported to Amgen Limited on +44 (0)1223 436441.

† Otezla met the primary endpoint of the pivotal trials in psoriasis: PASI-75 response vs placebo at 16 weeks. **ESTEEM 1:** 33.1% (N=562) vs 5.3% (N=282); **ESTEEM 2:** 28.8% (N=274) vs 5.8% (N=137), P<0.0001. OTEZLA met the primary endpoint of the pivotal trials in Psoriatic Arthritis: ACR 20 response vs placebo at 16 weeks. **PALACE 1:** 38% (N=168) vs 19% (N=168), P≤0.001. **PALACE 2:** 32% (N=162) vs 19% (N=159) P≤0.01; **PALACE 3:** 41% (N=167) vs 18% (N=169) P≤0.001.[2]

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Amgen Ireland Ltd., 21 Northwood Court, Santry, Dublin 9
IE-OTZ-0820-00002 | Date of preparation: September 2020

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- In combination with **fulvestrant in women who have received prior ET**
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IBRANCE® (PALBOCICLIB) PRESCRIBING INFORMATION:

Please refer to the Summary of Product Characteristics (SmPC) before prescribing IBRANCE 75 mg, 100 mg or 125 mg. **Presentation:** HHard capsules or film-coated tablets containing 75 mg, 100 mg or 125 mg palbociclib. **Indications:** Treatment of hormone receptor (HR) positive, human epidermal growth factor receptor 2 (HER2) negative locally advanced or metastatic breast cancer: in combination with an aromatase inhibitor; or in combination with fulvestrant in women who have received prior endocrine therapy. In pre- or perimenopausal women, the endocrine therapy should be combined with a luteinizing hormone releasing hormone (LHRH) agonist. **Dosage:** Therapy should be initiated and supervised by a physician experienced in the administration of anti-cancer medicinal products. The recommended dose is 125 mg of palbociclib once daily for 21 consecutive days followed by 7 days off treatment (Schedule 3/1) to comprise a complete cycle of 28 days. When coadministered with palbociclib, the aromatase inhibitor should be administered according to the dose schedule reported in the SmPC. Treatment of pre/perimenopausal women with the combination of palbociclib plus endocrine therapy should always be combined with an LHRH agonist (see SmPC section 4.4). Capsules and tablets should be swallowed whole (should not be chewed, crushed, split or opened prior to swallowing). Capsules should be taken with food, preferably a meal to ensure consistent palbociclib exposure (see SmPC section 5.2). Tablets may be taken with or without food. Palbociclib should not be taken with grapefruit or grapefruit juice (see SmPC section 4.5). Dose modification of IBRANCE is recommended based on individual safety and tolerability. Management of some adverse reactions may require temporary dose interruptions/delays, and/or dose reductions, or permanent discontinuation. For dose reduction guidelines for management of adverse reactions, haematologic and non-haematologic toxicities, refer to SmPC section 4.2. IBRANCE should be permanently discontinued in patients with severe interstitial lung disease (ILD)/pneumonitis. For patients who experience a maximum of Grade 1 or 2 neutropenia in the first 6 cycles, complete blood counts for subsequent cycles should be monitored every 3 months, prior to the beginning of a cycle and as clinically indicated. No dose adjustments of IBRANCE are required for patients with mild or moderate hepatic impairment (Child-Pugh classes A and B). For patients with severe hepatic impairment (Child-Pugh class C), the recommended dose of IBRANCE is 75 mg once daily on Schedule 3/1 (see SmPC section 5.2). No dose adjustments of IBRANCE are required for patients with mild, moderate or severe renal impairment (creatinine clearance [CrCl] ≥15 mL/min) (see SmPC section 5.2). No dose adjustment of IBRANCE is necessary in patients ≥65 years of age (see section 5.2). **Contraindications:** Hypersensitivity to the active substance or to any of the excipients (see SmPC section 6.1), use of preparations containing St. John's Wort (see SmPC section 4.5). **Warnings and Precautions:** Ovarian ablation or suppression with an LHRH agonist is mandatory when pre/perimenopausal women are administered IBRANCE in combination with an aromatase inhibitor, due to the mechanism of action of aromatase inhibitors. Palbociclib in combination with fulvestrant in pre/perimenopausal women has only been studied in combination with an LHRH agonist. Dose interruption, dose reduction, or delay in starting treatment cycles is recommended for patients who develop Grade 3 or 4 neutropenia. Appropriate monitoring should be performed (see SmPC sections 4.2 and 4.8). Severe, life-threatening, or fatal ILD and/or pneumonitis can occur in patients treated with cyclin dependent kinase 4/6 (CDK4/6) inhibitors, including IBRANCE when taken in combination with endocrine therapy. Across clinical studies (PALOMA-1, PALOMA-2, PALOMA-3), 1.4% of IBRANCE-treated patients had ILD/pneumonitis of any grade, 0.1% had Grade 3, and no Grade 4 or fatal cases were reported. Additional cases of ILD/pneumonitis have been observed in the post-marketing setting, with fatalities reported. Patients should be monitored for pulmonary symptoms and IBRANCE treatment should be immediately interrupted in patients suspected to have developed ILD/pneumonitis, see SmPC section 4.2, 4.4 and 4.8. Since IBRANCE has myelosuppressive properties, it may predispose patients to infections. Infections have been reported at a higher rate in patients treated with IBRANCE in randomised clinical studies compared to patients treated in the respective comparator arm. Grade 3 and Grade 4 infections occurred respectively in 5.6% and 0.9% of patients treated with IBRANCE in any combination (see SmPC section 4.8). Patients should be monitored for signs and symptoms of infection and treated as medically appropriate (see SmPC section 4.2). Physicians should inform patients to promptly report any episodes of fever. Strong inhibitors of CYP3A4 may lead to increased toxicity (see SmPC section 4.5). Avoid concomitant use of strong CYP3A inhibitors during treatment with palbociclib. Coadministration should only be considered after careful evaluation of the potential benefits and risks. If coadministration with a strong CYP3A inhibitor is unavoidable, reduce the IBRANCE dose to 75 mg once daily. When the strong inhibitor is discontinued, the dose of IBRANCE should be increased (after 3–5 half-lives of the inhibitor) to the dose used prior to the initiation of the strong CYP3A inhibitor (see SmPC section 4.5). Coadministration of CYP3A inducers may lead to decreased palbociclib exposure and consequently a risk for lack of efficacy. Therefore, concomitant use of palbociclib with strong CYP3A4 inducers should be avoided. No dose adjustments are required for coadministration of palbociclib with moderate CYP3A inducers (see SmPC section 4.5). Women of childbearing potential or their male partners must use a highly effective method of contraception while taking IBRANCE (see SmPC section 4.6). IBRANCE capsules contain lactose. Patients with rare hereditary problems of galactose intolerance, the Lapp lactase deficiency, or glucose-galactose malabsorption should not take this medicinal product. Palbociclib tablets do not contain lactose. **Drug Interactions:** The concomitant use of strong CYP3A inhibitors including, but not limited to: clarithromycin, indinavir, itraconazole, ketoconazole, lopinavir/ritonavir, nefazodone, nelfinavir, posaconazole, saquinavir, telaprevir, telithromycin, voriconazole, and grapefruit or grapefruit juice, should be avoided (see sections 4.2 and 4.4). No dose adjustments are needed for mild and moderate CYP3A inhibitors. The concomitant use of strong CYP3A inducers including, but not limited to: carbamazepine, enzalutamide, phenytoin, rifampin, and St. John's Wort should be avoided (see SmPC sections 4.3 and 4.4). No dose adjustments are required for moderate CYP3A inducers. The dose of sensitive CYP3A substrates with a narrow therapeutic index (e.g., alfentanil, cyclosporine, dihydroergotamine, ergotamine, everolimus, fentanyl, pimozide, quinidine, sirolimus, and tacrolimus) may need to be reduced when coadministered with IBRANCE as IBRANCE may increase their exposure. Based on in vitro data, palbociclib is predicted to inhibit intestinal P-glycoprotein (P-gp) and breast cancer resistance protein (BCRP) mediated transport. Therefore, administration of palbociclib with medicinal products that are substrates of P-gp (e.g., digoxin, dabigatran, colchicine, pravastatin) or BCRP (e.g., rosuvastatin, sulfasalazine) may increase their therapeutic effect and adverse reactions. Based on in vitro data, palbociclib may inhibit the uptake transporter organic cationic transporter OCT1 and then may increase the exposure of medical product substrates of this transporter (e.g., metformin). **Pregnancy & Lactation:** Females of childbearing potential who are receiving this medicinal product, or their male partners should use adequate contraceptive methods (e.g., double-barrier contraception) during therapy and for at least 3 weeks or 14 weeks after completing therapy for females and males, respectively (see SmPC section 4.5). There are no or limited amount of data from the use of palbociclib in pregnant women. Studies in animals have shown reproductive toxicity (see SmPC section 5.3). IBRANCE is not recommended during pregnancy and in women of childbearing potential not using contraception. Based on male reproductive organ findings (seminiferous tubule degeneration in testis, epididymal hypospermia, lower sperm motility and density, and decreased prostate secretion) in nonclinical safety studies, male fertility may be compromised by treatment with palbociclib (see SmPC section 5.3). Thus, men may consider sperm preservation prior to beginning therapy with IBRANCE. **Driving and operating machinery:** IBRANCE may cause fatigue and patients should exercise caution when driving or using machines. **Side Effects:** The most common (≥20%) adverse reactions of any grade reported in patients receiving palbociclib in randomised clinical studies were neutropenia, infections, leukopenia, fatigue, nausea, stomatitis, anaemia, diarrhoea, alopecia, and thrombocytopenia. The most common (≥2%) Grade ≥3 adverse reactions of palbociclib were neutropenia, leukopenia, anaemia, fatigue, infections, alanine aminotransferase (ALT) increased and aspartate aminotransferase (AST) increased. Dose reductions or dose modifications due to any adverse reaction occurred in 38.4% of patients receiving IBRANCE in randomised clinical studies regardless of the combination. Very common adverse events (≥1/10) are neutropenia, infections, leukopenia, fatigue, anaemia, asthenia, pyrexia, nausea, stomatitis, alopecia, diarrhoea, thrombocytopenia, vomiting, rash, decreased appetite, dry skin, AST increased and ALT increased. Commonly reported adverse events (≥1/100 to <1/10), are dysgeusia, epistaxis, ILD/pneumonitis, lacrimation increased, vision blurred, dry eye, febrile neutropenia. Refer to section 4.8 of the SmPC for further information on side effects, including description of selected adverse reactions. **Legal Category:** S1A. **Marketing Authorisation Numbers:** EU/1/16/1147/001 – 75 mg (21 capsules); EU/1/16/1147/003 – 100 mg (21 capsules); EU/1/16/1147/005 – 125 mg (21 capsules), EU/1/16/1147/010 – 75 mg (21 tablets), EU/1/16/1147/012 – 100 mg (21 tablets) and EU/1/16/1147/014 – 125 mg (21 tablets). **Marketing Authorisation Holder:** Pfizer Europe MA EEIG, Boulevard de la Plaine 17, 1050 Bruxelles, Belgium. For further information on this medicine please contact: Pfizer Medical Information on 1800 633 363 or at medical.information@pfizer.com. For queries regarding product availability please contact: Pfizer Healthcare Ireland, Pfizer Building 9, Riverwalk, National Digital Park, Citywest Business Campus, Dublin 24 + 353 1 467 6500.

Last revised: 01/2022.

Ref: 10_0.

Pfizer Oncology

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AI = aromatase inhibitor; **ET** = endocrine therapy; **HR+/HER2-** = hormone receptor-positive, human epidermal growth factor receptor 2-negative; **LHRH** = luteinising hormone releasing hormone; **mBC** = metastatic breast cancer; **SmPC** = summary of product characteristics.

