

WIN



Journal of the
Irish Nurses and
Midwives Organisation

Special report
from the INMO
ADC 2016
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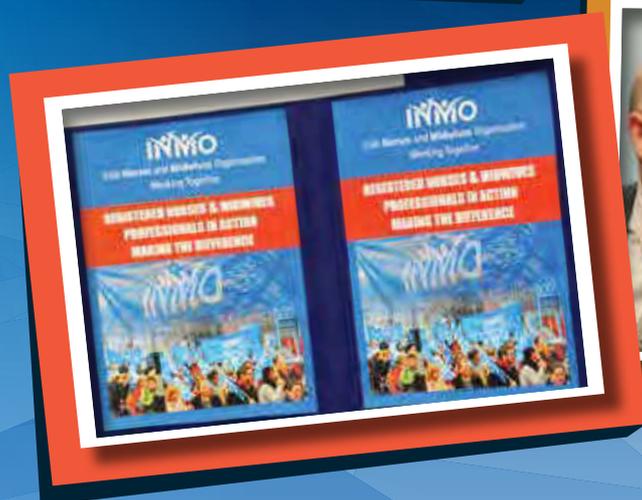
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New government – new minister – old problems

AT THE time of going to press the INMO was preparing for its first, formal meeting with the new Minister for Health, Simon Harris, following his recent appointment. The INMO wrote to Mr Harris wishing him every success in this most challenging of government portfolios.

We also wrote to the Minister to seek immediate discussions on several important issues affecting the health service, including the need for a political and societal consensus on a long term plan for our public health service. We are also seeking immediate measures to address the crises in recruitment and retention, and poor staffing levels in nursing and midwifery, the continuing overcrowding crises in emergency departments and wards across the country, and the need for additional bed and service capacity to deal with same, and an examination of other specific measures, listed in the new programme for government, which have been prioritised by the government and other political parties.

It is clear that while we have a new government and a new Minister, we continue to have the same old problems confronting our public health service. The recent damaging decision by the HSE to pause recruitment, pending a review of numbers and payroll, is just the latest manifestation of management focusing on finances while taking no account of standards of care, access to care, manageable workloads and the health, safety and welfare of staff.

At the forthcoming meeting the INMO will be saying, clearly and bluntly, that nursing and midwifery, in relation to staffing levels, recruitment and retention, is in crisis. This must be addressed by significant, targeted initiatives, including enhanced remuneration, in the face of the current international labour market. We will also have to stress to the Minister that any failure to address this staffing crises, or closed beds, will inevitably result in disputes. He cannot preside over a recruitment pause while patient care is being neglected, nursing/midwifery practice is being compromised and, generally, standards of care are falling.

With the appointment of a number of junior ministers to the Department of Health, with specific responsibility for areas such as older persons services and



disabilities, the INMO will also look for immediate engagement with these new ministers, to agree specific measures to address problems in these sectors. Our care of older people services continue to be grossly understaffed, with inappropriate skill mixes, while our disability services have been underfunded for a number of years, leading to a scaling back in staffing levels and a significant drop in the numbers of RNIDs employed in this vital sector.

The backdrop to all of these discussions will be the need, given some impetus in recent government statements, for a comprehensive review of how we structure, plan and fund our public health service in the medium to longer term. In the meeting with the new Minister, the INMO will push for this review to be commenced at an early stage, preferably chaired by a senior member of the Judiciary reporting back to the Oireachtas Health Committee. The need for political and societal consensus on how we fund, through progressive taxation, a single tiered equitable health service, which looks after everyone equally, must be a cornerstone of this new government's policy and should be initiated immediately.

We have changed political times in this country, with the potential for a different way of doing business in our parliament. Hopefully this new dynamic will provide the space for an honest, open and transparent debate, about our health system, which will look beyond the normal electoral cycle of three to four years. If this new government delivers this consensus, leading to a properly funded public health service for this and future generations, it will have served this country well and is something we should all support.

Liam Doran
General Secretary, INMO

Fury at HSE recruitment freeze

THE INMO reacted angrily to the suspension of recruitment of nurses and midwives announced last month by the HSE.

INMO deputy general secretary Dave Hughes said: "The health service and hospitals are already operating under severe strain due to lack of staffing. We are short by over 3,600 nurses and midwives already and this embargo will make an intolerable situation utterly impossible.

"Nurses and midwives are at breaking point due to the increasing demand for health services and staff shortages caused by previous embargoes during the recession. It is simply not possible to deliver safe care with such an embargo in place and this irresponsible act on the part of the HSE will cost lives."

The INMO called on new Minister for Health Simon Harris to immediately intervene and ensure that the recruitment of nurses and midwives continues in the public interest and to prevent utter chaos in an already severely strained health service.

The HSE is now saying that hospitals can continue to hire but only within existing budgets.

ED vacancies will be filled - HSE confirms at WRC review

THE INMO has secured confirmation, from the HSE, that all vacant nursing posts in the country's emergency departments will be filled, as provided for in the recent ED agreement, despite the HSE's recent announcement to pause recruitment.

The confirmation that all posts will be filled was given at the third review of the ED agreement, chaired by the Workplace Relations Commission (WRC) on May 23.

This part of the ED agreement provides for the filling of over 144 staff nurse posts in EDs across the country, as part of the comprehensive ED agreement, which was reached in January between the HSE/Department of Health and the INMO.

The agreement also provides for a system-wide escalation policy, weekly meetings between senior management and the INMO, and ongoing health and safety and hygiene audits of all EDs.

The meeting also noted that the level of overcrowding this year, to date, is almost identical to the level of overcrowding in 2015. However, the figures for the first three weeks of May 2016 are hopeful, indicating a 10% reduction on 2015.

The WRC review also

considered a number of other issues including:

- Ongoing implementation issues in a number of hospitals including the Mid-West, Sligo and St Vincent's University Hospital
- The appointment of an assistant director of nursing in each ED, with responsibility for patient flow, and an additional clinical nursing Manager post in 15 hospitals, with responsibility for admitted patients held in EDs, when no beds are available
- The need to have greater transparency with regard to the presence of senior clinical decision makers, out of hours and at weekends, in a number of hospitals
- The preliminary outcome of initial health and safety audits which indicate a series of problems requiring additional security measures in the interests of staff welfare.

The WRC will convene the parties again on July 25 to undertake its fourth review of the implementation of the ED agreement, and to begin preparing for the autumn/winter period ahead.

The meeting also noted that a special four person expert group, also provided for in the agreement, including one nominee from the INMO will be



INMO general secretary Liam Doran: "Any recruitment pause will be counterproductive, damage standards of care and, inevitably, lead to bed closures and curtailment of services"

established immediately. This will recommend staffing levels for all 26 EDs across the country and report within 10 weeks.

INMO general secretary Liam Doran said: "The INMO welcomes the confirmation by the HSE that all vacant nursing posts in EDs will be filled as provided for in the ED agreement. The INMO took the opportunity at the WRC review meeting to point out to the HSE/Department of Health that any recruitment pause in nursing and midwifery will be counterproductive, damage standards of care and, inevitably, lead to bed closures and curtailment of services. The INMO will continue to engage with senior management at hospital and group level to ensure the ongoing, 24/7, implementation of the ED agreement and also to begin preparing for the autumn/winter period when demand will inevitably increase".

Wage restraint totally unsustainable - INMO

THE current policy of wage restraint is unsustainable, warned Dave Hughes, INMO deputy general secretary, ahead of the ADC in Killarney last month.

The current housing crisis is the tip of the iceberg of homelessness unless wages significantly increase, Mr Hughes said. As house prices creep back to the levels they

were prior to the recession, he said nurses, midwives and all other public servants are now earning over 12% less than they did in 2008. Many other workers, throughout the economy, have had pay cuts or pay freezes, and this has led to a situation where the figures simply do not add up, he said.

The two key points determining the ability of workers

to buy a home are the amount they can borrow in relation to their income, which is now set at a minimum of 3.5 times the annual gross salary, and the maximum loan against the value of the property to be purchased, which is now capped at 90% on properties up to €220,000.

The simple reality is that workers on the average

industrial wage will not be in a position to purchase a home, even based on current property values. Mr Hughes said an individual nurse, after serving seven years, reaches a salary just above the average industrial wage which, based on the current loan to income ratio, would leave them €90,000 short of the purchase price of that average house.

Record ED overcrowding yet again

Latest figures confirm serious need for increased bed capacity

RECORD levels of overcrowding have been confirmed yet again for the first four months of the year by INMO trolley/ward watch figures.

A total of 35,756 patients waited for an inpatient bed in the first four months of 2016. This is the highest figure recorded for this four month period since records began and a 2% increase on 2015 figures.

In addition, figures for April showed unsustainable levels

of overcrowding in the majority of emergency departments across the country, with 8,145 patients on trolleys this year – an increase of 4% on 2015.

The latest figures confirm that the overcrowding crisis cannot be solved without significant increase in bed capacity, both acute and long-term. Despite the continuing overcrowding crisis, little focus was given to the challenges faced by the health service in

the recent negotiations to form a government.

INMO general secretary Liam Doran said: “These latest statistics confirm that our health service continues to be too small to adequately, and safely, meet the demands being placed on it.

“The recent ED agreement is not a substitute for the additional 1,500 acute beds required across the country, and the 2,000 long-term/

traditional care beds required to deal with demand and our aging population.

“We will continue to work under the current agreement with all parties, demanding the additional staffing stipulated, the presence of senior clinical decision makers at all times, including weekends, and greater resources, for the social and primary care areas to allow for admission avoidance and prompt discharge.”