PP-IBR-IRL-0485
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Genetic testing in cancer gene mutations

Specialist cancer nurse **Amy Nolan** discusses the implications of testing patients and their families for cancer gene mutations

PRIOR to presentation in 2014, a 33-year-old woman with a lump in her right breast had no other past medical history of note. Her breast lump measured 8cm on clinical examination, and her pathology confirmed a grade III invasive ductal carcinoma which was hormone positive (oestrogen and progesterone receptor positive) and HER2 negative.

Following discussion at a multidisciplinary team meeting, a clip was inserted at the site of the breast cancer and the woman commenced on neoadjuvant chemotherapy – adriamycin and cyclophosphamide (weekly) followed by paclitaxel (weekly).

Given her age of just 33 years at time of diagnosis, she was referred to the national cancer genetics department at St James's Hospital, Dublin. However, her cancer family history was not remarkable.

As with cancer detections, cancer genetic referrals have increased globally[1] and this reality has been reflected in the increasing numbers of incoming referrals noted at the national cancer genetic centre at St James's Hospital.

The patient had a maternal cousin who was diagnosed with leukaemia at six years of age and a maternal cousin diagnosed with breast cancer in her late 40s. On the paternal family history, there was a paternal grandmother with skin cancer diagnosed at an older age, and a paternal grandfather who died of pancreatic cancer in his 30s.

The woman had a Manchester score of 14, which is below the testing threshold. However, given the small family size and age of the patient, it was deemed appropriate to offer cancer genetic testing for diagnostic BRCA1 and BRCA2 gene mutations.

Counselling informed the patient that:

- Should a familial BRCA1 or BRCA2 gene be identified in her family, their risk of developing breast cancer during their lifetime would be up to 80%
- The lifetime risk of developing ovarian cancer is up to 40% in BRCA1 families and between 15-30% in BRCA2 families
- Additionally, the lifetime risk of developing male breast cancer is < 1% in a BRCA1 family, and 6-8% in a BRCA2 family
- The BRCA2 gene mutation is also associated with an increased risk of prostate cancer or melanoma.[2]

Effects of genetic testing

The physical and psychological effects on a family associated with the identification a cancer gene mutation must be borne in mind. Although the woman had breast cancer already, the identification of any gene mutation within her family would likely have a major impact on the psychological and (potentially) physical health of her first-degree relatives.

The emotions experienced and associated within genetic counselling are presented in the findings by Mendes et al,[3] where participants recognised several emotions during their genetic counselling

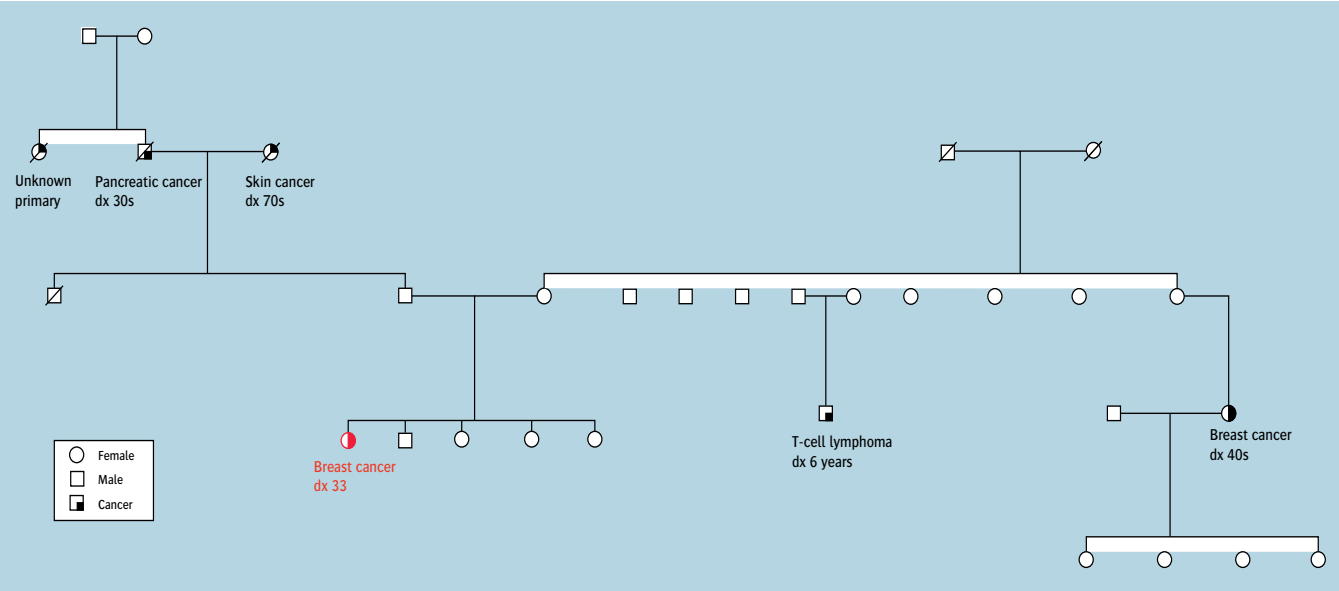

Figure 1: Cancer family pedigree of the case patient

cycle including anxiety, fear and guilt.

The patient consented to and proceeded with genetic testing for the BRCA1 and 2 gene mutations, and it was discovered she had a pathogenic germline mutation of the BRCA2 gene.

This woman's first-degree relatives were considered to be at a 50% risk of inheriting the BRCA2 mutation and therefore at-risk of inheriting the associated cancers (breast, ovarian and prostate cancer). Individualised counselling for at-risk relatives to clarify risks and provide predictive genetic testing was appropriate and offered.

The patient had one brother and three sisters who opted for predictive genetic testing to determine if they also carried the BRCA2 mutation. Her three sisters harboured the gene mutation and her brother did not carry the gene mutation. *Figure 1* shows the cancer family pedigree of the case patient.

The screening process for the women adhered to the NICE guidelines[4] which stipulate a breast MRI every six months, alternating with a mammogram every six months.

Women in a BRCA mutation family with a breast tissue risk are advised to undertake breast cancer surveillance (including monthly breast self-examination), beginning at the age of 18 years. In addition it is advised to undergo a clinical breast examination at a six-monthly interval at age 25 years, and annual radiographic surveillance with mammogram and breast MRI beginning at age 25-30 years, depending on the cancer family history.

Ovarian cancer screening, such as transvaginal ultrasound, is not known to be a valid screening tool and has not been shown to reduce ovarian cancer mortality in any significant measure. Therefore, women should discuss risk-reducing surgery with a gynaecological surgeon once child bearing is complete. Such surgery should ideally occur at 35 years of age (BRCA1) carriers and 40 years (BRCA2) carriers.[5] While it is important to note that no matter how diligently surveillance is applied, it does not guarantee that cancer will be detected at a stage that is curable, or amenable, to minimal treatment.

Males and the BRCA gene mutation

In this patient's case, it was difficult to determine if the positive BRCA2 gene mutation transcended from the paternal or maternal germ line. Hence, BRCA testing was offered to the both the mother and father of the patient.

A positive result for BRCA2 was identified in the patient's father – it is important to note that men may also harbour a BRCA gene mutation and it is not just considered a 'female gene'.

Men need to understand their BRCA cancer risks and communicate such genetic risk details to their families.[6]

The author researched the unmet needs of patients attending cancer genetic services in a national cancer genetic department, through action research. A key-finding was that male BRCA carriers were highlighted as a service user cohort requiring specific and relatable information, and this was corroborated in a study by Rauscher et al.[7]

Participants in the Rauscher et al[7] study suggested that men are slow to engage with cancer genetic services, as they misunderstand the impact of carrying a gene mutation or because they have feelings of guilt and/or anxiety. Dean et al[6] stressed the importance of addressing male risks and medical management from a family-focused approach. Importantly, Rauscher et al[7] identified that when men understand their potential cancer risk (for themselves and their families), they are more proactive in their information-seeking and screening behaviours.

The NICE guidelines[5] determine that male BRCA carriers require chest self-examination and annual clinical examination at 35 years of age, and a prostate screening (including a PSA blood test), from 40 years onwards.

While the research states a positive genetic mutation can be distressing, it is reported by Albada et al[8] that cancer genetic service users had enhanced perceived personal control, within one year, post counselling. Positive support and information should lead to a subsequent increase in referrals for genetic testing.[9,10]

Key learning points

Unfortunately in this case, the patient had residual disease with a positive lymph node identified within a year, and proceeded to have further surgery. Despite multiple lines of chemotherapeutic agents, the patient developed liver metastasis and subsequently, she developed a brain metastasis. As a result, her prognosis is extremely guarded.

On reflection, if knowledge of the BRCA2 gene mutation had been prevalent within her family, then screening the patient may have resulted in an earlier diagnosis of breast cancer, with curative disease.

The identification of a BRCA mutation within a family can cause psychological distress, including feelings of fear, anxiety, survivor guilt, fear of social stigma, genetic discrimination and a potential for alteration of the family dynamic.

The positives of appropriate cancer genetic testing and identification of a BRCA mutation is that it can clarify any cancer risk, and act as a decision aid for those with a gene mutation. There may even be psychological relief for those receiving results, whether they are positive or negative, and it may guide other family members when considering predictive testing.

Finally, men should be made aware of autosomal dominance of the BRCA gene, the potential cancer risk and impact on their family members, via appropriate education channels.

Amy Nolan is lead cancer nurse at St James's Hospital, Dublin

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NOW YOU CAN

Give them more

TALZENNA is a proven alternative to chemotherapy* that provides patients with greater efficacy in a convenient, once-daily oral dose[1]

LONGER MEDIAN PROGRESSION-FREE SURVIVAL (PFS)
TALZENNA significantly prolonged median PFS vs chemotherapy: 8.6 months vs 5.6 months (HR=0.54 [95% CI: 0.41-0.71]; P<0.0001)[1]

DOUBLED OBJECTIVE RESPONSE RATE (ORR)
ORR for TALZENNA was 62.6% (95% CI: 55.8-69.0) vs 27.2% (95% CI: 19.3-36.3) with chemotherapy (OR=4.99 [95% CI: 2.93-8.83]; P<0.0001)†‡

CONVENIENT DOSING
TALZENNA provides convenient, once-daily oral dosing, with or without food[1]

Indication: TALZENNA is indicated as monotherapy for the treatment of adult patients with germline *BRCA1/2*-mutations, who have HER2-negative locally advanced or metastatic breast cancer. Patients should have been previously treated with an anthracycline and/or taxane in the (neo)adjuvant, locally advanced or metastatic setting unless patients were not suitable for these treatments (see section 5.1 of full SmPC). Patients with hormone receptor (HR)-positive breast cancer should have been treated with a prior endocrine-based therapy, or be considered unsuitable for endocrine-based therapy.

CI=confidence interval; gBRCA=germline breast cancer susceptibility gene;
HER2-=human epidermal growth factor receptor 2 negative;
HR=hazard ratio; **HR+**=hormone receptor-positive;
OR=odds ratio;
RECIST=Response Evaluation Criteria in Solid Tumors.

* Capecitabine, eribulin, gemcitabine, or vinorelbine.
† Conducted in the intent-to-treat population with measurable disease at baseline. Per RECIST v1.1, confirmation of response was not required.1
‡ ORR is the proportion of patients who have a partial or complete response to treatment.

Reference: 1. TALZENNA Summary of Product Characteristics.

PRESCRIBING INFORMATION

▼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. Refer to section 4.8 of the SPC for how to report adverse reactions.

Talzenna® ▼ 0.25 mg and 1 mg hard capsules IE Prescribing Information:

Before prescribing Talzenna (talazoparib) please refer to the full Summary of Product Characteristics (SmPC). **Presentation:** Each 0.25 mg hard capsule contains talazoparib tosylate equivalent to 0.25 mg talazoparib. Each 1 mg hard capsule contains talazoparib tosylate equivalent to 1 mg talazoparib. **Indications**: Talzenna is indicated as monotherapy for the treatment of adult patients with germline BRCA1/2 mutations, who have HER2-negative locally advanced or metastatic breast cancer. Patients should have been previously treated with an anthracycline and/or a taxane in the (neo)adjuvant, locally advanced or metastatic setting unless patients were not suitable for these treatments. Patients with hormone receptor (HR)-positive breast cancer should have been treated with a prior endocrine-based therapy, or be considered unsuitable for endocrine-based therapy. **Dosage and Administration:** Treatment should be initiated and supervised by a physician experienced in the use of anticancer medicinal products. Patients should be selected for the treatment of breast cancer with Talzenna based on the presence of deleterious or suspected deleterious germline BRCA mutations determined by an experienced laboratory using a validated test method. Genetic counselling for patients with BRCA mutations should be performed according to local regulations, as applicable. The recommended dose is 1 mg talazoparib once daily. Patients should be treated until disease progression or unacceptable toxicity occurs. Complete blood count should be obtained prior to starting Talzenna therapy and monitored monthly and as clinically indicated. To manage adverse drug reactions, interruption of treatment or dose reduction based on severity and clinical presentation should be considered (see SmPC section 4.2). Special populations: Hepatic impairment: See SmPC section 4.2. No dose adjustment is required for patients with mild, moderate or severe hepatic impairment. Renal impairment: See SmPC section 4.2. No dose adjustment is required for patients with mild renal impairment. For patients with moderate renal impairment, the recommended starting dose of Talzenna is 0.75 mg once daily. For patients with severe renal impairment, the recommended starting dose of Talzenna is 0.5 mg once daily. Talzenna has not been studied in patients with CrCL < 15 mL/min or patients requiring haemodialysis. Elderly: No dose adjustment is necessary in elderly (≥ 65 years of age) patients. Paediatric population: The safety and efficacy of Talzenna in children and adolescents < 18 years of age have not been established. **Method of administration**: Talzenna is for oral use. To avoid contact with the capsule content, the capsules should be swallowed whole, and must not be opened or dissolved. They can be taken with or without food (See SmPC section 5.2). **Contra-indications:** Hypersensitivity to the active substance or to any of the excipients. Breast-feeding. **Special Warnings and Precautions:** Myelosuppression: Myelosuppression consisting of anaemia, leucopenia/neutropenia, and/or thrombocytopenia, have been reported in patients treated with talazoparib (see section 4.8). Talazoparib should not be started until patients have recovered from haematological toxicity caused by previous therapy (≤ Grade 1). Precautions should be taken to routinely monitor haematology parameters and signs and symptoms associated with anaemia, leucopenia/neutropenia, and/or thrombocytopenia in patients receiving talazoparib. If such events occur, dose modifications (reduction or interruption) are recommended. Supportive care with or without blood and/or platelet transfusions and/or administration of colony stimulating factors may be used as appropriate. Myelodysplastic syndrome/Acute myeloid leukaemia: Myelodysplastic syndrome/Acute Myeloid Leukaemia (MDS/AML) have been reported in patients who received poly (adenosine diphosphate-ribose) polymerase (PARP) inhibitors, including talazoparib. Overall, MDS/AML has been reported in < 1% of solid tumour patients treated with talazoparib in clinical studies. Potential contributing factors for the development of MDS/AML include previous platinum-containing chemotherapy, other DNA damaging agents or radiotherapy. Complete blood counts should be obtained at baseline and monitored monthly for signs of haematologic toxicity during treatment. If MDS/AML is confirmed, talazoparib should be discontinued. Contraception in women of childbearing potential: Talazoparib was clastogenic in an in vitro chromosomal aberration assay in human peripheral blood lymphocytes and in an in vivo bone marrow micronucleus assay in rats but not mutagenic in Ames assay (see section 5.3), and may cause foetal harm when administered to a pregnant woman. Pregnant women should be advised of the potential risk to the foetus (see section 4.6). Women of childbearing potential should not become pregnant while receiving Talzenna and should not be pregnant at the beginning of treatment. A pregnancy test should be performed on all women of childbearing potential prior to treatment. A highly effective method of contraception is required for female patients during treatment with Talzenna, and for at least 7 months after completing therapy. Since the use of hormonal contraception is not recommended in patients with breast cancer, two non-hormonal and complementary contraception methods should be used. Male patients with female partners of reproductive potential or pregnant partners should be advised to use effective contraception (even after vasectomy), during treatment with Talzenna and for at least 4 months after the final dose. **Interactions:** Talazoparib is a substrate for drug transporters P-gp and Breast Cancer Resistance Protein (BCRP) and it is mainly eliminated by renal clearance as unchanged compound. Concomitant treatment with inhibitors of P-glycoprotein (P gp): Strong inhibitors of P gp may lead to increased talazoparib exposure. Concomitant use of strong P gp inhibitors (including but not limited to amiodarone, carvedilol, clarithromycin, cobicistat, darunavir, dronedarone, erythromycin, indinavir, itraconazole, ketoconazole, lapatinib, lopinavir, propafenone, quinidine, ranolazine, ritonavir, saquinavir, telaprevir, tipranavir, and verapamil) during treatment with talazoparib should be avoided. Co-administration should only be considered after careful evaluation of the potential benefits and risks. If co-administration with a strong P gp inhibitor is unavoidable, the Talzenna dose should be reduced to 0.75 mg once daily. When the strong P-gp inhibitor is discontinued, the Talzenna dose should be increased (after 3 5 half lives of the P-gp inhibitor) to the dose used prior to the initiation of the strong P gp inhibitor. No talazoparib dose adjustments are required when co administered with rifampin. However, the effect of other P-gp inducers on talazoparib exposure has not been studied. Other P-gp inducers (including but not limited to carbamazepine, phenytoin, and St. John's wort) may decrease talazoparib exposure. BCRP inhibitors: The effect of BCRP inhibitors on PK of talazoparib has not been studied in vivo. Co-administration of talazoparib with BCRP inhibitors may increase talazoparib exposure. Concomitant use of strong BCRP inhibitors (including but not limited to curcumin and cyclosporine) should be avoided. If co administration of strong BCRP inhibitors cannot be avoided, patient should be monitored for potential increased adverse reactions. Effect of acid-reducing agents: Population PK analysis indicates that co-administration of acid-reducing agents including proton pump inhibitors and histamine receptor 2 antagonists (H2RA), or other acid reducing agents had no significant impact on the absorption of talazoparib. Systemic hormonal contraception: Drug-drug interaction studies between talazoparib and oral contraceptives have not been conducted. **Fertility, pregnancy and lactation:** Fertility: There is no information on fertility in patients. Based on non-clinical findings in testes (partially reversible) and ovary (reversible), Talzenna may impair fertility in males of reproductive potential. Women of childbearing potential should not become pregnant while receiving Talzenna and should not be pregnant at the beginning of treatment. A pregnancy test should be performed on all women of childbearing potential prior to treatment. Women of childbearing potential must use highly effective forms of contraception prior to starting treatment with talazoparib, during treatment, and for 7 months after stopping treatment with talazoparib. Since the use of hormonal contraception is not recommended in patients with breast cancer, two non-hormonal and complementary contraception methods should be used. Male patients with female partners of reproductive potential or pregnant partners should be advised to use effective contraception (even after vasectomy) during treatment with Talzenna, and for at least 4 months after the final. Pregnancy: There are no data from the use of Talzenna in pregnant women. Studies in animals have shown embryo foetal toxicity. Talzenna may cause foetal harm when administered to a pregnant woman. Talzenna is not recommended during pregnancy or for women of childbearing potential not using contraception. Breast-feeding: It is unknown whether talazoparib is excreted in human breast milk. A risk to breast-fed children cannot be excluded and therefore breast-feeding is not recommended during treatment with Talzenna and for at least 1 month after the final dose. **Undesirable Effects:** The overall safety profile of Talzenna is based on pooled data from 494 patients who received talazoparib at 1 mg daily in clinical studies for solid tumours, including 286 patients from a randomised Phase 3 study with germline BRCA-mutated (gBRCAm), HER2-negative locally advanced or metastatic breast cancer and 83 patients from a non-randomised Phase 2 study in patients with germline BRCA-mutated locally advanced or metastatic breast cancer. The most common (≥ 25%) adverse reactions in patients receiving talazoparib in these clinical studies were fatigue (57.1%), anaemia (49.6%), nausea (44.3%), neutropenia (30.2%), thrombocytopenia (29.6%), and headache (26.5%). The most common (≥ 10%) Grade ≥ 3 adverse reactions of talazoparib were anaemia (35.2%), neutropenia (17.4%), and thrombocytopenia (16.8%). Dose modifications (dose reductions or dose interruptions) due to any adverse reaction occurred in 62.3% of patients receiving Talzenna. The most common adverse reactions leading to dose modifications were anaemia (33.0%), neutropenia (15.8%), and thrombocytopenia (13.4%). Permanent discontinuation due to an adverse reaction occurred in 3.6% of patients receiving Talzenna. The median duration of exposure was 5.4 months (range 0.03-61.1). Very common adverse reactions (>1/10) are Thrombocytopenia, Anaemia, Neutropenia, Leucopenia, Decreased appetite, Dizziness, Headache, Vomiting, Diarrhoea, Nausea, Abdominal pain, Alopecia and Fatigue. Commonly reported adverse reactions (>1/100 to <1/10), are Lymphopenia, Dysgeusia, Stomatitis and Dyspepsia. Refer to SmPC section 4.8 for further information on side effects. **Legal Category:** Product subject to prescription which may not be renewed (A): S1A. **Marketing Authorisation Number:** Talzenna 0.25 mg hard capsules – EU/1/19/1377/001-004; Talzenna 1 mg hard capsules – EU/1/19/1377/005-006. **Marketing Authorisation Holder:** Pfizer Europe MA EEIG, Boulevard de la Plaine 17, 1050 Bruxelles, Belgium.

For further information on this medicine please contact: Pfizer Medical Information on 1800 633 363 or at medical.information@pfizer.com. **For queries regarding product availability please contact:** Pfizer Healthcare Ireland, Pfizer Building 9, Riverwalk, National Digital Park, Citywest Business Campus, Dublin 24 + 353 1 4676500.

Date of Preparation: 11/2021.

Ref: TE 3_0.

PP-TAL-IRL-0045
Date of Preparation January 2022

▼This medicine is subject to additional monitoring. This will allow quick identification of new safety information. You can help by reporting any side effects you may get to HPRA Pharmcoviglance, Earlsfort Terrace, Dublin 2, IRL. Tel: +353 1 676 4971, Fax: +353 1 676 2517, Website: www.hpra.ie, E-mail: medsafety@hpra.ie

Pfizer Oncology

Digital health initiative aids recovery

Key role played by cardiovascular nurse prescriber in a innovative digital disease prevention and recovery programme developed by heart and stroke charity Croí

Pictured following the publication of a report into the outcomes of the Croí MySláinte digital cardiovascular disease prevention and recovery programme are Irene Gibson, trained cardiovascular nurse specialist and director of programmes and innovation, National Institute for Prevention and Cardiovascular Health, with Neil Johnson, Chief Executive, Croí

THE Croí MySláinte programme, funded by the government's Sláintecare Integration Fund, had to be delivered virtually due to restrictions on traditional healthcare delivery imposed as a result of the Covid-19 pandemic. Croí created an interactive platform which enabled participants to access the programme from their homes, including access to pre-recorded videos, resources and links to weekly live Zoom sessions.

The core components of the programme included lifestyle modifications such as:

- Smoking cessation, healthy food choices and physical activity
- Medical risk factor management of blood pressure, cholesterol and glucose
- Electronic prescribing of cardio-protective medication where appropriate.

A total of 105 people who had experienced a cardiac event such as a heart attack, opted to take part in the initiative. Participants were aged between 35 and 84 years, and were referred from cardiac centres across the west of Ireland, including Galway, Mayo, Sligo, Limerick and Donegal. The programme was led by a nurse prescriber with the support of a consultant cardiologist.