Table 1. INMO trolley and ward watch analysis January 2006 – April 2016

Hospital	Jan - April 2006	Jan - April 2007	Jan - April 2008	Jan - April 2009	Jan - April 2010	Jan - April 2011	Jan - April 2012	Jan - April 2013	Jan - April 2014	Jan - April 2015	Jan - April 2016
Beaumont Hospital	1,629	2,123	2,785	3,020	3,384	2,316	2,670	2,547	2,185	2,750	2,821
Connolly Hospital, Blanchardstown	900	1,035	928	1,140	714	1,544	1,348	1,903	1,813	2,066	1,156
Mater Misericordiae University Hospital	1,826	1,601	2,078	1,772	2,037	1,185	1,427	1,269	1,003	1,837	1,611
Naas General Hospital	1,616	669	897	1,504	1,143	2,103	853	853	890	1,430	1,615
St Colmcille's Hospital	914	306	190	909	838	870	829	619	n/a	n/a	n/a
St James's Hospital	1,692	492	971	1,000	666	664	472	834	546	1,190	603
St Vincent's University Hospital	1,491	1,633	1,975	1,952	2,003	2,015	1,574	1,718	819	1,924	2,418
Tallaght Hospital	2,937	1,242	2,397	2,829	2,254	2,439	928	1,254	1,288	1,545	1,665
Eastern	13,005	9,101	12,221	14,126	13,039	13,136	10,101	10,997	8,544	12,742	11,889
Bantry General Hospital	n/a	79	163	398							
Cavan General Hospital	1,508	1,241	892	625	1,042	1,825	1,179	799	198	224	517
Cork University Hospital	1,503	1,237	1,712	1,398	2,555	2,732	2,299	1,519	1,362	1,477	2,030
Kerry General Hospital	472	237	513	153	303	319	173	376	298	441	526
Letterkenny General Hospital	1,090	1,020	174	142	206	178	235	424	1,128	1,544	496
Louth County Hospital	78	45	137	87	23	n/a	n/a	n/a	n/a	n/a	n/a
Mayo General Hospital	819	768	567	543	724	380	672	798	896	968	783
Mercy University Hospital, Cork	707	569	558	609	625	836	595	1,095	775	908	889
Mid Western Regional Hospital, Ennis	346	718	132	95	133	362	96	244	0	41	220
Midland Regional Hospital, Mullingar	52	59	71	181	905	1,012	1,105	1,207	1,433	1,877	1,738
Midland Regional Hospital, Portlaoise	196	11	214	184	93	492	381	222	708	807	1,141
Midland Regional Hospital, Tullamore	45	11	10	47	203	750	630	514	1,152	898	1,712
Monaghan General Hospital	12	203	138	100	n/a						
Nenagh General Hospital	n/a	39	79								
Our Lady of Lourdes Hospital, Drogheda	1,241	1,235	921	1,546	1,232	1,934	2,422	1,435	1,954	2,585	2,122
Our Lady's Hospital, Navan	125	399	367	461	216	724	384	412	710	446	211
Portiuncula Hospital	245	190	240	129	397	276	359	527	278	629	180
Roscommon County Hospital	282	290	423	372	475	n/a	n/a	n/a	n/a	n/a	n/a
Sligo Regional Hospital	433	281	375	372	729	735	576	554	799	945	1,114
South Tipperary General Hospital	418	194	441	190	414	275	598	763	984	887	1,718
St Luke's Hospital, Kilkenny	n/a	n/a	n/a	n/a	n/a	169	272	546	1,017	1,061	1,274
University Hospital Galway	819	766	1,179	1,246	1,517	2,088	1,942	1,619	1,807	2,243	2,235
University Hospital Limerick	852	569	592	836	1,265	1,187	1,264	2,491	2,154	2,442	2,642
University Hospital Waterford	n/a	n/a	60	253	349	431	435	567	1,337	787	1,407
Wexford General Hospital	1,417	434	510	424	461	1,200	388	681	322	981	435
Country total	12,660	10,577	10,226	9,993	13,764	18,380	16,005	16,793	19,391	22,393	23,867
NATIONAL TOTAL	25,665	19,678	22,447	24,119	26,803	31,516	26,106	27,790	27,935	35,135	35,756

Comparison with total figure only:

Increase between 2015 and 2016: 2%
Increase between 2014 and 2016: 28%
Increase between 2013 and 2016: 29%

Increase between 2012 and 2016: 37%
Increase between 2011 and 2016: 14%
Increase between 2010 and 2016: 33%

Increase between 2009 and 2016: 48%
Increase between 2008 and 2016: 59%
Increase between 2007 and 2016: 82%
Increase between 2006 and 2016: 39%

INMO calls on HSE to clarify several issues on sick leave entitlements

CLARIFICATION on a number of issues outstanding in relation to sick leave has been sought from the HSE by INMO director of industrial relations Phil Ní Sheaghdha.

A number of issues are outstanding on the manner in which the HSE is introducing the new sick leave scheme. These matters remain the subject of dialogue between the INMO and other health service trade unions and the HSE, and several concerns have been raised by the staff panel of trade unions over the approach taken by the HSE.

Following a meeting with the HSE in late April Ms Ní Sheaghdha has sought further attention be brought to seven areas discussed as follows:

Civil awards

In the event that a civil award is made, the HSE continues to record an individual's leave as paid sick leave, even when they have repaid monies resulting from this civil award. The HSE's position is that this is a matter which is currently under review by the Department of Public Expenditure and Reform (DPER) and is awaiting the outcome of this review.

Temporary rehabilitation remuneration

The HSE confirmed the application is as per the calculation used for retirement on the grounds of ill health and that additional years must be included. It agreed to issue a letter to the system, reconfirming the calculation that is to be used. The HSE is to consider the current manner in which it deals with this and revert to the trade unions.

Critical illness protocol

Again the HSE said the critical illness protocol is currently under review at the DPER and is awaiting the outcome of



Phil Ní Sheaghdha, INMO director of industrial relations: Several issues are outstanding on the manner in which the HSE is introducing the new sick leave scheme for public service workers

this. However, the trade unions requested that any application for critical illness protocol be processed as a priority via occupational health and that delays should not cause employees to temporarily lose income. The trade unions requested a meeting involving Dr Linda Sisson, recently appointed head of occupational health for the HSE.

Injury Grant and Article 109

The application of the Injury Grant (Article 109) and the result of the High Court settlement was discussed at length. The HSE is insisting that each case will be viewed on its own merit and that a general position cannot be arrived at. The INMO and other unions disagree with this position and requested the HSE to review its approach to this.

Partial sickness absence

The trade unions requested adherence to the absence management policy, particularly the phased return to work protocol set out within it, and requested that employees who are to return to work on a phased basis, on medical advice, be granted a partial

entitlement to sick leave for the days on which they are absent. The unions also sought that rehabilitation to work is covered by a joint written agreement between local management and the employee in question, to ensure that the best possible outcome is agreed between the parties.

The HSE expressed that there may be some difficulty in respect of social welfare benefit on a partial return to work, but agreed to examine the issues raised, to consider the unions' position, and revert.

Psychological injury

The trade unions sought that psychological injuries be recognised in the same manner in which physical injuries are recognised under the revised physical assault at work scheme. This is on the basis that confining benefits to a physical injury and excluding psychological injuries could be viewed as discriminatory.

TB and occupational acquired illnesses

The staff panel is seeking that occupational acquired illness/injury, including TB, be provided the same status as blood borne diseases and MRSA. The HSE said it would consider this point and revert.

The trade unions notified that in the event of agreement or progress not being possible, these matters will be referred to the Workplace Relations Commission.

Further to the above points, letters received by the INMO in mid May from John Delamere, HSE head of corporate employee relations, referred to: the critical illness protocol under the sick pay scheme; the HSE standardised

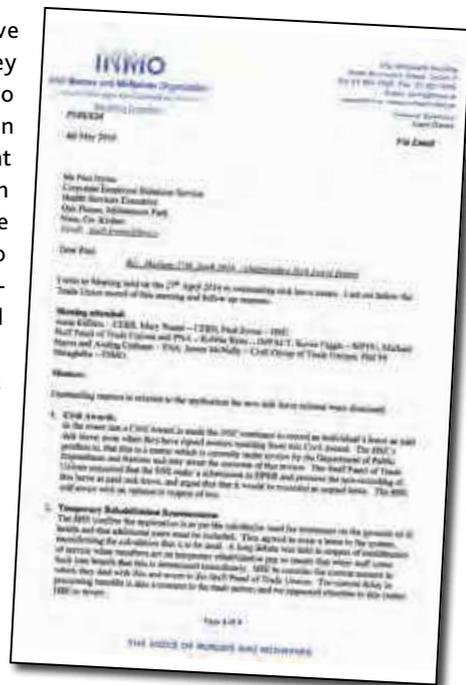
arrangement for recording of sickness absence; and the calculation of temporary rehabilitation remuneration (TRR).

Critical illness protocol (CIP)

In referring to the critical illness protocol under the sick pay scheme (HSE HR circular 05/2014), Mr Delamere asked HR staff to ensure that all CIP applications are dealt with by management in a timely manner and particular consideration is given to employees who may be due to exhaust their normal sick pay entitlements so that a decision can be made without undue delay.

He continued that where managers consider that employees who are absent on sick leave may come within the scope of the CIP, they should be proactive in ensuring that employees have access to the CIP application form. Employees should be facilitated to submit their completed form to the relevant manager as soon as possible so that the required medical assessment can be carried out.

In order to give priority to



occupational health assessments for CIP applications, managers should arrange for the following information to be provided:

- A note requesting a medical assessment under the CIP protocol
- A copy of the specialist medical letter from the employee's consultant.

Mr Delamere asked that this procedure be brought to the attention of managers to ensure that delays in awarding extended sick pay to employees eligible under the CIP are avoided.

Recording of sickness absence

Further to this, a letter issued to HR managers on the HSE standardised arrangement for recording of sickness absence.

Under this standardised recording arrangement, rest periods/weekends should only be counted for sickness absence purposes when the employee's absence spans the rest period/weekend, ie. the employee must be absent on sick leave both before and after the rest period/weekend. Rest period/weekends which immediately precede the day the employee resumes duty should not be counted.



At a recent meeting with the health service unions, it was claimed that the effective date for the implementation of this arrangement is not being applied consistently across the HSE. Mr Delamere then asked if the necessary arrangements could be made to ensure that the standardised arrangement has been backdated to March 31, 2014 in accordance with a letter which issued on November 11, 2015.

Temporary rehabilitation remuneration (TRR)

Finally in his letter regarding the calculation of temporary rehabilitation remuneration, Mr Delamere stated that it was claimed that

TRR calculations in some cases have not included the appropriate ill health added years entitlement.

Section 6 of the Public Service Management (Sick Leave) Regulations 2014 provides for payment of TRR to employees subject to the relevant pension scheme rules for eligibility for the grant of an ill health retirement pension.

TRR is calculated by reference to the same reckonable service and the same pensionable remuneration at which an ill health retirement pension would be paid to the relevant person if such a pension were to be awarded at the date of application.