It was found that Croí MySláinte successfully achieved and exceeded the agreed project targets with significant improvements in medical and lifestyle risk factor management and psychosocial health being attained. Following a total of 423 virtual consultations over a 12-week period, a range of health improvements resulted for those involved, according to a newly-published outcomes report on the programme. These included:

- Physical activity levels increased almost six-fold
- Blood pressure control improved from 24% to 68%
- LDL cholesterol target achievement increased from 14% to 41%
- More than half of participants (57%) lost over 2% of their body weight, with almost a quarter (23%) losing 5% or more
- Anxiety and depression levels among participants were reduced by more than half
- Increased adherence to the Mediterranean diet.

There was an 84% retention rate among patients with 2,540 engagements throughout the programme. Many participants were also living with other health issues such as diabetes, arthritis, chronic kidney disease or cancer, meaning wider benefits for their other conditions also.

Participants were empowered to manage their health and wellbeing, stress and emotional eating. Advice was also provided on making and maintaining lifestyle changes in the areas of sleep hygiene, sexual health and returning to work.

In addition, participants were provided with a Fitbit device to track their daily exercise activity, as well as blood pressure monitors for home measurement and food and exercise diaries to help monitor progress towards their goals.

The programme, which was overseen by a consultant cardiologist, was delivered by a specialist interdisciplinary health team comprising a cardiovascular nurse prescriber, a physiotherapist and a dietitian.

The report found that:

- E-learning and digital expertise are essential to developing virtual platforms and healthcare professionals need to be provided with support and training to adapt to online programme delivery
- Virtual delivery can minimise barriers (travel, work, childcare and carer responsibilities) associated with accessibility and can be service user friendly. For example, participants stated that they enjoyed accessing the recordings in their own time and then valued coming together in a peer-supported environment for the interactive discussion
- Age is not a barrier to accessing an online programme. With support, people of any age can engage once they have access to broadband and a device
- Through providing necessary tools and support, digital programmes can successfully engage patients in self-management. Sufficient time needs to be allowed for the set-up of digital programmes
- Nurse prescribing on programme helped to ensure efficient medical management. This has been especially important during Covid-19 where access to general practice and hospital based cardiology support has been limited.

The report stressed that scaling up of the project was feasible as the clinical protocols, care pathways and the online platform have already been developed. There is 'existing buy in' from local clinical leads and key stakeholders, including patients. However, further roll out is dependent on mainstream funding being made available over a longer period of time and integrations with the newly established HSE Integrated Care Programme for the Prevention and Management of Chronic Disease.

The full report is available at: **www.croi.ie/MySlainte.**

Lynparza®
olaparib
tablets 150 mg

Lynparza (olaparib) tablets are now reimbursed as monotherapy for the maintenance treatment of adult patients with advanced (FIGO stages III and IV) BRCA1/2-mutated (germline and/or somatic) high-grade epithelial ovarian, fallopian tube or primary peritoneal cancer who are in response (complete or partial) following completion of first-line platinum-based chemotherapy.[1†]

*In the SOLO-1 trial, the use of maintenance therapy with Lynparza provided a substantial benefit with regard to progression-free survival among women with newly diagnosed BRCAm advanced ovarian cancer, with a 70% lower risk of disease progression or death with Lynparza than with placebo.[2]

†Please see full Lynparza tablet indication below in the API

Abridged prescribing information

LYNPARZA™ (olaparib) 150mg & 100mg FILM-COATED TABLETS

Consult Summary of Product Characteristics (SmPC) before prescribing. Indication: Ovarian Cancer: As monotherapy for the maintenance treatment of adult patients with advanced (FIGO stages III and IV) *BRCA1/2*-mutated (germline and/or somatic) high-grade epithelial ovarian, fallopian tube or primary peritoneal cancer who are in response (complete or partial) following completion of first-line platinum-based chemotherapy. As monotherapy for the maintenance treatment of adult patients with platinum-sensitive relapsed high-grade epithelial ovarian, fallopian tube, or primary peritoneal cancer who are in response (complete or partial) to platinum-based chemotherapy. **Lynparza in combination with bevacizumab:** As maintenance treatment of adult patients with advanced (FIGO stages III and IV) high-grade epithelial ovarian, fallopian tube or primary peritoneal cancer who are in response (complete or partial) following completion of first-line platinum-based chemotherapy in combination with bevacizumab and whose cancer is associated with homologous recombination deficiency (HRD) positive status defined by either a *BRCA1/2* mutation and/or genomic instability. **Breast Cancer:** As monotherapy for the treatment of adult patients with germline *BRCA1/2*-mutations, who have HER2 negative locally advanced or metastatic breast cancer. Patients should have previously been treated with an anthracycline and a taxane in the (neo)adjuvant or metastatic setting unless patients were not suitable for these treatments. Patients with hormone receptor (HR)-positive breast cancer should also have progressed on or after prior endocrine therapy, or be considered unsuitable for endocrine therapy. **Adenocarcinoma of the pancreas:** As monotherapy for the maintenance treatment of adult patients with germline *BRCA1/2*-mutations who have metastatic adenocarcinoma of the pancreas and have not progressed after a minimum of 16 weeks of platinum treatment within a first-line chemotherapy regimen. **Prostate Cancer:** As monotherapy for the treatment of adult patients with metastatic castration-resistant prostate cancer and *BRCA1/2*-mutations (germline and/or somatic) who have progressed following prior therapy that included a new hormonal agent. **Presentation:** 150mg and 100mg olaparib film-coated tablets. **Dosage and Administration:** Treatment should be initiated and supervised by a physician experienced in the use of anticancer therapies. **First-line maintenance treatment of *BRCA*-mutated advanced ovarian cancer:** Before Lynparza treatment is initiated for first-line maintenance treatment of high-grade epithelial ovarian cancer (EOC), fallopian tube cancer (FTC) or primary peritoneal cancer (PPC), patients must have confirmation of deleterious or suspected deleterious germline and/or somatic mutations in the breast cancer susceptibility genes (*BRCA*) 1 or 2 using a validated test. **Maintenance treatment of platinum-sensitive relapsed ovarian cancer:** There is no requirement for *BRCA1/2* testing prior to using Lynparza for the monotherapy maintenance treatment of relapsed EOC, FTC or PPC who are in a complete or partial response to platinum-based therapy. **First-line maintenance treatment of HRD positive advanced ovarian cancer in combination with bevacizumab:** Before Lynparza with bevacizumab treatment is initiated for the first-line maintenance treatment of EOC, FTC or PPC, patients must have confirmation of either deleterious or suspected deleterious *BRCA1/2* mutation and/or genomic instability determined using a validated test. ***gBRCA1/2*-mutated HER2-negative metastatic breast cancer:** For germline breast cancer susceptibility genes (*gBRCA1/2*) mutated human epidermal growth factor receptor 2 (HER2)-negative locally advanced or metastatic breast cancer, patients must have confirmation of deleterious or suspected deleterious *gBRCA1/2* mutation before Lynparza treatment is initiated. *gBRCA1/2* mutation status should be determined by an experienced laboratory using a validated test method in breast cancer and ovarian cancer patients. **First-line maintenance treatment of *gBRCA*-mutated metastatic adenocarcinoma of the pancreas:** For first-line maintenance treatment of germline *BRCA1/2*-mutated metastatic adenocarcinoma of the pancreas, patients must have confirmation of a deleterious or suspected deleterious *gBRCA*1/2 mutation before Lynparza treatment is initiated. *gBRCA*1/2 mutation status should be determined by an experienced laboratory using a validated test method. ***BRCA1/2*-mutated metastatic castration-resistant prostate cancer:** For *BRCA1/2*-mutated metastatic castration-resistant prostate cancer (mCRPC), patients must have confirmation of a deleterious or suspected deleterious *BRCA1/2* mutation (using either tumour or blood sample) before Lynparza treatment is initiated. *BRCA1/2* mutation status should be determined by an experienced laboratory using a validated test method. Genetic counselling for patients tested for mutations in *BRCA1/2* genes should be performed. Recommended dose in monotherapy or in combination with bevacizumab is 300mg (two 150mg tablets) twice daily, equivalent to a total daily dose of 600mg. The 100mg tablet is available for dose reduction. Tablets should be swallowed whole and not chewed, crushed, dissolved or divided and may be taken without regard to meals. **Lynparza monotherapy:** Patients with platinum-sensitive relapsed high-grade epithelial ovarian, fallopian tube, or primary peritoneal cancer who are in response (complete or partial) to platinum-based chemotherapy should start Lynparza treatment no later than 8 weeks after completion of their final dose of platinum-containing regime. **Lynparza in combination with bevacizumab:** When Lynparza is used in combination with bevacizumab for the first-line maintenance treatment of high-grade epithelial ovarian, fallopian tube, or primary peritoneal cancer following completion of first-line platinum-based therapy with bevacizumab, the dose of bevacizumab is 15 mg/kg once every 3 weeks. **First-line maintenance treatment of *BRCA*-mutated advanced ovarian cancer:** Patients can continue treatment until radiological disease progression, unacceptable toxicity or for up to 2 years if there is no radiological evidence of disease after 2 years of treatment. Patients with evidence of disease at 2 years, who in the opinion of the treating physician can derive further benefit from continuous treatment, can be treated beyond 2 years. **Maintenance treatment of platinum sensitive relapsed ovarian cancer:** For patients with platinum sensitive relapsed high-grade epithelial ovarian, fallopian tube or primary peritoneal cancer, it is recommended that treatment be continued until progression of the underlying disease or unacceptable toxicity. **First-line maintenance treatment of HRD positive advanced ovarian cancer in combination with bevacizumab:** Patients can continue treatment with Lynparza until radiological disease progression, unacceptable toxicity or for up to 2 years if there is no radiological evidence of disease after 2 years of treatment. Patients with evidence of disease at 2 years, who in the opinion of the treating physician can derive further benefit from continuous Lynparza treatment, can be treated beyond 2 years. ***gBRCA1/2*-mutated HER2-negative metastatic breast cancer:** It is recommended that treatment be continued until progression of the underlying disease or unacceptable toxicity. **First-line maintenance treatment of *gBRCA*-mutated metastatic adenocarcinoma of the pancreas**: It is recommended that treatment be continued until progression of the underlying disease or unacceptable toxicity. There are no data on retreatment with Lynparza following first or subsequent relapse in ovarian cancer patients or on retreatment of breast cancer patients. ***BRCA1/2*-mutated metastatic castration-resistant prostate cancer:** It is recommended that treatment be continued until progression of the underlying disease or unacceptable toxicity. Medical castration with luteinising hormone releasing hormone (LHRH) analogue should be continued during treatment in patients not surgically castrated. **The tablets and capsules should not be substituted for each other on a milligram-to-milligram basis due to differences in the dosing and bioavailability of each formulation. Specific dose recommendations for each formulation should be followed.** If a patient misses a dose of Lynparza, they should take their next normal dose at its scheduled time. **Dose adjustments:** Treatment interruption to manage adverse reactions such as nausea, vomiting, diarrhoea, anaemia and dose reduction can be considered. Recommended dose reduction is to 250mg (one 150mg tablet and one 100mg tablet) twice daily, equivalent to a total daily dose of 500mg. If further dose reduction is required, then reduction to 200mg (two 100mg tablets) twice daily, equivalent to a total daily dose of 400mg is recommended. Concomitant use of strong or moderate CYP3A inhibitors is not recommended and alternative agents should be considered**.** If a strong CYP3A inhibitor must be co-administered, recommended dose reduction is to 100mg (one 100mg tablet) twice daily, equivalent to a total daily dose of 200mg. If a moderate CYP3A inhibitor must be co-administered, recommended dose reduction is to 150mg (one 150mg tablet) twice daily, equivalent to a total daily dose of 300mg. **Elderly:** No adjustment in starting dose is required. **Renal impairment:** Patients with moderate renal impairment (creatinine clearance 31 to 50 ml/min) the recommended dose is 200mg (two 100mg tablets) twice daily, equivalent to a total daily dose of 400mg. Lynparza can be administered in patients with mild renal impairment (creatinine clearance 51 to 80 ml/min) with no dose adjustment. No studies have been conducted in patients with severe renal impairment or end-stage renal disease (creatinine clearance ≤ 30 ml/min) and Lynparza is not recommended for use. It may only be used in patients with severe renal impairment if the benefit outweighs the potential risk with careful monitoring of renal function and adverse events. **Hepatic impairment:** Can be administered in patients with mild or moderate hepatic impairment (Child-Pugh A or B) with no dose adjustment. Not recommended in patients with severe hepatic impairment (Child-Pugh C). **Contraindications:** Hypersensitivity to the active substance or to any of the excipients. Breast-feeding during treatment and for 1 month after the last dose. **Warnings and Precautions: Haematological toxicity:** Treatment should not be started in patients until they have recovered from haematological toxicity caused by previous anticancer therapy (haemoglobin, platelet and neutrophil levels should be ≤CTCAE grade 1). Baseline testing followed by monthly monitoring of complete blood counts is recommended for first 12 months of treatment and periodically thereafter. Treatment should be interrupted and appropriate haematological testing should be initiated if patient develops severe haematological toxicity or blood transfusion dependence. **Myelodysplastic syndrome/Acute Myeloid Leukaemia (MDS/AML):** If MDS/AML is suspected, the patient should be referred to a haematologist for further investigations, including bone marrow analysis and blood sampling for cytogenetics. If, following investigation for prolonged haematological toxicity, MDS/AML is confirmed, Lynparza should be discontinued and the patient treated appropriately. **Pneumonitis:** Interrupt Lynparza treatment and promptly investigate as appropriate. Discontinue Lynparza if pneumonitis is confirmed and treat patient appropriately. **Embryofoetal toxicity:** Lynparza could cause foetal harm when administered to a pregnant woman. **Pregnancy/contraception:** Lynparza should not be used during pregnancy. Women of childbearing potential must use two forms of reliable contraception, before starting Lynparza, during therapy and 1 month after receiving the last dose. Two highly effective and complementary forms of contraception are recommended. Male patients and their female partners of childbearing potential should use reliable contraception during therapy and for 3 months after receiving the last dose. **Sodium:** This medicinal product contains less than 1 mmol sodium (23 mg) per 100 mg or 150 mg tablet, that is to say essentially "sodium-free". **Drug Interactions:** The recommended Lynparza monotherapy dose is not suitable for combination with myelosuppressive anticancer medicinal products. Caution and close monitoring if vaccines or immunosuppressant agents are co-administered. **Effect of other drugs on Lynparza:** Strong CYP3A inhibitors (e.g. itraconazole, telithromycin, clarithromycin, protease inhibitors boosted with ritonavir or cobicistat, boceprevir, telaprevir) or moderate CYP3A inhibitors (e.g. erythromycin, diltiazem, fluconazole, verapamil) are not recommended. If co-administered, the dose of Lynparza should be reduced. It is also not recommended to consume grapefruit juice. Strong CYP3A inducers (e.g. phenytoin, rifampicin, rifapentine, carbamazepine, nevirapine, phenobarbital, and St John's Wort) are not recommended with Lynparza as the efficacy of Lynparza could be substantially reduced. The magnitude of the effect of moderate to strong inducers (e.g. efavirenz, rifabutin) on olaparib exposure is not established, therefore the co-administration of Lynparza with these medicinal products is also not recommended. **Effect of Lynparza on other drugs**: Caution and appropriate clinical monitoring is recommended when sensitive CYP3A substrates or substrates with a narrow therapeutic margin (e.g. simvastatin, cisapride, cyclosporine, ergot alkaloids, fentanyl, pimozide, sirolimus, tacrolimus and quetiapine) or P-gp substrates (e.g. simvastatin, pravastatin, dabigatran, digoxin and colchicine) are combined with Lynparza. Lynparza may reduce efficacy of hormonal contraceptives. Lynparza may increase the exposure to substrates of BCRP (e.g. methotrexate, rosuvastatin), OATP1B1 (e.g. bosentan, glibenclamide, repaglinide, statins and valsartan), OCT1, MATE1, MATE2K (e.g. metformin), OCT2 (e.g. serum creatinine), OAT3 (e.g. furosemide and methotrexate). Caution if co-administered with any statin. **Pregnancy and Lactation:** Women of childbearing potential should not become pregnant while on Lynparza and not be pregnant at the beginning of treatment. A pregnancy test should be performed prior to treatment and considered regularly throughout treatment. The efficacy of some hormonal contraceptives may be reduced if co-administered with Lynparza. Therefore, an additional non-hormonal contraceptive method should be considered during treatment. For women with hormone dependent cancer, two non-hormonal contraceptives should be considered. Lynparza could cause foetal harm to a pregnant woman. Lynparza is contraindicated during breast-feeding and for 1 month after receiving last dose. Male patients must use a condom during therapy and for 3 months after receiving last dose when having sexual intercourse with a pregnant woman or with a woman of childbearing potential. Female partners of male patients must also use highly effective contraception. Male patients should not donate sperm during therapy and for 3 months after treatment. **Ability to Drive and Use Machines:** Asthenia, fatigue and dizziness have been reported and patients who experience these symptoms should observe caution when driving or using machines. **Undesirable Events:** Consult SmPC for full list of side effects**. Very common:** Anaemia, neutropenia, thrombocytopenia, leukopenia, nausea, vomiting, diarrhoea, dyspepsia, dysgeusia, decreased appetite, fatigue (including asthenia), headache, dizziness, cough, dyspnoea. **Common:** Lymphopenia, stomatitis, upper abdominal pain, rash, blood creatinine increased. **Uncommon:** Myelodysplastic syndrome/Acute myeloid leukaemia, hypersensitivity, dermatitis, angioedema, mean cell volume increased. **Rare:** Erythema nodosum. **Legal Category:** Product subject to prescription which may not be renewed (A) **Marketing Authorisation Number:** EU/1/14/959/002-003 (100mg tablets); EU/1/14/959/004-005 (150 mg tablets). **Marketing Authorisation Holder:** AstraZeneca AB, SE-151 85 Södertälje, Sweden. **Further product information available on request from:** AstraZeneca Pharmaceuticals (Ireland) DAC, Block B, Liffey Valley Office Campus, Dublin 22. Tel: +353 1 609 7100. LYNPARZA is a trade mark of the AstraZeneca group of companies. **Date of API preparation:** 02/2021 **Veeva ID:** IE-2421