The service factor is actual accrued service enhanced by appropriate ill health added years entitlement calculated in accordance with the relevant pension scheme rules. Employees with 20 years whole-time equivalent service who have reached 60 years of age do not have an ill health added years entitlement.

Calculation of the TRR payment is based on whole-time equivalent salary and pensionable allowances and aggregate whole-time service, inclusive of ill health added years if applicable. Therefore, calculations of TRR payments are inclusive of ill health added years if applicable.

Members urged to support Tesco workers

AS AN affiliated union to the ICTU, the INMO supports Mandate trade union in respect of the dispute with Tesco.

Talks between the union and the employer at the Workplace Relations Commission (WRC) failed to result in an agreement and pickets were due to be placed on Tesco stores as we went to press.

The INMO requests all members to observe normal trade union practice of not passing pickets placed by colleagues in other trade unions in disputes of this nature, said Phil Ní Sheaghda, INMO director of industrial relations.

Mandate confirmed that pickets will be placed on more than 70 Tesco outlets across the Republic of Ireland, due to the company attempting to implement pay cuts and changes to conditions of employment for up to 300 of their staff. The strike could affect up to 14,500 workers employed by Tesco across its 140 stores.

Mandate say Tesco has the capacity to prevent the strike by withdrawing its threat to cut workers' wages without agreement or by attending the Labour Court for a hearing on the matters in dispute.

Tesco management is attempting to force changes to workers' conditions of employment including:

- 15-35% pay cuts
- The slashing of overtime
- Cuts to Sunday and unsociable hours premiums from double pay to time and a half
- A reduction in the annual bonus
- Changes to rosters.

Gerry Light, Mandate assistant general secretary said: "Tesco management are forcing changes to contracts for workers employed before 1996. These changes will seriously undermine living standards for

our members who have mortgages and other commitments made on the back of their conditions of employment over the last 20 to 30 years."

More than 99% of pre-1996 staff at Tesco voted to take industrial action in a ballot last month. Furthermore, 88% of their colleagues in pre-1996 stores not affected by the cuts balloted in favour of supportive industrial action.

Mandate said pickets will be placed at more than 70 Tesco stores throughout Ireland and will remain in place until Tesco reverses its cuts or confirms attendance at the Labour Court.



INMO Executive Council Member Karen Clarke protesting with colleagues outside Our Lady of Lourdes Hospital, Drogheda last month in order to highlight unsafe staffing levels



Work to rule continues at OLOL

Talks adjourned at WRC as management fails to produce proposals

RENEWED talks between the INMO and management of Our Lady of Lourdes Hospital, Drogheda were adjourned at the Workplace Relations Commission as we went to press, due to the failure of management to produce any firm proposals for consideration by the Organisation.

The dispute is over inadequate staffing levels at the hospital. Management accepts that the hospital currently has a deficit of 104 whole time equivalent posts, which remain unfilled. However, the hospital continues to operate at full

capacity, which means there are insufficient nurses on duty to provide safe and appropriate care to patients.

There is now a major problem with recruitment and retention of adequate nurses throughout the country. The government and the HSE need to address this issue urgently, otherwise services will have to be curtailed, ensuring an exacerbation of emergency department overcrowding and the lengthening of waiting lists.

INMO members at OLOL began industrial action in the

form of a work-to-rule following an initial breakdown of WRC talks in late May. This means nurses are setting aside non-core working duties in order to increase their ability to provide direct care to patients. It is likely this action will enhance patient care as nurses will be focusing on their clinical duties rather than non-essential administrative tasks.

The current action, in the form of a work to rule, by INMO members at the hospital will remain in place.

Following the latest adjournment of talks, INMO IRO Tony

Fitzpatrick said: "The INMO will now await a formal written proposal from the management team and will then consider if there is a basis for further negotiations under the auspices of the WRC. However, management must realise that this is a very serious issue which must be addressed as a matter of urgency.

"There needs to be a realisation on the part of the HSE that health services are going to be greatly impacted if they do not devise strategies to recruit more nurses and retain those who are currently in the service."

Call to resolve differences

THE INMO has called on the managements of St Vincent's University Hospital and the National Maternity Hospital, to resolve, immediately, the difficulties leading to delays in finalising the relocation of the National Maternity Hospital.

The new National Maternity Strategy, and other recent reports, all clearly identify the need for strong, separate and distinct clinical governance structures for maternity services.

"The current stand-off between management in the two hospitals cannot continue any longer, and must be addressed without delay," said INMO general secretary Liam Doran.

UH Limerick engaging on staff issues

INMO members at University Hospital Limerick met with group director of nursing, Margaret Gleeson, over the critical shortage of registered nurses on the wards.

On foot of this meeting it was agreed that an independently chaired engagement process will commence to address both immediate and longer term issues related to the shortage as follows:

- Consultation will occur with the CEO Prof Colette Cowan regarding the ongoing high activity/acuity and full bed capacity within the hospital with a view to matching same to the available nursing resources. In addition the placement of both an extra bed and trolley on some wards will be reviewed
- The cumbersome sign off of

the requirement for specials for patients will be reviewed

- Management will endeavour not to redeploy staff from the wards
- Management was advised by the INMO that nurses do not get their statutory breaks while on duty; this was discussed as a health and safety issue and breach of the Organisation of Working Time Act. The INMO has requested that the inability of nurses to take their breaks is captured as this is free time given to the HSE and must be returned to individual nurses
- The meeting was advised that all vacant CNM1 posts are in the process of being filled
- A hospital staff bank will be progressed but this requires rosters to be planned one month in advance.

Management was made aware by members of nurses' concerns about their ability to oversee/implement clinical care to patients when there are inadequate nurse to patient ratios and high acuity levels.

INMO IRO Mary Fogarty advised members that, in the event that a staff nurse or CNM in charge of a ward is put under pressure to redeploy a nurse, contrary to your professional opinion that this poses a risk, the matter must be formally recorded on a risk assessment form/near risk form and by a follow-up email to management.

She also advised members that they need to record with their ward manager or the assistant director of nursing on duty if they are unable to take their breaks.

Record media coverage for INMO

2015 was by far the best year for the INMO in terms of media coverage, generating a total value of €24 million. This figure is measured by the advertising value equivalent (AVE) which would be the equivalent cost of buying advertising space for all the reportage we received.

The INMO featured in 3,653 radio and television segments, 3,365 internet articles and 1,841 print articles and appeared in the media in some format on average 24 times per day – double that of 2014.

Press and broadcast coverage of the Organisation, valued at €11.8m was more than double that of 2014 which amounted

to €5.6m. In 2015 the INMO also obtained a value for online media, with the Organisation garnering coverage worth €12m in this for.

INMO general secretary Liam Doran generated almost €6m worth of that total while the INMO trolley/ward watch campaign produced over €6m AVE.

The main findings were:

- **Internet coverage** – 3,365 internet articles featured the INMO in 2015, valued at over €12m. The site that provided the most coverage was www.irishtimes.com. No internet value was available in 2014
- **Broadcast coverage** – the INMO featured in 3,653 radio and

television segments in 2015 valued at €8.2m, up from €3.7m in 2014. RTÉ had the most coverage with 330 segments on both radio and television. Newstalk featured INMO in 280 segments while Midwest Radio gave the most regional coverage with 238 pieces

- **Print coverage** – the INMO featured in 1,841 print articles over the year valued at €3.6m, up from €1.9m in 2014. Of the national papers, the *Irish Examiner* gave the most coverage while the *Limerick Leader* was the biggest carrier of INMO news in regional titles
- **Social media coverage** – it has been just over a year since the

INMO setup its Facebook and Twitter profiles. The total insights of how many people viewed INMO social media content are Facebook – 2,489,000 total impressions and Twitter – 500,700 total impressions.

Members are urged to follow the INMO Twitter page: @INMO_IRL and Facebook page: www.facebook.com/irishnursesandmidwivesorganisation. The hashtag most used by INMO was #trolleywatch

– Ann Keating, INMO media relations officer



Work to rule suspended in Cork radiotherapy ward

INMO members at Cork University Hospital suspended their work to rule following a settlement reached at the Workplace Relations Commission. Agreement was reached on nursing and HCA staffing levels in the GB radiotherapy ward. A

recruitment process is now taking place. The WRC has agreed to reconvene with the parties on June 28 to review progress. The planned industrial action came about when six additional beds were opened on the ward without a commensurate increase

in staffing levels. The INMO formally outlined its concerns to management in December 2015. Following a meeting in December, management failed to respond to the issues raised despite repeated correspondence from the INMO up to April

2016. In an effort to have their grievance addressed and legitimate concerns about their ability to provide safe care recognised, members felt they were left with no option but to ballot for industrial action.

– Mary Rose Carroll, IRO

Registered Nurse in Intellectual Disability Section Conference

Date: Tuesday, November 1, 2016

Venue: Dublin

Topics will include, amongst others, the following:

- Federation of Voluntary Bodies
- Assisted Decision Making (Capacity) Bill 2013
- Behaviours that challenge

'RNID Nurses in the community' sessions will include:

- Early intervention
- Palliative care
- Breast check
- Dual diagnosis

For further information please contact INMO section development officer at email: jean.carroll@inmo.ie





L-R: Jo Ubas, assistant treasurer; Isabel Redulla, assistant secretary; Narcinia Gansatao, treasurer; Pamela O'Brien, secretary; Emma Morake, public relations officer; Philip McAnenly, INMO industrial relations officer, SVUH; Claire Mahon, outgoing INMO president; Bernie Stenson, chairperson; Tom Hefferon, vice chair; Liam Conway, recruitment officer; and Liam Doran, INMO general secretary

INMO NEW SVUH BRANCH

INMO SVUH Branch
Email: beestenston@hotmail.com

Branch workplaces

- St Vincent's University Hospital

Branch Officers

Chairperson



Bernie Stenson
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Vice Chairperson



Tom Hefferon
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IRO



Philip McAnenly
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THE new St Vincent's University Hospital (SVUH) Branch of the INMO was formed on April 28, 2016. This is a landmark development for the INMO as the branch is the first hospital-based branch formed. The inaugural meeting was attended by then INMO president, Claire Mahon, INMO general secretary, Liam Doran and Philip McAnenly, INMO IRO.