Adverse events should be reported directly to: HPRA Pharmacovigilance, **Website:** www.hpra.ie **Adverse events should also be reported to AstraZeneca Patient Safety on Freephone 1800 800 899**

References

1. LYNPARZA 100 mg and 150 mg film-coated tablets Summary of Product Characteristics

2. Moore K et al. N Engl J Med 2018; DOI: 10.1056/NEJMoa1810858

BRCAm = BRCA-mutated; FIGO = International Federation of Gynecology and Obstetrics

Veeva ID: IE-2661 Date of preparation: May 2021

MSD AstraZeneca

aimovig® ▽
erenumab

THIS IS FEWER MIGRAINE DAYS.[2,3] THIS IS LONG-TERM EVIDENCE.[4]

THIS IS PREVENTION[1,2]

AIMOVIG® IS REIMBURSED FOR CHRONIC MIGRAINE PATIENTS WITH THREE OR MORE PREVIOUS PROPHYLACTIC TREATMENT FAILURES

ABBREVIATED PRESCRIBING INFORMATION
▽ **Aimovig®** (erenumab) **70 mg and 140 mg solution for injection in pre-filled pen**
Important note: Before prescribing, consult full prescribing information.
Presentation: Aimovig 70 mg solution for injection in pre-filled pen. Each pre-filled pen contains 70 mg erenumab. Aimovig 140 mg solution for injection in pre-filled pen. Each pre-filled pen contains 140 mg erenumab. **Indications:** Aimovig is indicated for prophylaxis of migraine in adults who have at least 4 migraine days per month. **Dosage and administration:** Adults: The recommended dose of Aimovig is 70 mg administered subcutaneously every 4 weeks. Some patients may benefit from a dosage of 140 mg once every 4 weeks. Each 140 mg dose is given either as one subcutaneous injection of 140 mg or as two subcutaneous injections of 70 mg. Aimovig is intended for patient self-administration in the abdomen, thigh, or, if someone else is giving the injection, also into the outer area of the upper arm. Administration should be performed by an individual who has been trained to administer the product. The needle cover of Aimovig prefilled pen contains dry natural rubber, which may cause allergic reactions in individuals sensitive to latex. **Special populations: Paediatric patients:** The safety and effectiveness of Aimovig has not been studied in paediatric patients. **Elderly (aged 65 years and over):** The safety and effectiveness of Aimovig has not been studied in elderly patients. No dose adjustment is necessary as the pharmacokinetics of erenumab are not affected by age. **Renal impairment:** No dose adjustment is necessary in patients with mild to moderate renal impairment. **Hepatic impairment:** No studies have been performed in patients with hepatic impairment. Hepatic clearance is not a major clearance pathway for erenumab. **Contraindications:** Hypersensitivity to the active substance or to any of the excipients. **Warnings and precautions:** Hypersensitivity reactions: Serious hypersensitivity reactions, including rash, angioedema, and anaphylactic reactions, have been reported with erenumab in post-marketing experience. These reactions may occur within minutes, although some may occur more than one week after treatment. In that context, patients should be warned about the symptoms associated with hypersensitivity reactions. If a serious or severe hypersensitivity reaction occurs, initiate appropriate therapy and do not continue treatment with erenumab. Constipation: Constipation is a common undesirable effect of Aimovig and is usually mild or moderate in intensity. In a majority of the cases, the onset was reported after the first dose of Aimovig; however patients have also experienced constipation later on in the treatment. In most cases constipation resolved within three months. In the post marketing setting, constipation with serious complications has been reported with erenumab. In some of these cases hospitalisation was required, including cases where surgery was necessary. History of constipation or the concurrent use of medicinal products associated with decreased gastrointestinal motility may increase the risk for more severe constipation and the potential for constipation related complications. Patients should be warned about the risk of constipation and advised to seek medical attention in case constipation does not resolve or worsens. Patients should seek medical attention immediately if they develop severe constipation. Constipation should be managed promptly as clinically appropriate. For severe constipation, discontinuation of treatment should be considered. Traceability: In order to improve the traceability of biological medicinal products, the name and the batch number of the administered product should be clearly recorded. Latex sensitive individuals: The removable cap of the Aimovig pre-filled pen contains dry natural rubber latex, which may cause Allergic reactions in individuals sensitive to latex **Pregnancy, lactation, fertility:** Pregnancy: There are a limited amount of data from the use of erenumab in pregnant women. As a precautionary measure it is preferable to avoid the use of Aimovig during pregnancy. Lactation: It is not known whether erenumab is present in human milk. The use of Aimovig could be considered during breastfeeding only if clinically needed. Fertility: There is no data available on the impact of Aimovig on male and female fertility. Animal studies showed no impact on female and male fertility. **Adverse drug reactions:** Common (≥1/100 to <1/10): Hypersensitivity reactions including anaphylaxis, angioedema, rash, swelling/oedema and urticaria. Injection site reactions, constipation, muscle spasm, pruritus. **Interactions:** No effect on exposure of co-administered medicinal products is expected based on the metabolic pathway of monoclonal antibodies. No interactions with oral contraceptives (ethinyl estradiol and norgestimate) or sumatriptan were observed in studies with healthy volunteers. **Legal Category:** POM. **Marketing Authorisation Holder:** Novartis Europharm Ltd, Vista Building, Elm Park, Merrion Road, Dublin 4, Ireland. **Marketing Authorisation Numbers:** EU/1/18/1293/001 006. **Date of last revision of Abbreviated Prescribing Information:** September 2020. **Full prescribing information is available upon request from:** Novartis Ireland Limited, Vista Building, Elm Park Business Campus, Merrion Road, Dublin 4, Ireland, Tel: + 353 1 220 4100 or at www.medicines.ie. Detailed information on this product is also available on the website of the European Medicines Agency http://www.ema.europa.eu.