The INMO has had a strong presence at SVUH with the formation of an in-house committee in 2001. However, members believed that the large and growing membership at SVUH merited a decision making presence at the annual delegate conferences to further promote the interests of nurses working in the acute hospital sector.

Members at SVUH have led many campaigns in recent years including the recent ED dispute, enhancing theatre and radiology on-call rates, expanding areas for payment of the specialist qualification allowance and representing members' interests in the introduction of the national simultaneous pancreas and kidney transplant service.

The INMO has resisted the calculation of absences on sick leave in hours rather than shifts and has negotiated permanent contracts of employment for all 2015 graduate nurses.

In recent years the INMO has delivered numerous on-site safe practice workshops at no cost to hundreds of INMO members. This has ensured nurses are aware of how to protect their registration in a challenging and unsafe environment. Recent presentations on the implications of changes to the fitness to practise procedures for nurses have been welcomed and well received. INMO general secretary, Liam Doran has in recent weeks attended a meeting with CNMs to provide an update on the interim report on staffing levels for medical and surgical wards.

The growth of the INMO in recent years at SVUH means the new branch is one of the largest in Ireland. INMO IRO, Philip McAnenly, has welcomed this exciting new development that will result in an enhanced representative structure for our large membership at SVUH. "The establishment of our new branch is a pioneering and innovative

step by our representatives at SVUH. In consultation with established INMO representatives, we have drawn up an organisational map of SVUH to ensure that all areas have the opportunity to progress issues and can be supported to raise concerns. This will facilitate the development of an enhanced and responsive structure to ensure our members' concerns are progressed via existing policies and procedures, including referral to the disputes resolution machinery of the State if necessary."

Our members at SVUH have endured a most challenging working environment in recent years due to understaffing and overcrowding. The effects of the moratorium on recruitment has adversely impacted on our members' ability to deliver safe and quality patient care. Our new Branch structure will provide a conduit for members to speedily progress concerns and claims to conclusion. I now encourage all areas to nominate a representative to ensure we have an effective INMO branch that can respond to any and all concerns our members may wish to progress," he said.

Section roundup

Director of Nursing Section seminar

THE INMO is holding a seminar for the Director of Nursing, Midwifery and Public Health Nursing Section on Wednesday, June 15, from 12.30pm to 4.30pm at INMO HQ. Topics covered will include a national overview of the strategic and operational opportunities and challenges for directors of nursing and midwifery, an overview of the operation of the grievance and disciplinary procedures, fitness to practise considerations, and the duty to provide reasonable accommodation under the Employment Equality Acts. Booking is essential, please contact the INMO at Tel: 01 664 0616 or log onto www.inmoprofessional.ie

Care of the Older Person Section meeting

THE COOP Section is meeting on June 21 at INMO HQ for a session, specific to the care of the older person, on safe practice. It is a three-hour session starting at 10am and is accredited by the NMBI. Booking is essential so please contact the INMO at Tel: 01 664 0616 or log onto www.inmoprofessional.ie to book your free place.

Emergency Nurses Section meeting

THE recently re-established Emergency Nurses Section will be meeting on June 17 at INMO HQ from 12pm. It is hoped that as many ED nurses as possible can come along. During the course of this meeting, a calendar of events for the Section will be devised. If you have any queries or suggestions, we would be delighted to hear from you. Please contact INMO Section development officer at email: jean.carroll@inmo.ie

ODN conference sees record attendance levels

THE Operating Department Nurses Section conference took place in April and over 160 perioperative nurses attended over the two-day event, which was one of the most well attended ODN conferences in a number of years. Speakers from the UK, Brazil and every corner of Ireland attended.

The winners of this year's poster competition were, in first place; Catriona Donohoe with her poster entitled 'Chemical Soup – Not Tasty and Dangerous'. Ms Donohoe is a clinical facilitator in St James's Hospital. Runners up included Margaret Given, CNM2, from Sligo University Hospital with her poster entitled 'Here to Treat, not Facebook or Tweet! Social Media: a dangerous distraction or a treasured tool.' The final runner up in this competition was Breege McKiernan from University Hospital Galway with her poster entitled 'Creating and Maintaining a Sterile Field'.

The ODN Section's next meeting will take place in INMO HQ on Thursday, June 9 at 6pm and teleconferencing facilities will be available for those who wish to avail of them. Please contact the INMO at Tel: 01 664 0616



Pictured at the Operating Department Nurses Section annual conference were (l-r): Marillia Ferrari Conchon; Claire Mahon, outgoing INMO president; and Liz Waters



Pictured (l-r) at the ODN Section conference: Audrey Al Kaisy, Teresa Herity, Gordon Maher, Regina Reynolds and Claire Mahon



The organising committee of the conference (l-r) with outgoing EORNA reps Monica Griffin, Teresa Herity, Audrey Al Kaisy, Caroline Higgins, Claire Mahon, Liz Waters, Allison O'Connell, Jean Carroll and Sandra Morton

requesting the access number and PIN required.

The Association of Peri-Operative Registered Nurses (AORN) is accepting education session proposals for the International AORN Surgical Conference and Expo in Boston, Massachusetts

from April 1 to April 5, 2017. The theme for the conference is 'The Power of You.' See www.aorn.org/surgicalexpo/information/call-for-proposals-and-abstracts for more information regarding proposals and abstracts.



Catriona Donohoe, who won first place in the ODN annual conference poster competition for her poster 'Chemical Soup – Not Tasty and Dangerous'



Mona Guckian Fisher (left) who spoke at the ODN conference; and Sally Boland, INMO member, Sligo General Hospital



The logo for INMIO ADC 2016. It features the word "INMIO" in blue, stylized letters with human figures above the 'I' and 'O'. Below it, "ADC" is written in white on a red ribbon, and "2016" is written in blue below that. The entire logo is set within a white speech bubble shape with a blue outline.





Ensuring our voice is heard

Unity is our strength, Claire Mahon told delegates in her final ADC address as INMO president



THE COMMITMENT, dedication, excellence and tenacity of members as they strive to deliver the best possible care to their patients and clients, in the most challenging of circumstances, will be the most abiding memory of her term in office, outgoing INMO president Claire Mahon told delegates at ADC 2016.

"The past four, and indeed the past eight, years have been extremely challenging. Nurses and midwives have been in the midst of immense upheaval and cutbacks," Ms Mahon said. "During my presidency I have been acutely aware that members have had to struggle just to survive against the backdrop of the recession."

International stage

She said she had taken every opportunity to ensure that "our voice, and our vision, is heard here at home by forging links with many national organisations using every forum available to raise issues of concern."

Ms Mahon represented INMO members at European and international events, partaking in both the European Federation of Nurses Associations (EFN) and the International Council of Nurses (ICN). She was one of the founders of Global Nurses United. "It is important that the truth about the lack of planning and foresight by our own and many governments most affected by austerity, is conveyed to our colleagues across the globe. These mistakes must not and cannot be repeated," she said.

National health policy

The INMO policy on the future of the public health service would ensure that health is high on the agenda of the new government, she said, calling on members to use it to demand from the new political environment an initiative leading to a

national consensus on health service provision. "A world class health service is good for citizens, communities and the economy. It is too precious a social good to be left to politicians and their parochial interests," Ms Mahon said.

"We are calling on the new government to initiate a national debate on health, which will look beyond the normal five year electoral horizon, to determine how we want our health service to serve us now and for the next 25 years."

Taskforce on nurse staffing

"We always constructively engage with the Minister for Health, on behalf of all our members, on all our issues. The key priority at this time is the crisis now existing due to staff shortages and excessive workloads," she said. This is why a major priority for her has been to seek the establishment of safe minimum nurse and midwifery staffing levels and why the *Safe Staffing Campaign* was launched in May 2014. This campaign led to the establishment of the Taskforce on Nurse Staffing in September 2014.

"I am pleased at the development of this framework, for safe nurse staffing and skill mix in general and specialist medical and surgical care settings. It is a first step, and a commitment, to move from staffing levels controlled by finances, to staffing levels governed by patient need and acuity as determined and applied by nursing staff," Ms Mahon said. Three pilot sites have been chosen to undertake an initial study, using the framework, on some of their medical and surgical wards.

"We will not rest until we have proper, consistent, safe, stable and agreed staffing levels, determined by an agreed dependency tool and the professional judgement

of nurses and midwives, in all areas of our services."

National Maternity Strategy

The INMO also welcomed the recent launch of Ireland's first National Maternity Strategy. The Organisation was represented on this strategy group by Mary Gorman and Mary Reilly.

The strategy maps out how Ireland can improve maternity and neonatal care in the years ahead, ensuring that it is safe, standardised, of high quality and offers a better experience and more choice to women and families. A National Women and Infants Health Programme is to be established, to drive forward the implementation of the strategy. This strategy must lead to a positive transformation of maternity services in Ireland, with much improved staffing levels, moving to a midwife to birth ratio of 1:29.5.

The INMO has already commenced discussions with the Department of Health and the HSE on how the additional 450 midwives required to achieve this ratio can be found in the next four years, she said.

Transfer of tasks

As part of the Lansdowne Road Agreement, the INMO and other unions sought that the role of the nurse/midwife would be expanded to incorporate involvement in undertaking four specified tasks – intravenous cannulation, emergency phlebotomy, IV drug administration – first dose, and nurse/midwife led delegated discharge of patients.

The INMO signed off on an agreement with government departments in February, which is dependent on training being provided and agreed staffing levels being in place so that nurses/midwives can take

on these tasks in a safe manner. The premium pay of time plus one-sixth for the 6pm to 8pm period, which was removed from members under the HRA, will be fully restored. This equates to a 2% increase in salary and will be paid on July 1 and back-dated to January 1, 2016.

One of the central aims of the proposal is improving patient care. Once staffing levels allow, and the nurse/midwife is trained, they will have the authority to undertake these expanded roles within their workplace. This will greatly increase the profile and autonomy of nursing/midwifery grades, and lead to a greater level of satisfaction, in respect of the performance of the role in acute hospitals, and services in long-term care/community and ID settings.

Overcrowding

Ms Mahon reiterated that the emergency department agreement, and the system-wide escalation policy attached to it, clearly stipulates that the INMO remains absolutely opposed to what is termed 'full capacity protocol' or, in layman's terms, extra beds/trolleys up on in-patient wards.