▽ This medicinal product is subject to additional monitoring. Reporting suspected adverse reactions of the medicinal product is important to Novartis and the HPRA. It allows continued monitoring of the benefit/risk profile of the medicinal product. All suspected adverse reactions should be reported via HPRA Pharmacovigilance, website: www.hpra.ie. Adverse events could also be reported to Novartis preferably via www.report.novartis.com or by email: drugsafety.dublin@novartis.com or by calling 01 2080 612.

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*Image used is not an actual Aimovig® patient

IE145414 | August 2021

NOVARTIS

Breaking the vicious circle of migraine and stress

In the first of a series on migraine management, **Tara Horan** focuses on one of the main triggers – stress – and general mental health

IN IRELAND, approximately 12-15% of the population live with migraine, equating to well over half a million people in the country.[1,2] Migraine is classed as the world's second most common cause of disability, and first in young women, according to the Global Burden of Disease study 2019 (GBD2019).[3]

There is a variety of triggers for migraine, with stress being one of the main ones. Indeed, stress has been identified as a trigger for more than 70% of migraineurs.[3] In turn, living with migraine can have a serious impact on mental health. This is often referred to as a vicious circle – with migraine and stress each being a causative factor for the other.

"Stress itself can develop into a medical diagnosis of a generalised anxiety disorder. If you're constantly stressed and in pain you can understand where the depression might come in," said Dr Sabina Brennan, a neuroscientist at Trinity College Dublin, when discussing the comorbidities of anxiety and depression with migraine in a recent podcast produced by the Migraine Association of Ireland.[4]

In a recent survey of migraine patients in Ireland, 30% stated they feel "depressed and sad" and 25% feel "depressed and anxious" as a result of their condition.[5]

There are several possible explanations for mental health comorbidities with migraine, according to Dr Brennan. "One possibility is the burden of the constant pain and the anxiety linked in with migraine". Another possibility she suggested is that "migraine, anxiety and depression share a common pathophysiology – there is something in the way the brain operates that is shared between anxiety, migraine and/or depression."

Dr Brennan stressed that it is critical for anyone with migraine to manage their stress, which she suggested could start with acceptance of the condition and having a regular lifestyle. "For everyone, with or without migraine, regularity is critical to the functioning of the brain. The brain looks after everything a person does. It manages your emotions, controls and regulates your hormones, and your hormones in turn regulate your behaviour."

As seen with post-viral infections over many years, Dr Brennan said it is not surprising that people with long Covid are now developing migraine as "there has been an assault on the brain through the infection".

Management of migraine

As well as an increased risk of medical comorbidities such as depression, anxiety, fibromyalgia and obesity, migraineurs are also at increased risk of overuse of painkillers/analgesics.[2] In the general management of migraine it is therefore important to emphasise the key factors of a healthy lifestyle, daily exercise, a balanced diet, good hydration, moderate caffeine intake, good sleep hygiene, stress management and the avoidance of alcohol, smoking and other stimulants.

People may experience episodic or chronic symptoms of migraine, with the latter usually causing the most significant disability and having a major impact on their quality of life.[2]

Patients should take acute treatments as early as possible during an attack, preferably before the headache is well established. As it is difficult to predict how severe an attack will be, detailed migraine diaries and personal awareness are important.[2]

Acute migraine episodes can be managed with paracetamol, NSAIDs or triptans (which should be taken as early in an attack as possible). Individuals may respond effectively to simple analgesia combinations, such as paracetamol and ibuprofen taken together. Others may need a combination of medications from all three categories.[2]

Prophylactic therapies are usually indicated when migraine symptoms occur on at least eight to 10 days per month and are of moderate to severe intensity. The goal of preventative treatments is to reduce the frequency of migraine attacks. This in turn will also help to avoid the risk of overuse of acute medications.[2]

Most current preventative agents have been identified by chance, after being used to treat other medical conditions, including epilepsy, depression and hypertension.[3] The most commonly used migraine prophylactic therapies include beta-blockers, anticonvulsants, such as sodium valproate (not for use in female children or women of childbearing age); calcium channel blockers, tricyclic anti-depressants and 5-HT antagonists.[2]

Other preventative strategies include physiotherapy, occipital nerve blocks, Botox and neuromodulation. Greater occipital nerve blocks involves injecting a mixture of steroid and local anaesthetic around the greater and lesser occipital nerves located on the back of the head, just above the neck area.[2] Alternative migraine therapies such as biofeedback, mindfulness, reflexology and TENS machines may be helpful for some migraine patients.[2]

More recently, promising new preventative treatments are the calcitonin gene-related peptide (CGRP) monoclonal antibodies. Anti-CGRP treatments, which block the CGRP pathway, are mainly for prophylaxis and are delivered by sub-cutaneous or intravenous injection once every four to 12 weeks.[6]

The next part in this series will focus on migraine and the influence of hormones

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Babies cleansed with WaterWipes® are less likely to get nappy rash** and if they do it doesn't last as long as with other leading brands*†.

In a clinical study of 698 babies, nappy rash lasted fewer days in babies cleansed with WaterWipes® *†. For each day of nappy rash** experienced by the WaterWipes® babies, it would have lasted approximately 50% longer had they used the other leading brands *†. For more information on some of the work we are doing visit our **Healthcare Professional page at www.waterwipes.com/uk/en/health-care/resources/clinical-study-different-baby-wipes**

* WaterWipes® are a cosmetic product and do not treat, cure or prevent nappy rash

** Moderate to severe nappy rash

† Reference: Price AD et al.. The BaSICS (Baby Skin Integrity Comparison Survey) study: A prospective experimental study using maternal observations to report the effect of baby wipes on the incidence of irritant diaper dermatitis in infants, from birth to eight weeks of age, Pediatrics and Neonatology in UK 2020, https://doi.org/10.1016/j.pedneo.2020.10.003

SKIN HEALTH ALLIANCE DERMATOLOGICALLY APPROVED

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eczema association australasia

APPRAL

Vegan

Healthcare heroes awarded Pure Foundation bursaries

New parents nominated staff for their "beyond incredible care"

THREE nurses and midwives have won the WaterWipes Pure Foundation Fund award for their 'beyond incredible' care. Claire Fitzpatrick, Anne Buckley and Pauline O'Connor have each been awarded €2,500 for their respective departments from the WaterWipes Pure Foundation Fund, which celebrates the achievements of healthcare professionals working with parents and babies in maternity and neonatal care.

Steve Pitman, INMO head of education and professional development, congratulated the three winners.

"2021 has been an extremely challenging year for nurses and midwives due to the continuing pandemic. This award provides a fantastic opportunity to recognise the work of nurses and midwives caring for parents and babies in maternity and neonatal care," he said.

WaterWipes launched the Pure Foundation Fund in 2020 to celebrate and recognise the incredible work of healthcare professionals involved in maternity and neonatal care. They actively encouraged both healthcare professionals and expectant and new parents to nominate individuals, specifically involved in neonatal and maternity care, who had gone above and beyond to make a difference to the lives of parents and babies. Representatives from WaterWipes, the INMO and Irish Neonatal Health Alliance (INHA) review the entries and select the winners each year.

Claire Fitzpatrick, clinical midwife and specialist in lactation at Midland Regional Hospital Portlaoise, was nominated for her work supporting breastfeeding mothers during the lockdowns. She maintained her support of expectant mothers through online breastfeeding classes, while also working as a vaccinator outside her standard work hours.

"I feel very proud and absolutely delighted to have won. I am passionate about helping women to reach their goals with breastfeeding and it is wonderful to receive this recognition. We hope to use the money to enhance the experience for the women and babies by making our lactation room more comfortable for women, as well as to aid with the education of staff," Ms Fitzpatrick said.

Pure Foundation bursary winners

Claire Fitzpatrick, clinical midwife specialist at the Midland Regional Hospital, Portlaoise

Anne Buckley, neonatal nurse, Cork University Maternity Hospital

Pauline O'Connor, public health nurse, Claremorris, Co Mayo

Neonatal nurse Anne Buckley works at Cork University Maternity Hospital. She was nominated by second-time mum Elaine Bourke for the care she gave to her daughter who was born premature at only 24 weeks.

"My little girl Nell was born in June 2020 at 24 weeks weighing a tiny 660 grams. Nell was a very sick baby and Anne, along with other nurses and doctors in the unit, saved her life. If Anne wasn't minding Nell on a particular day, she would always check in to see how we all were. Her bubbly personality and compassionate nature got us through some tough days. We will be forever grateful to Anne and all the fantastic nurses and doctors in the neonatal unit at CUMH," said Ms Bourke.

The INHA along with the INMO and WaterWipes are part of the panel that reviews nominations each year. Mandy Daly from INHA explained why these awards are so important: "Preterm birth flips the paradigm of parenthood on its axis and robs families of their expectations, hopes and dreams. Neonatal nurses, midwives and public health nurses help families see beyond the medical equipment of the neonatal unit as well as connect and care for patients under challenging circumstances. We are delighted to be in a position to acknowledge the incredible work of this community."

The final award winner, Pauline O'Connor, a public health nurse (PHN) from Claremorris, Co Mayo, was nominated by patient Laura McHugh for her support with her new baby AJ. Recognition of the valuable work PHNs do in the community meant a lot to her and her colleagues.

"Pauline heard that we were really struggling. Although she wasn't our designated PHN, she invited me to meet her. I had tried everything with my baby, but he would not sleep. She explained 'controlled crying' in detail. That night we started the process and my baby took to it immediately. Pauline called me the next day to check how it went and again over the next few weeks. He now sleeps 12 hours alone in his cot. I'm so grateful to Pauline," Ms McHugh said.

Speaking about the awards, Ailbhe O'Briain, WaterWipes HCP marketing manager, said the company was delighted to launch the second Pure Foundation Fund to celebrate the dedication of healthcare heroes "who have provided beyond-incredible care for expectant or new parents and their babies".

She added: "We were thrilled to see such fantastic and remarkable entries. Stories of those nominated included devoted nurses, midwives and public health nurses, who supported parents throughout the pandemic, helping with difficult births, homebirths, and upping the ante to take care of unwell babies and struggling parents during a particularly difficult year for the world."

Delivering the future

IN *Delivering the Future – Reflections of a Rotunda Master*, former master of Dublin's Rotunda Hospital Sam Coulter-Smith forcefully advocates for the continued independence of voluntary hospitals, arguing their importance to the Irish health service. He says that the pandemic has illustrated how these hospitals can be trusted to adapt and show flexibility and leadership, emphasising their ability to be more agile than other parts of our health service.

Prof Coulter-Smith argues that if the voluntary hospitals were treated as a trusted partner of the health service, the effect on the Irish hospital system could be considerable; that recognition of their legal and cultural difference would allow them to further evolve and "influence" HSE hospitals. Prof Coulter-Smith also looks at the lessons to be learned from an examination of how our health service has been managed in the past and he questions how we can use this knowledge to plan for a better future.