"The INMO never has, and never will support this as a measure which will alleviate, or address, the shortcomings which led to the current crisis in ED overcrowding. Extra beds or trolleys on wards only allows management to avoid their obligation to deal with the core problem, and most definitely compromise the care of all inpatients in those overcrowded wards which are already understaffed," she said. "The ED agreement is not a substitute for the additional 1,500 acute beds required across the country, and the 2,000 long-term/traditional care beds required to deal with demand and our aging population. This is another reason why we need a national consensus on our public health service."

In relation to the ED agreement itself the INMO has, in recent weeks, sought to work the agreement on a 24/7 basis, in the interests of patients and staff.

Restoration of undergraduate pay

The INMO has recently secured significant restoration of the pay of student nurses and midwives, when they undertake their rostered placement, she said. The revised arrangements also provide for the restoration of incremental credit, on graduation, for this 36-week period resulting in the new graduate moving to the second point of the salary scale after 16 weeks.

This restoration will result in almost €4,000 additional pay over the 36 weeks. This represents a major step in correcting

the unjust cuts experienced by our interns and graduates. However, negotiations are still ongoing to pursue the outstanding issue of granting retrospective incremental credit to nurse/midwife graduates who qualified in the 2011 to 2015 period.

Missed care

The INMO has also recently launched a *Missed Care in the Community* report, which it commissioned as part of its professional programme and strategy to develop community services in Ireland. The report's first recommendation is a Commission, to report within one year, on what is required to maximise the role of nursing in the community as part of developing our primary care services. This must be actioned without delay.

“ We must never lose the ability, whatever faces us, to lean on and support each other so that the irresistible forces of nursing and midwifery always prevail regardless of what storms confront us ”

Social media

The INMO communicates with members through email, text messaging, posted circulars, *WIN* and through social media to further facilitate focused professional debate on matters of mutual interest. Social media offers a powerful medium to communicate the message of the Organisation, and to receive the full views of members. The Organisation welcomes members communicating with them through social media in a respectful and professional way.

The future

As Ms Mahon departs she notes that she is "glad that we are facing a brighter future, a future where we will see our professions grow, where staffing will be based on need as determined by nurses/midwives, and a future that will see nurses and midwives given the respect they deserve.

"However, as we look to the future, let us not forget the past and what we lost during the times of austerity. Being resilient is not always about how you react in a time of crisis, it is about reacting in a way

that allows you to bounce back when the time is right. The enormous role we have played in rescuing our nation must be acknowledged. We deserve to have all of our rights, working conditions and salaries reinstated.

"That is why the coming months will see the INMO demand accelerated restoration of the savage pay cuts, and reduction in the pension levies imposed in recent years. We want, and we will not rest until we have, a 37 hour week, for nurses and midwives across this country. We will drive these campaigns, not just because it is our right, as our economy grows, but also because it is the only way that our health service will have a supply of nurses and midwives to meet its needs. Let everyone understand, and I mean everyone, that there is a crisis with regard to recruiting and retaining nurses and midwives in this country," she said.

"This will only be solved by government firstly realising there is a crisis, secondly government and health employers sitting down with the INMO and agreeing initiatives to address this crisis and finally, definitive action, which involves pay increases and staffing improvements, that will arrest this crisis.

"Nurses and midwives have carried an unfair burden of the recession and this country's recent difficulties. As a result of that burden we have mass emigration, severe burnout and a sense that little or no respect has been shown in recent years, despite the miracles that frontline staff have worked. This must end and will only end when the mindset of government and others, changes. We cannot and will not wait any longer," she said.

Ms Mahon thanked members for their support over her time in office.

"I hope the brief overview of what we have been doing over the past year is proof that the INMO is the key voice for nurses and midwives in Ireland," she said.

"As I stand down as president, and despite all of the challenges, difficulties and indeed dark times of the last number of years, I am still strengthened by your commitment to excellence, your commitment to each other and your commitment to the nursing and midwifery professions.

"Remember that unity is our strength. United we speak, with authority and commitment, for our respective professions and we must continue to do this, now more than ever. If I may borrow a famous phrase, remember you will never walk alone as a member of the INMO," she concluded.



Immediate pay restoration and a focus on incentives to improve recruitment and retention of nurses and midwives are needed, Phil Ní Sheaghda told delegates. Eimear Vize reports

Pay restoration a top priority

A NUMBER of important industrial relations motions were debated at the INMO annual delegate conference in Killarney including demands for immediate action in the following areas:

- Pay restoration
- A review of the current role of the nurse and midwife
- Real, immediate retention and recruitment

measures for the grades of nurses and midwives.

Staffing shortfalls

INMO director of industrial relations Phil Ní Sheaghda revealed damning figures on nursing and midwifery staffing shortfalls around the country, which employers have confirmed now total more than 1,700. She stressed that this "extraordinary shortfall"

is the number of nurses and midwives needed "just to keep the service ticking over, to provide the basic care."

Ms Ní Sheaghda threw cold water on the Department of Public Expenditure and Reform's claim that 1,000 nurses had been recruited. "What they're not saying is we didn't hold on to them; we lost a large proportion of them and only maintained 252 over 14 months in the staff nurse grade. I'm amazed at how we can be expected to provide services without these nurses on the wards, and there are now 74 less staff nurses than there were in December 2015."

She also pointed out that 66% of the supposed 1,000 nurses recruited had actually been employed elsewhere in the health service and were not new appointments at all.

INMO general secretary Liam Doran commented: "The figures disclosed today are absolutely shocking. The total and utter misinformation by government and senior public servants about recruiting in nursing has been blown out of the water today. They haven't recruited 1,000 new nurses at all."

Both Ms Ní Sheaghda and Mr Doran highlighted several other major issues for nurses and midwives which are high on the INMO's IR agenda for the future, including restoration of pay, hours of work and a complete re-evaluation of the role of the nurse and midwife in Irish society.

Ms Ní Sheaghda said that the reductions in salaries from 2008 to 2016 for all nurses and midwives have been considerable, ranging from €2,000 to more than €4,000 per annum, depending on the grade. Overall, the percentage difference in annual salary is very high at 6%.

With regard to hours worked, Mr Doran stressed: "Let the message go out, this union will never rest for as long as a nurse or midwife has a longer standing working week than any other professional colleague."

Lansdowne Road Agreement (LRA)

Ms Ní Sheaghda discussed the LRA in relation to two particular pay issues. The threshold at which the pension levy applies was improved as part of the LRA and the new threshold applies from January 2016. The average value of that for the full calendar year amounts to €732.

In accordance with the LRA, as of January 1, 2016, annualised salaries up to €24,000 saw a 2.5% pay increase and annualised salaries between €24,000 and €31,000 were increased by 1%. On September 1, 2017, annualised salaries up



Pictured at the press conference at the start of the annual delegate conference in Killarney were (l-r): Elizabeth Adams, director of professional development; Dave Hughes, deputy general secretary; Geraldine Talty, second vice president; Liam Doran, general secretary; Claire Mahon, president; Martina Harkin-Kelly, first vice president; Edward Mathews, director of regulation and social policy; and Phil Ni Sheaghda, director of industrial relations, with members of the Executive Council in the background

to €65,000 will be increased by €1,000.

Ms Ni Sheaghda told delegates that the Nursing Midwifery Board of Ireland (NMBI) annual retention fee will now be capped at €100 until 2018, under the LRA.

The INMO has argued that the group director of nursing pay should be comparable to that of the chief operating officers. Independent arbitrator, Ray McGee ruled that the pay gap needed to be corrected and in the interim, prior to the full submission going forward to the Department of Health, his recommendations were for €600 per month (€7,200 per annum) pending the completion of the grading process.

This grading submission has now been made to the Department of Health and it is recommending that the parity of pay is conceded.

"That is very good news for our profession. Why should we be paid less at the highest level than other senior managers" Ms Ni Sheaghda demanded.

Restoration of premium pay

Considerable progress has been made concerning the restoration of the 2% paid to nurses working between 6pm and 8pm (time and one-sixth payment).

Previously, the INMO sought a mechanism by which nurses and midwives could demonstrate that it was possible, through taking on four tasks, to generate savings that would allow the time and one-sixth to be paid. Indeed, some of these tasks – IV cannulation, first dosage medication, out of hours phlebotomy and nurse led discharge – are already being carried out by nurses, according to HSE data.

Following intensive negotiations, a proposal document was agreed on December

1, 2015. "Where this expanded role is not already the case, the document sets out how this can happen when training and staffing levels are agreed and are in place to ensure these new roles can be undertaken safely," said Ms Sheaghda.

"If it is confirmed that we have engaged in the process, not impeded the process, and the transfer of tasks process has commenced (verification process to commence in June 2016), then time and one-sixth will be paid to all nurses who work between the hours of 6pm and 8pm, retrospective to January 2016.

Student pay

There was a successful outcome also in negotiations on the pay and conditions of student nurses and midwives.

Fourth year nurses and midwives will now receive 70% of the staff nurse scale during their 36-week clinical placement in fourth year. It had been slashed to only 50% of the staff nurse scale. Incremental credit is also being restored for the 36 weeks spent on clinical placement in their final year, and they are rostered for 35 hours per week with four hours reflective learning to be incorporated into the roster. These restored benefits combined mean an increase of €4,006 for fourth-year students.

"It is nonsensical that anyone could argue that the effects of dropping the pay so severely and removing incremental credit would not have an effect on our ability to retain our students," said Ms Ni Sheaghda.

"We have to make very strong arguments that the crisis in nursing affects the entire public health service and it also



"Let the message go out, this union will never rest for as long as a nurse or midwife has a longer standing working week than any other professional colleague," said Liam Doran, INMO general secretary

affects the care of all of our citizens, if we do not introduce immediate measures to retain and recruit we will not have a sufficient public health service.

"So we need direct and immediate restoration of salaries to 2008 salaries; particular focus on nurse and midwife-led initiatives that add value and are cost effective; extraordinary and special measures to incentivise retention and recruitment in the nursing and midwifery professions; and recalibrating and updating of the role and function of the nurse and midwife in the Irish public health services," said Ms Ni Sheaghda.



A bold vision for our health services

Edward Mathews outlined the thinking behind the INMO's vision for the future of health services in Ireland. Tara Horan reports



THERE could be no better testament to how seriously motions at annual delegate conference are dealt with by the INMO, than the draft *Healthy Policy – Excellence in Healthcare* presented to delegates in Killarney last month. This policy is a direct result of a motion adopted at ADC 2015 for the INMO to draw up a policy document stating its position on the future of the health services in Ireland.

Arising from that motion, the Organisation undertook an extensive consultation exercise. The motion specifically called for a health policy conference to be held, which took place in late 2015, and heard from health economists, health policy experts, nursing experts and members. The INMO commissioned independent research on health service funding, models of funding, quantum of funding and other relevant areas. A survey of members was carried out and every care was taken to ensure the numerous responses were reflected in the draft document, which was presented to ADC 2016 by Edward Mathews, INMO director of regulation and social policy.

"We hope this document represents a policy which will make manifest a shared vision of nurses and midwives on the principles that should underpin the delivery of a health service in Ireland and also the specific measures that are required to improve the health service. It is not set in stone – we want to hear your contributions and we will reflect those contributions in a final document, to be published shortly.

"It's so difficult and so disheartening to constantly hear of the ills and woes of our health service," Mr Mathews said, urging

delegates to suspend their disbelief that change can happen. Borrowing words from a late Northern Ireland politician, he said: "We have to have no surrender in seeking a better health service for Ireland."

"The policy before you has a bold vision for the future of health services in Ireland. While it focuses on the difficulties we have encountered thus far and the difficulties you encounter every day, it also looks at what a health service should be and what should motivate us."

Social solidarity

Mr Mathews said: "Society can either be based on a libertarian model that allows people to have healthcare on the basis of what they can afford; or we can have an egalitarian model that sees health not as a commodity but as a human right. The reality is that the health of our nation, of our individuals, and the health services which promote health, prevent illnesses, offer curative interventions and assist people to a peaceful death, are extremely important to us as a society.

"Society should promote an egalitarian model where social solidarity sees health as a good for society – a good that should be planned for, should be fostered and should be funded, and a service delivered to attain it, which meets the goal of our society to have equitable access to healthcare, not based on the ability to pay but based on need. Need can be differently defined but how could you not be depressed by a vista of having to wait 25 times longer for a diagnostic test if you're a public patient, whereas you can get it within days if you're a private patient.

"Privatisation of health services is

a failed ideology. It decreases equity, decreases access and it is an ideology that we can eradicate the need for by increasing the needs met in the public service. Consequently we reject the two-tier model of health service provision in this jurisdiction. We want a single-tier model which meets the health needs of our population, based on need, which is equitable at the point of access and has nothing to do with your ability to pay, but is solely based on your health needs," he said, to the applause of delegates.

Mr Mathews outlined the need to have a truly integrated health system, which according to the World Health Organization is organised and managed so that people get the care they need, when they need it, in ways that are user-friendly and achieve desired results and provide value for money.

ICT structure

He pointed to the need for a proper information and computer technology (ICT) structure. "Healthcare professionals should be able to access health records. Whether somebody comes into a health centre, a GP surgery, a minor injury clinic, for a diagnostic test, to a podiatrist, a consultant, the emergency department, the maternity services – you should be able to pull up a single record. This improves safety and is long overdue. Investment is needed in an ICT system to allow patient information to be tracked so that we can develop and deliver an integrated health system."

Healthy Ireland framework

He said the aim is to increase the proportion of people who are healthy at all stages of life. "We have to deliver a health service

that is patient focused, that is organised and delivered to meet patient need – that should be the only motivating principle in the organisation and delivery of our health service,” he said.

Patient safety

The INMO believes in a health service where patient safety is at the core of everything that the service does, Mr Mathews said. Patient safety should be the motivating factor in all decisions made by individual practitioners and professionals.

“When we talk about patient safety we have to reflect on the stringent cuts which were imposed on our health services. It is long since past the time that we need a regulatory framework for managers within the health service who are not registered healthcare professionals.”

Structure and organisation

The INMO policy states that the health service needs a central coordinating force to ensure adequate service planning, policy development and implementation, quality assurance, clinical governance and most of all to “advance, protect and defend the public interest in social solidarity directed towards the development and maintenance of an effective health service”.

The Organisation is concerned about the reorganisation of community services and of acute hospital services, he said. “We had unplanned, uncoordinated, disastrous reconfiguration of our acute hospitals, where we simply reduced bed numbers in one hospital and trundled everyone down the road so that they could all get backlogged in the emergency department and then overcrowded inpatient wards. That’s not the type of reform that’s required.”

While he acknowledged that hospital groups have potential, there is concern that they could be a prelude to privatisation of the delivery of health services, he said. “We must be ever vigilant to ensure that is not allowed. The public ownership of the delivery of health services is an absolute imperative. Health is not about profit – health is about health. We don’t want private sector interests to own our services of general interest.”

Value for money and transparency

In calling for increased investment in the health services, there must be value for money and transparency, Mr Mathews said. “We are using public money and we must use it well, in a way that increases access to services and reduces health inequality. Akin to the development of a proper ICT structure, there should be the collection of proper data, which allows

each functional unit of the health services to be properly benchmarked in relation to value for money, and also in relation to quality and safety, to allow us to properly assess how health services are being managed and delivered to ensure that we can show that we are providing value for money, to ensure that we can show that the private sector is not a cheaper model and to ensure that we can show where services are being mismanaged that remedial action has been taken.

“ We want a single-tier model which meets the health needs of our population, based on need, which is equitable at the point of access and has nothing to do with your ability to pay but is solely based on your health needs ”

Funding

“We’ve had robust debate in the last few years at conferences on what model of funding the health service is appropriate. Universal Health Insurance (UHI) is not what we want. It is a model that will increase cost, reduce access and will not serve the needs of the population well.

“If you’re extracting a profit margin from the delivery of healthcare, that is money that the public sector can use to invest in the health of our nation,” he said. “Thus we are calling for the health services to be funded from general taxation. We want to preserve the authentic possibility of a cost reducing government regulation and intervention in the healthcare sector – also known as the non-privatisation system. We want to abolish the current two-tier system of healthcare. We want to establish a single-tiered health service funded from general taxation. The quantum of that funding and the policies governing the delivery of that service must form a part of a social solidarity pact, which doesn’t rely only on the government but relies on all the political parties and all interested parties in the delivery of health services. We have to sit down and honestly agree what is required on the basis of a multi-annual

plan, what will be allocated and how we will all work to deliver excellence in healthcare in this country,” he said.

Developing services

The document sets out the INMO’s position on numerous areas of the health service, including:

- Maternity services, stating support for the implementation of the National Maternity Strategy and the need for the international best practice standard of one midwife to 29.5 births
- The provision of dental care and the “scandalous” reduction in medical card cover
- The delivery of acute care and the need for 1,500 additional beds in the system and the need to deliver diagnostics over a 24/7 cycle.
- Mental health and the need to allocate sufficient resources to provide care in the community and sufficient inpatient beds
- The cost of medication and the need to have a new way of thinking in relation to the purchase of medicines.
- Pre-hospital emergency care services must be sufficiently funded and developed to ensure both in infrastructure terms and professional access terms that the right people are available at the earliest possible opportunity.
- End of life care and the need for sufficient professionals trained and available to deliver end of life care in an appropriate environment.
- Primary and community care, including the need to address community nursing structures, improved access to GPs and need for practice nurses employed by the state; and the provision of minor injury units to divert patients from EDs.

“We want to move to a primary care model but we can’t at the same time, develop primary care and reduce bed capacity. We have to develop the capacity *and* primary care and see if it’s possible then to reduce our bed numbers, considering the demographic challenges, the increase in general population and the massive increase in our elderly population,” said Mr Mathews. “We need as a society to preserve the possibility that at our most vulnerable moment we will be able to access a health service which meets our needs which will ensure that we have an appropriate professional available and which will be available on one premise only – do I need help? Not have I got money?”

The draft ‘INMO Healthy Policy – Excellence in Healthcare’ can be viewed in full on the INMO website, www.inmo.ie



Elizabeth Adams updated delegates on the numerous tools developed by the Professional Development Centre to support members' continuing education. Eimear Vize reports

Making CPD relevant and accessible

ALMOST 20,000 nurses and midwives attended education programmes organised by the INMO Professional Development Centre (PDC) and Library over the past three years, with more than 6,000 of these attending in 2015 alone.

That's according to Elizabeth Adams, INMO director of professional development, who presented an overview of the PDC's outstanding work to the ADC in Killarney.

She praised as 'invaluable' the contribution made by the Executive Council and the over 40 elected education officers from INMO branches and sections, who are central to informing the strategic direction with regard to subject and programme suggestion, as well as helping in the dissemination of INMO education programmes, conferences and events.

The Nursing and Midwifery Board of Ireland (NMBI) has been developing schemes

for the purposes of monitoring the maintenance of professional competence, which will be required soon under the Nurses and Midwives Act 2011. Ms Adams assured the delegates: "At every moment and at every opportunity we will be demanding on your behalf that any scheme has to be affordable, relevant, it has to be do-able and has to be supported by both the profession and the employers."

Education programmes

In relation to the educational programmes, she said: "Just to give you a flavour, over the last three years we've had nearly 20,000 participants in our half-day, one-day and two-day education programmes."

Illustrating the challenges and commitment involved in delivering these services, she pointed out that in 2015 more than 6,000 individual nurses and midwives attended PDC education programmes. That means we delivered 256 one- and two-day education programmes, co-ordinated by Marian Godley and the team. With our expert associate lecturers, we deliver the most comprehensive range of one- and two-day education programmes specifically designed for our members.

"We also delivered seven national conferences with 825 participants, and my colleague Jean Carroll who's responsible for Section Development did a tremendous amount of work in co-ordinating the 26 sections. She also facilitated 60 meetings on top of the seven conferences last year," she added.

The INMO industrial relations officers also received high praise for helping to identify where members need the Tools for Safe Practice workshop: "We have delivered 409 education programmes and we've had over 8,000 participants since the Tools for Safe Practice commenced in 2012," Ms Adams said.

Delegates were informed about the new *Education and Continuing Professional Development Directory for Nurses and Midwives*, which contains 95 generic programmes with outlines, aims, objectives and sample reading lists. They are all approved by the NMBI with Continuing Education Units (CEUs). Also included in the Directory are a number of support tools, such as a template for reflective practise and recording CPD activities.

The PDC calendar of events, which is being constantly updated, contains dates, times and venues for more than 100 programmes scheduled until the end of the year. However, Ms Adams emphasised that

onsite education programmes or additional programmes will be facilitated based on members' requirements.