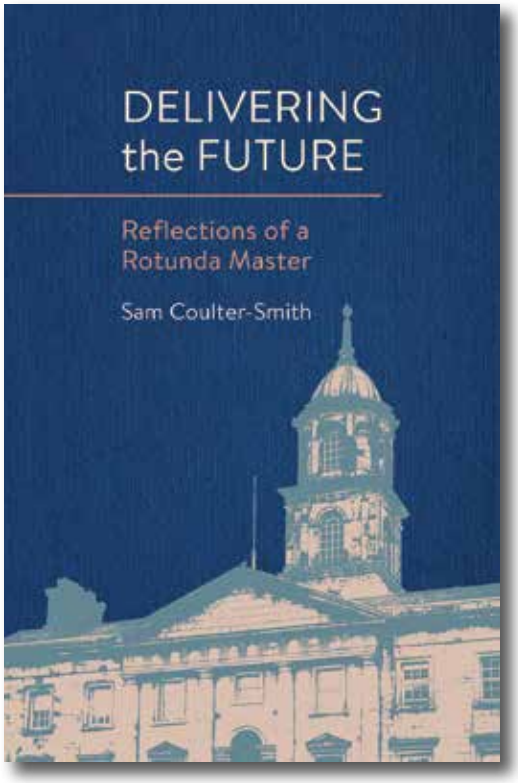
Looking further back, history buffs will enjoy reading about the Rotunda's early days and establishment on its current site in 1757; in fact, it is the oldest continuously running maternity hospital in the world.

Overcrowding and overstretched facilities are a recurring theme in the Rotunda's history and Prof Coulter-Smith recounts the HSE's lack of interest in helping him to mitigate risk in this area during his term as master when the hospital became dangerously busy while still reliant on 1757 facilities in the 2000s.

The book is interspersed with personal stories and recollections from Prof Coulter-Smith who, as the son of a Rotunda midwife and doctor, very much grew up with the hospital as a backdrop before going on to study medicine in the RCSI. It is both a recommended and enjoyable read.

– Alison Moore

Delivering the Future - Reflections of a Rotunda Master is published by Irish Academic Press. ISBN: 9781788551632. €29.95/£27.99



INMO
Irish Nurses and Midwives Organisation
Working Together

Attention NEW GRADUATES

New Grads who received their NMBI Pin in 2021 start on point 1 of the nursing salary scale, which is €31,109.

Once you have completed a further 16 weeks of work post your internship, this can include your pre-reg experience. You then skip point 2 of the salary scale and move to point 3, which is worth €33,888.

However, if you received your NMBI Pin in 2020, you should now be moving to point 4 of the salary scale on your next increment date. This means that you are now eligible to apply for the Enhanced Practice Contract. This would allow you to move onto point 1 of the enhanced nurse salary scale, worth €37,661.

Depending on your work location you may also be entitled to the medical and surgical ward allowance, worth €2,371 per annum.

Many of you will be moved to the new pay scale automatically and will already be receiving the allocation allowance, but it is important to check with your HR/payroll department.

TOP TIP

Check your payslip, as this should state what point of the scale you are on and when your next increment is due.

If you have any further questions get in touch with INMO Student/New Grad Officer Róisín at **roisin.oconnell@inmo.ie.**

If you're not a new graduate but have questions about your pay, call our **information office on 016640600**

WIN a €50 gift voucher

Take a break with CROSSWORD Competition

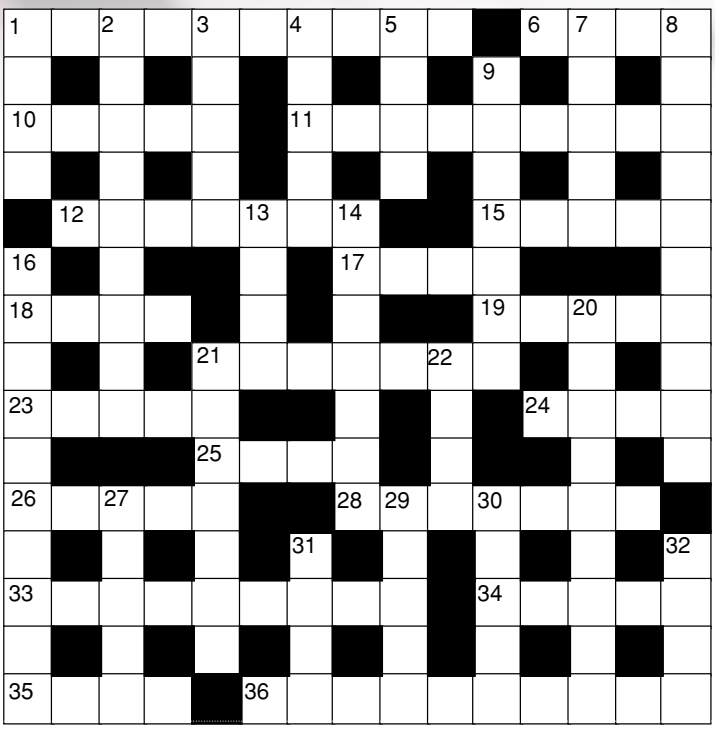
alh Affordable Live-In Homecare

Across

1 High-ranking clergyman (10)
6 Was in debt (4)
10 Being upset, Paul swallows one rice dish (5)
11 Collection of poetry (9)
12 Dilemma, conundrum (7)
15 Type of dance or type of sauce (5)
17 Female relative (4)
18 Prolific killer developing from HIV (1 1 1 1)
19 It's the order one cited, strangely enough (5)
21 She may not be for real - she's a bit fishy! (7)
23 The fourth-largest city in Belgium (5)
24 Ache (4)
25 A send-up (4)
26 Cuticles (5)
28 Netting used as a bed, traditionally by sailors (7)
33 & 34 Found in theatre, it seems the furniture is functioning properly! (9,5)
35 Convenience, comfort (4)
36 One's judgment of the situation may create the sanest mess (10)

Down

1 European mountain range (4)
2 Did the writer of 'The Rime of the Ancient Mariner' ogle cider like this? (9)
3 Explanatory information on the cover of a book (5)
4 & 31d Is it leftover bones one uses for a barbecue treat? (5,4)
5 Cereal used to make porridge (4)
7 Constituent of a fingerprint pattern (5)
8 Cocktail created in some yard in Trim (3,7)
9 Competed in a medieval tournament (7)
13 Entice, tempt (4)
14 Prehistoric elephantine creature (7)
16 An autumn of heady emotion, or what you do to make it so? (4,2,4)
20 Easily upset by having to rewrite a cable, Iris? (9)
21 Saviour (7)
22 Separate article on a list (4)
27 Notions (5)
29 Viewpoint; measure of turn (5)
30 School subject with numbers (5)
31 See 4 down
32 This amphibian went astray (4)



Name:
Address:

You can email your entry to us at nursing@medmedia.ie by taking a photo of the completed crossword with your details included putting 'crossword competition' in the subject line. Closing date: **Monday, March 21, 2022.** If preferred you can post your entry to: WIN Crossword, MedMedia Publications, 17 Adelaide Street, Dun Laoghaire, Dublin, A96E096

February crossword solution

Across: 1 Fig 3 Downtrodden 8 Meadow 9 Cold snap 10&25 Lapis lazuli 11 Roads 13 Faint 15 Retinol 16 Crew cut 20 Scent 21 Yemen 23 Faced 24 Polyglot 26 Sidetracked 27 Elk

Down: 1 Familiarity 2 Goalpost 3 Doors 4 Nicosia 5 Order 6&13 Dental floss 7 Nap 12 Spotted Dick 14 Tarot 17 Conclude 18 Genetic 19 Smiled 22 Night 23 Fraud 24 Pus

The winner of the February crossword is: Maureen Nagle, Liscannor, Co Clare

Irish study blindness breakthrough

DEVELOPING therapies for genetic forms of blindness is extremely challenging because they vary so widely, but researchers from Trinity College Dublin (TCD) have highlighted a target with great promise for treating a range of these conditions.

The scientists have highlighted that a specific gene (SARM1) is a key driver in the damage that ultimately leads to impaired vision (and sometimes blindness) and, in a disease model, showed that deleting this gene protects vision after a chemical kick-starts the chain of dysfunction that mimics a host of ocular conditions.

This means that therapies targeting suppression of SARM1 activity may hold the key to effective new options for treating a suite of diseases that can have a devastating impact on quality of life, and for many of which there are no treatment options currently available.

The scientists, led by a team from TCD's School of Genetics and Microbiology, have just published their findings in the *International Journal of Molecular Sciences*.

"In response to injury SARM1 contributes to a process that leads to the degeneration of specialised cells and their axons in the eye. When this happens it essentially means that the optic nerve can no longer deliver signals from the eye to the brain.

"Impaired vision and blindness is extremely debilitating for millions of people across the globe, which is one of the main motivations for us to seek to better understand the genetic causes and, potentially, develop life-changing therapies," said first author on the paper, Laura Finnegan, who is a PhD candidate at TCD.

Jane Farrar, professor at TCD's School of Genetics and Microbiology, and the senior author on the paper, explained that another important finding was that visual function was still preserved when reassessed four months after SARM1 was deleted, indicating that the benefits can remain over time. "This raises hopes that a targeted therapy delivered early enough may offer people diagnosed with an ocular neuropathy long-lasting preservation of sight.

"We have a way to go before such a therapy is available but this work represents a significant step, sheds light on the pathway forward and offers hope that a range of diseases involving the optic nerve – from maternally inherited conditions such as Leber Hereditary Optic Neuropathy to the more commonly known glaucoma – will one day be treatable via such therapies."

The research is the result of collaboration between Prof Farrar's lab in the School of Genetics and Microbiology and that of Prof Andrew Bowie's in the School of Biochemistry and Immunology in the Trinity Biomedical Sciences Institute.

The research was funded by the Irish Research Council, Science Foundation Ireland, the Health Research Board of Ireland and Fighting Blindness Ireland.

Experiencing difficulties paying?

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

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

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

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

ICN: nurses obligated to get vaccine

Council re-iterates call for vaccine patent waiver to combat inequity

THE International Council of Nurses' (ICN) new board of directors has issued a statement on Covid-19 vaccinations, highlighting nurses' professional responsibility to be vaccinated, the continuing and lamentable inequality of access to vaccines, and the need for nurses to be protected from harm.

In the statement the ICN affirms its belief in the safety and efficacy of Covid-19 vaccines and its conviction that nurses have a fundamental role in enhancing public trust in vaccines and encouraging people to have them. It says nurses have a professional responsibility to follow public health measures, including getting vaccinated, to protect themselves, the public they serve and health systems they work in.

The statement also urged governments to do more to ensure vaccine equity around the globe, especially for vulnerable people and nurses and other professionals who care for them, and calls for better protection of nurses against the abuse and violence that they have suffered while conducting their health education and vaccine administration roles.

"Nurses have consistently been voted the most trusted professionals on the planet and they have a vital role in providing up-to-date, evidence-based healthcare advice to their patients and the communities they serve. Nurses are great role models and the positive advice they give about vaccines can only be effective when they themselves take advantage of the protections the vaccines provide," said ICN president Dr Pamela Cipriano.

Since the start of the pandemic the ICN has consistently called for the prioritisation of the vaccination of healthcare workers and reported on the disproportionate impact on the most vulnerable populations and remains deeply concerned at the slow speed of the rollout, especially in Africa.

"Progress in vaccinating in Africa continues to be painfully slow, with 85% of the population still to receive a single dose and less than half of healthcare workers being fully vaccinated. What is also alarming is that only 0.1% of the total African population have been given boosters. This is a moral, health and rights crisis and we are urging governments to take immediate and sustained action to ensure equitable global vaccine access for people of all nations. This will require countries to step up their sharing of vaccines and for companies to waive their patents to maximise the efficiency of financing and support for manufacturing, distribution and delivery of vaccines.

"We must not fall into the trap of thinking that the end of the pandemic is in sight. There must be no false sense of security because individual nations alone will not be able to boost the world out of the pandemic," said ICN chief executive Howard Catton.

The ICN said that the inequity was plain to see in the UN's Development Programme's data, which suggests that while nearly 68% of people in high-income countries have had at least one dose of the vaccine, in low income countries that figure is less than 12%.

Referring to the abuse nurses have faced during the pandemic, Dr Cipriano said that she and her colleagues on the board were extremely concerned that much of it is linked to incorrect and misleading vaccine information: "Nurses have faced abuse and even physical attacks during the pandemic and the toxic environment around vaccinations in some situations has further put them at risk. We all know that nursing can be a challenging profession, but to have to face violence and aggression on top of the rigours of the job is totally unacceptable. The physical and mental toll of the pandemic on nurses is being made worse when irresponsible lies about vaccinations are spread, and people take out their fears and anger on the very people who are there to help them. The violence and abuse must be stopped, and it is up to governments to make sure their nurses are protected and kept safe."

Tribute to nurse Imelda Whelan who inspired Jack & Jill care

NURSE Imelda Whelan of Oldtown in Bantinglass, Co Wicklow, was born on July 24, 1961 and sadly passed away on February 4, 2022. In 1996 with three young children at home, Imelda was working in the busy emergency department in Naas Hospital. Through the community nurse she heard of us and our very sick baby Jack, whom my husband, Jonathan Irwin, and I were attempting to care for at home.

Jack was profoundly brain damaged and needed around the clock medical care to manage his 18/20-hour per day tube feeding schedule and management of his severe epilepsy. To put it mildly we were struggling. Imelda came to our house, arriving at the door with a big, beautiful smile and offered to mind Jack for us three or so nights a week, to give us some sleep and a breather. I honestly thought an angel had arrived at our door.

She transformed our lives with her time, her advice, her expert nursing and her warm friendship. The whole house just loved her from the first day.

Imelda was our inspiration to start the Jack and Jill Children's Foundation, a charity that has provided nursing and care for over 2,700 sick children in their own homes since 1997 and raising over €65 million to do so. We will always be indebted to her and I honestly do believe she was an angel sent to us.

Jack and Jill is a charity that always remained close to Imelda's heart. As an avid hiker (*see photo right*) she recently completed an 'Up the Hill for Jack & Jill' challenge, helping to raise money for the charity.


Imelda Whelan

She was a great and loving wife to Christy and a brilliant mother to her three sons Conor, David and John. They will miss her forever but her beautiful spirit will never be far from her four lads. Imelda will always be loved and never forgotten by anyone that was fortunate enough to meet her."

– Mary Ann O'Brien, co-founder of the The Jack & Jill Foundation

For further details on any events listed, contact jean.carroll@inmo.ie

March

Tuesday 29
Maternity Festival in person and online. Croke Park. Free to attend. See **inmoprofessional.ie** to book

Wednesday 30
Nursing Festival in person and online. Croke Park. Free to attend. See **inmoprofessional.ie** to book

April

Saturday 2
PHN Section meeting. 10.30am. Zoom

Wednesday 6
Telephone Triage Section meeting. 11am via Zoom

Thursday 7
ED Section meeting. 11am via Zoom

Thursday 21
Retired Section meeting. 11am. Richmond Education and Event Centre. Also available via Zoom

Tuesday 26
Care of the Older Person Section meeting. 12pm via Zoom

Thursday 28
ADON Section meeting. 2pm via Zoom

May

Friday 6
Irish Nephrology Nurses Association 21st Conference and AGM. Maldron Hotel, Tallaght, Friday, May 6. To register, contact Geraldine Slowey: gerslowey@gmail.com

Saturday 14
School Nurses Section meeting. 10.30am via Zoom

Thursday 19
SALO networking group meeting. 12pm via Microsoft Teams

Saturday 28
Special Schools Section meeting. 10am via Zoom

Retirement

- The Clare Branch would like to congratulate Assumpta McMahon on her retirement from Regina Community Nursing Unit, Kilrush. Assumpta had been director of nursing in Kilrush in recent years and had previously spent many years as CNM2 and ADON in St Joseph's Hospital, Ennis. We wish her every happiness in her retirement.
- On behalf of the staff of St Bernadette's Children's Unit, University Hospital Galway, we would like to wish our esteemed colleague Frances Flanagan all the best of health and happiness in her retirement from children's nursing. We are very proud to have worked with you and you will be missed by all. *Ag guí chuile rath ort i gconaí*.

Condolences

- It was with great sadness that we learned that Pavee Point co-director Ronnie Fay had passed away. Ronnie recently contributed to *WIN* outlining the health inequalities faced by Travellers. She worked tirelessly to improve the status and participation of Travellers and Roma in Ireland and fought for greater solidarity, understanding and social justice. We extend our deepest sympathies to Ronnie's colleagues and friends, her husband Philip and children Veronica and Patrick. *Ar dheis Dé go raibh a h-anam*.
- We extend our deepest condolences to the family and friends of Margaret Daly (née Watters) who passed away just before her 86th birthday. Margaret trained as a nurse in Dr Steevens' Hospital in the 1950s and went on to become a midwife in the Rotunda Hospital. After her marriage in 1962, she left public practice but continued her career in the private sector and returned to public practice in the late 1980s. Her family describe her as a wonderful, kind, elegant person who was so very proud of her profession. May she rest in peace.

INMO Membership Fees 2022

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

Nurse On Call

Nursing services and recruitment

Zoom interviews available from Monday-Friday, 8am-5pm (text 0871437417 for application forms)

Nurses, midwives, student nurses and healthcare assistants: we all want more flexibility in our work lives, and that's what **Nurse On Call** offers.

- Do you want to be able to work around family life and work when it suits you?
- Do you want to be in charge of your own work schedule?
- Do you want to make some extra money for holidays or for something special?
- Do you want to avoid a stressful work environment?
- Try out a hospital/worksite/community nursing with agency shifts through Nurse On Call before committing to a permanent position.

If any of the above apply to you, please join Nurse On Call, an approved supplier of agency nurses, student nurses and HCAs to every HSE/HSE-funded worksite in the Republic of Ireland – we would love to have you!

For more information, email **interviewer@nurseoncall.ie** or **corkoffice@nurseoncall.ie** if you are based in the south.

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INMO

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Please recruit your friend/colleague and ask them to complete an INMO new member Application Form (*please contact any INMO office for a supply of Application Forms*). Insert **your** name and INMO membership number on the 'Recruited By' portion of the application form at the end of Section 1.

*For every new member or re-joining member recruited, you receive a €20 One4all Gift Card.

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Our midwives are the key to our success. Passionate and committed, they enjoy a high level of job satisfaction and manage their own caseloads to suit their lifestyle.

Contact us today to find out more.

Irish Cancer Society Nurses

The Irish Cancer Society are seeking registered nurses who can provide a minimum of two nights per week and have some palliative experience. Training will be provided.

- Job description on **www.cancer.ie**
- Email CV to **recruitment@irishcancer.ie**
- Informal enquiries to 01-231 0524 or **mferns@irishcancer.ie**

Irish Cancer Society

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

12th ICN NP/APN NETWORK CONFERENCE

21–24 August 2022 | Dublin, Ireland

Advanced Practice Nursing Shaping the Future of Healthcare

The INMO is delighted to be collaborating with the IAANMP in hosting the 12th International Council of Nurses, Nurse Practitioner / Advanced Practice Nurses Network Conference in University College Dublin from 21st to 24th August 2022. This year marks 26 years of Advanced Nursing / Midwifery practice in Ireland, and the conference will showcase and celebrate advancements in nursing and midwifery practice from around the world

Who attends?

Who attends? Nurse/ Midwife Practitioners • Advanced Practice Nurses and Midwives • Clinical Nurse and Midwife Specialists • Registered Nurses and Midwives • Those on the pathway to Advanced Practice • Educators • Policy Makers and Managers • Industry Partners • Media

Conference Themes

- Advancing nursing practice to address inequality
- Leading innovation in advanced practice nursing
- Health and Wellbeing
- Global Health and Climate Change
- Building a NP/APN workforce for health
- Evidencing the impact of advanced practice nursing

Call for abstracts now open until 14th March 2022
Visit www.npapndublin2022.com for further details

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Tuaisceart Chathair & Tuaisceart Chontae Baile Átha Cliath

Community Healthcare Organisation
Dublin North City & County

Nursing positions available

Who are we?
CHO Dublin North City and County (CHO DNCC) is responsible for providing care and services to a population of around 621,405 people. Community Health Services are the broad range of health services delivered outside of the acute hospital setting. They are delivered through the HSE and its funded agencies to people in local communities, as close as possible to their homes.

Our services
Primary care; older persons; disabilities; mental health and wellbeing; quality, safety and service improvement

Our current vacancies
We have excellent opportunities for nurses: Staff Nurse, Clinical Nurse Specialists, Clinical Nurse Managers and ADON. If you are interested in providing quality care and developing a career in nursing, we offer a wide range of opportunities with many benefits.

We welcome applications from all qualified individuals who meet the eligibility criteria for these roles. Further information is available in the Job Specification for each position. Search 'Rezoomo CHO DNCC Jobs' or visit **Rezoomo CHO DNCC Jobs** for all our current vacancies.

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✓ **Do you want to increase your income with complete flexibility over how & when you work with a role that works perfectly alongside any current employment or other commitments?**
✓ **Do you want excellent rates of pay?**
✓ **Do you want great job satisfaction?**

We are recruiting in Ireland to enhance our self-employed nurse network. You will be responsible for undertaking ad hoc domiciliary insurance medicals and pathology tests for applicants of life insurance at a scheduled appointment that is convenient to you and the applicant. Each visit takes between 15-40 minutes depending upon the requirements of the case. MSS will provide full PPE, operational training and any ongoing assistance required through our support team.

Interested applicants will need to:
- have an active Registration and Indemnity
- have experience in phlebotomy (desirable)
- have transport and sufficient flexibility to conduct regular appointments at your convenience

You will be paid monthly for all completed cases.

For an information pack please e-mail Julie Collett including a current CV if available.

Email: recruitment@trustmss.co.uk
Tel: 01 447 5172
www.trustmss.co.uk

Saint John of God Community Services clg.
Liffey Services

Are you open to new opportunities to grow and develop your nursing career?

Contact St John of God Liffey Services

St John of God Liffey Services is currently recruiting all grades of nursing staff, including leadership roles to deliver excellent care and support across Dublin South West and North Kildare.

SJOG Liffey Services provides supports to over 850 children and adults with intellectual disabilities to reach their potential through Respite, Residential, Day Services and Early Services. We aim to provide each individual with the support that they need in a person centred manner through health and social models of care.

We are seeking Nurses and Clinical Nurse Managers (Grade 1 & 2) who can drive a high quality service and promote positive life experiences and achievements for children and adults with intellectual disabilities to join and lead our teams. SJOG Liffey Services provides a comprehensive training programme to help employees gain confidence in their new role and ensure ongoing professional growth. We also provide clinical support to all nursing staff across the service. We are recruiting for:

- CNM1 & CNM2 roles in Dublin 8
- CNM2 in Children's Respite based in Dublin 24
- Staff Nurses in Dublin and Kildare Services

Please email **LiffeyServicesRecruitment@sjog.ie** with a cover letter and CV with reference to the role you are applying for.

GALWAY HOSPICE FOUNDATION

Galway and Mayo Hospice

Galway: Renmore Avenue, Renmore, Galway, H91 R2TO. **Tel: 091 770868**
Mayo: Knockaphunta, Castlebar, Co Mayo, F23 YY40. **Tel: 095 900 5100**
Regional West of Ireland Specialist Palliative Care Centre, with CHKS Accreditation and ISO 9001:2015 Certification. Winner of CHKS International Quality Award 2011 and 2014

Clinical Nurse Manager I (IPU) - Galway Hospice

Full-time Position / Part-time position

The primary role of the CNM II will be the responsibility for the overall quality of service delivery to all patients within the 18-bed In-Patient Unit (IPU) and, with the support of three experienced CNM1s, the provision of professional, clinical leadership and management for all staff within the team.

Informal enquiries can be made by telephoning Ms. Mairead Carr (Director of Nursing and Therapy Services) at **091-770868** or by email at **mcarr@galwayhospice.ie**

Please contact Ann Dolan, Director of HR, at **adolan@galwayhospice.ie** for a detailed job description and Application Form or with expressions of interest.

Further information available on **https://galwayhospice.ie/the-charity/work-with-us/vacancies**

Irish Nurses and Midwives Organisation
Working Together

Sláintecare.

All Ireland Nursing Festival

Sláintecare

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