"We are always looking for opportunities to work with appropriate partners to support members to attend affordable programmes. For example, a recent programme developed entitled *Making a difference to your patient – smoking cessation* only incurred a minimum administrative charge with the support of Omega Pharma," she said.

Ms Adams outlined a new initiative being undertaken in partnership with UCD – the INMO/UCD Education Pathway Partnership – in which any nurse or midwife who has completed six INMO education programmes or 30 CEUs over the previous two years can apply to UCD to do a professional certificate on 'Enhancing Clinical Practice'. Mandatory as part of the qualifying 30 CEUs is the INMO Academic Writing and Research Appraisal Simplified programme. The course fee is €300 and the INMO is offering a €50 bursary for each successful student who enrolls in the certificate course.

The course is run over 12 continuous weeks, which involves 125 hours of blended learning with one-day attendance in UCD. Course content is delivered online with tuition and continuous assessments/assignments contributing to a final reflective portfolio. The next programmes commence on September 22, 2016 and January 26, 2017.

Day to day CPD activities

"There are lots of activities that contribute to your CPD – it's not all about attending education programmes. What we're trying to do is to support members in their day to day work to gain their CPD activities," she explained, listing over a dozen such activities including mentoring, coaching, policy development, peer review, training on new equipment and research studies.

"So in trying to come up with tools to assist you with that, we've developed a new CPD Article Collection in partnership with Clarity Informatics, who started writing CPD articles for *WIN* back in February. Clarity Informatics is contracted by the National Institute for Health and Care Excellence (NICE) to provide clinical content for the clinical knowledge summaries. We've collated these into a booklet and there's a short CPD quiz and reflective reading log after each article to record your learning," said Ms Adams. The diverse collection of articles feature clinical topics including heartfailure, jaundice in the

newborn, Zika virus and venous leg ulcers. Reading this collection of evidence-based articles, recording your multiple choice questions and reflection on your knowledge in practice will assist you to maintain your ongoing lifelong learning.

INMO Library

There is also a new Library Education Programme on advanced Library Searching Techniques available, which has five CEUs for a full day and 2.5 CEUs for a half day.

Ms Adams went on to highlight a new point of care tool called Prodigy, which is endorsed by the National Institute for Health and Care Excellence (NICE). Prodigy is an encyclopaedia of high quality evidence-based information and is available through the INMO PDC website, www.inmoprofessional.ie

"This is a terrific clinical resource. You can have it as an app on your smartphone or on your laptop in your work environment. It can improve clinical practice, enable quality prescribing, and provide practical advice at point of care. There are hundreds of topics and they're very broad – from palliative care, risk assessment in falls, to cancer – and it's very simple to use," she said.

The PDC has now signed up with the Joanna Briggs Institute – an internationally renowned research and development centre and the leading body in evidence-based practice. This database of over 3,000 records across seven publication types contains, among others, evidence-based recommended practices, best practice information sheets, and systematic review protocols. The information is continually updated.

All new publications, education programmes, reading lists, evidenced based resources, tools and services such as the Library can be accessed through the inmoprofessional.ie website. In addition, the website includes a safe and secure online booking system and a facility to maintain your professional profile and record your CPD and lifelong learning activity.

"One of the significant reports commissioned by the Executive Council on *Missed care: community nursing in Ireland* was launched recently. The UCD independent report is significant as it provides solid data in relation to demonstrating the amount of missed care in the community that actually has happened: 50% state missed care in the previous working week, and 17% indicated they had a caseload over a geographic population of 10,000, which is absolutely incredible. This report is available on the INMO website

www.inmo.ie and I'd like to give due recognition to all the public health nurses and community RGNs that were involved," said Ms Adams.

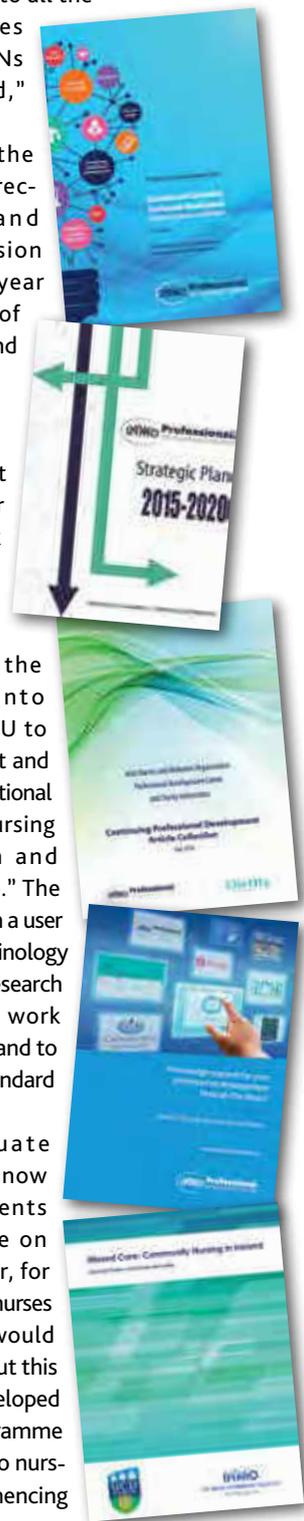
She added that the report contains 16 recommendations and calls for a commission to report within a year to examine the role of community nursing and midwifery.

Standardisation of research

One of the persistent frustrating issues for members is the lack of standardisation of nursing and midwifery documents, according to Ms Adams: "So the INMO has gone into partnership with DCU to establish Ireland's first and only accredited International Classification for Nursing Practice Research and Development Centre." The centre aims to establish a user group for nursing terminology in Ireland and set up research clusters. It will also work alongside eHealth Ireland to promote the use of standard health terminologies.

The undergraduate nursing programme now requires that students complete a module on informatics. However, for those long-graduated nurses and midwives who would like to learn more about this area, the PDC has developed a new education programme with DCU in relation to nursing informatics, commencing this September. The two new programmes, which have six CEUs each, are Introduction to Nursing Informatics and Introduction to International Classification for Nursing Practice.

Concluding her address, Ms Adams told delegates that, both nationally and internationally, the INMO is continuing to work with key strategic groups to help deliver quality, safe and cost effective healthcare systems and enhance the professions of nursing and midwifery.





Solidarity in the face of adversity

Against a global background of terrorism and human tragedy, the INMO continued the good fight for better conditions for nurses and midwives in Ireland, Dave Hughes told delegates

"ON A global basis, 2015 was scarred by the ability of terrorists to shock the world through appalling atrocities and waste of human life," Dave Hughes, INMO deputy general secretary, said in his review of the year at the annual delegate conference.

He recounted how the year started with the killing of 12 staff of the French satirical magazine, *Charlie Hebdo* and ended with the worst act of terror on the streets of Paris since the Second World War when 130 people died in a series of co-ordinated attacks across the city. The Middle East was torn apart by war. Scenes on our television left us shocked to see such terror still happening in the 21st century. The unrest in the Middle East caused over a million refugees to flee to Europe, with even more lives lost as people tried to cross the sea during 2015. An airplane was shot down by ISIS, highlighting the depth of terrorism that we have reached. INMO member Lorna Carthy, a registered nurse from Co Meath, was one of the victims of a terrorist attack when 38 people were killed on a Tunisian beach in June 2015.

"All of these acts of terrorism were met with an overwhelming response by healthcare workers across the globe who responded in magnificent ways to help those who were suffering at the hands of terrorism, showing that we will not be beaten by acts of terrorism," Mr Hughes told delegates.

The year also saw a lot of Irish losses, with the deaths of six young Irish students when a balcony collapsed in Berkeley, and the death of 10 people following a fire at a Travellers' halting site in Carrickmines.

While much of 2015 was marked by terrorism and tragedy, the year also brought with it some positive advancements,

particularly for Ireland when it became the first country in the world to vote yes to legalise marriage equality, changing the image of Ireland in the eyes of the world.

Unsustainable emergency department overcrowding also dominated much of 2015 as overcrowding continued at record levels each month throughout the year.

"In January 2015, after a week of severe overcrowding in EDs, RTE went to the INMO to get reports from across the country on the overcrowding. This highlighted how important nurses and midwives and this Organisation, as INMO leaders in the public psyche, are in letting the people of Ireland know what's happening in hospitals," said Mr Hughes.

"ED overcrowding wasn't the only part of nursing and midwifery that the INMO responded to in terms of trying to deal with the staffing crisis and, while it took longer than expected, the INMO did see the delivery of the report by the taskforce on staffing and skillmix for nursing in medical and surgical wards. Safe staffing pilots are now in progress and, in future, dependency will determine numbers and skillmix on wards. Progress was also made in the development of a midwifery strategy following a call for a national strategy and the INMO demanded a 1:29 birth ratio. Implementation of the strategy and ratios are currently in progress," Mr Hughes said.

The INMO was active and successful throughout 2015 in representing its members' best interests in a number of areas, including freezing the NMBI fee increase and launching a Campaign for Excellence in intellectual disability (ID) services.

RNIDs called for recognition as the specialists in intellectual disability and the INMO responded to this call by launching

the Campaign for Excellence, which included a Dáil demonstration showing commitment to the service and a poster campaign which highlighted the services provided by RNIDs, Mr Hughes said.

"When the NMBI proposed a 50% fee increase, over half of nurses and midwives refused to pay and the INMO called for financial accountability, which saw the INMO stance fully vindicated when an independent audit review issued an indictment of NMBI conduct and governance. The freezing of the retention fee was a huge achievement in the first instance and the decision to keep the fee at €100 for a further three years represented an extraordinary milestone in terms of the ability of the INMO to show itself as the most effective representative body for nurses and midwives," said Mr Hughes.

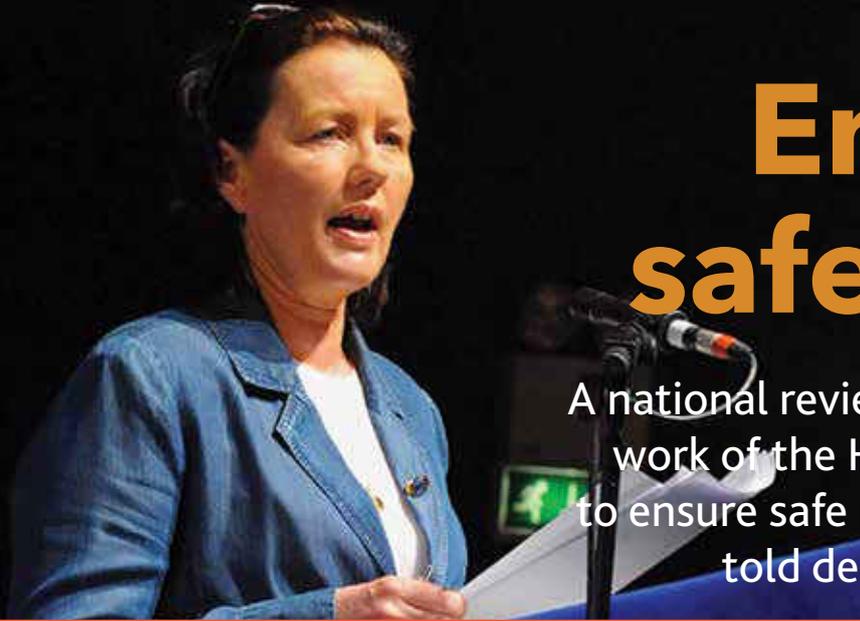
"In May, following the conferences of the INMO and all other unions, the government, through the Workplace Relations Commission, commenced discussions with public service unions on the reversal of public sector pay and pension cuts. The outcome of those negotiations were a set of proposals known as the Lansdowne Road Agreement (LRA). Under the LRA the majority of public servants will receive around €2,000 extra over three phases between January 2016 and September 2017," he said. The INMO also negotiated a significant increase in payments to undergraduate students and restoration of incremental credit on appointment.

Mr Hughes completed his review of the year by introducing a video entitled *Who You Gonna Call?*, which highlights the extensive work of the INMO and its members in 2015. The video can be viewed at www.inmo.ie

– Sinéad Makk

Ensuring a safe skillmix

A national review of the role, functions and work of the HCA needs to be undertaken to ensure safe patient care, Geraldine Talty told delegates. Eimear Vize reports



NURSES and midwives must not delegate tasks to healthcare assistants (HCAs) if an inadequate staff mix means they are exposing patients to potential medical mishap and themselves to a fitness to practise referral, delegates at the annual delegate conference were told.

Speaking on the Organisation's new position statement in relation to the role of HCAs, which was launched at the annual conference in Killarney, INMO general secretary Liam Doran said that the document's underlying message is that the INMO and its members have to take control.

"If you are left in a situation where you do not have the skilled staff to allow you to delegate to maximise your contribution, then the INMO has to step in and support you to fight and fight until it's better," he said.

"If there's one message I can send you away with it's that nurses and midwives have got to learn when to delegate, when not to delegate and when to demand the INMO to assist on making changes."

Geraldine Talty, INMO first vice president, presented the contents of the position statement, which addressed several topics including delegation and accountability, job description, education and staffing. It also calls for a review of the HCA role.

The document stressed that the HCA can never be a substitute for the role and function of that of the registered nurse or registered midwife, and a HCA should never be expected to make a clinical decision or judgement alone.

"It is essential that a national review of the role, functions and work of the HCA be undertaken, which will ensure the HCA

has the appropriate skills to provide safe, effective patient or client care under the governance of qualified nurses and midwives. It is essential that the INMO forms part of the national review group," said Ms Talty.

She reiterated the INMO's support of a grade mix of 80% RGNs and 20% HCAs, which should be examined in line with international standards once a comprehensive review of the HCA role is completed. The document also states that there should be a grade mix of 60% RGNs and 40% HCAs in older person care services.

"We do know that there are several places around the country in care of the older person settings where this is not the case but the INMO does not support this," she told the conference.

"The INMO further supports a rich grade mix for RNIDs to HCAs in intellectual disability services. The grade mix in midwifery services will evolve in line with the Maternity Strategy and that's 100% registered midwives in all stages of labour," she added.

With regard to HCA education and training, Ms Talty said the INMO supports the European Federation of Nurses Associations' (EFN) call for a more cohesive approach in this area, including the development of a framework for the education of HCAs.

The INMO reiterated its support for the continuing education of HCAs throughout their career to ensure emerging patient needs are met on the ward, department or care facility. To this end, it called for a national review of the education and training of the HCA.

Ms Talty said this education programme should be based on appropriate skills that

are quality assured and reflect the needs of the patients and clients, and ensure that adequate nurse/midwife supervision is always present in wards or care areas where HCAs undertake delegated care duties.

"You can't be accountable or responsible if you're not there; you cannot delegate to somebody if you're not there. That's the fundamental principle of all this," she said.

The INMO will also be seeking a review of the national job description for HCAs to better reflect the role and function of the HCA as a part of the multidisciplinary team. The revised job description must incorporate the fact that the care is delegated by nurses/midwives, and the reporting relationship is to the nurse manager. This review must happen in collaboration with the appropriate bodies, including the nursing trade unions, and should form part of the broader national review of the HCA.

With regard to delegation and accountability, the INMO policy document stated that it is essential each nurse and midwife exercise their professional judgement against clear criteria, when deciding to delegate a task or role. Tasks delegated must not contain elements of professional practice assessment, diagnosis, planning and evaluation – they all remain the nurse's responsibility.

The INMO called on the NMBI to provide clarity on the changing role of the nurse and midwife, and to reflect and clarify the responsibility of the delegator and the specified accountability of the HCA in delivering care, in all communication and subsequent documentation to registrants.

The full policy document is available on www.inmo.ie



The gift of gratitude

Keynote speaker Gerard Moran stressed the importance of feeling grateful for all we have, rather than feeling let down about what we don't have. Tara Horan reports

WE CAN all achieve far more from ourselves than we are currently experiencing. This was the message behind the keynote address from motivation speaker Gerard Moran at the ADC in Killarney.

He said there was absolutely nothing he could do about the situation of nurses and midwives working in the Irish health service. "The only crumb of comfort is that this year, at last, the Irish electorate put the national interest ahead of self interest. We all want tax cuts but people said no. Not if it comes at the price of people being homeless and not if it comes at the price of the health service being on its knees. Maybe it's the start," he said.

"You are overworked, underpaid, under-appreciated. Your health service is understaffed. Everything I'm saying is true and you know it's true. You live it," he said. "Other things are also true. If you have a roof over your head, a bed to sleep in, clothes on your back, food in your fridge, you are better off than 75% of the world's population. If you have access to any amount of money, even a fiver, you are among the 8% of the world's most wealthy people. That's also true," he said.

He gave delegates the option of looking at their situation through a round window or a square window. "Looking through the round window you might say 'I'm underpaid' – no argument there. 'We're understaffed' – no argument. 'Overworked, under-appreciated' – these are all true but there's not much we can do about it. These

feelings are justified but they breed anger, frustration, resentment, low self esteem.

"But let's look through the square window. On the other hand I am among the 8% of the world's most wealthy people. I am better off than 75% of people who live in the world. Now we start to feel differently. Our situation hasn't changed but it makes us feel completely different," Mr Moran said.

"If you are running those negative emotions, you aren't going to be feeling too good. This is your life and it is the only one you've got," he told delegates, explaining the importance of having a strategy.

Dynamo versus differential engines

Mr Moran went on to explain the difference between how the body and the mind work. "Your body is a dynamo engine. Your mind is a differential engine. If you were training for a marathon, the best way to do it wouldn't be to sit on the couch thinking you'll be the best prepared because you'll be so rested! You have to go out and run and run. The person who wins has been doing 20 mile runs again and again – you'd think he'd be jaded but he's not. That's a dynamo.

"Your mind is different – it is a differential engine. It appreciates difference," he said, explaining with the example of being squeezed in an economy seat on an airplane and then being moved to first class. You think your seat is so comfortable and you're delighted with your individual screen and porcelain plates. "But at home

you have your couch, a large screen TV and plenty of porcelain in the kitchen. But you don't come home from work every day feeling so lucky at all you have. The mind appreciates difference – it's a differential engine."

Reminding the conference of people less fortunate, he said he was going to give delegates a gift. "It's called the gift of gratitude. When you wake up in the morning, many people go 'Oh not another day'. That's where we have to stop and introduce gratitude. Why? Because you have just won the biggest prize on offer. *You got another day!* You don't have a right to it – it's blind luck. You have won first prize in the lotto of life. A lot of people didn't win – they went to sleep last night and they didn't get to wake up. If they could swap with you for one day, how do you think they would live the day?

"Every morning you have so much to be grateful for. Unfortunately you won't realise that until it is taken away from you."

Mr Moran's next piece of advice for delegates was to get out and walk. "It sounds bizarrely simple. Create some chemicals for yourself. I'm talking about stepping it out and while you're out start to become grateful."

He said when he takes people out on walks, at first he often hears moans like 'I've got to go walking'. But tells them: 'No you don't – you *get* to go walking'. If they are in any doubt about how lucky they are, he suggests they visit the National Rehabilitation Centre and tell the patients how lucky they are to be lying in bed, unable to get up.

"When you go to bed at night tell yourself that 75% of the world's population don't have a roof over their head, clothes to wear or food to eat. It's not hard to become grateful but we must keep it at the forefront of our mind. It has got to become habitual." Don't just say it, he told delegates, "You've got to *feel* it. Keep your health and the health of your family in mind – go out walking. Your body is the only one you've got. You've got to look after it and you've got to be grateful. If you have that, you have absolutely everything.

He concluded by giving delegates three things to do to change their lives:

- Be grateful every morning
- Go out walking up to an hour a day
- Be grateful before you go to bed at night.

He said this would change the chemical flow in your body. "It will change nothing about your situation, but it will change everything about how you feel."



INMO director of regulation and social policy Edward Mathews assured delegates that all members referred to the NMBI fitness to practise committee can be sure they will be defended by the INMO and their legal costs will be covered

INMO saves members thousands in costly fitness to practise hearings

THE INMO has successfully overturned a significant 75% of complaints referred to the NMBI fitness to practise preliminary proceedings committee (PPC), delegates at the annual delegate conference in Killarney were told.

However, Edward Mathews, INMO director of regulation and social policy, said: "It is my view, and the considered view of the legal advisors who we work with, that the NMBI embarks on some cases where there is insufficient evidence to muster a case against you, and that they refuse to withdraw

allegations where it was thought evidence would be available but it then appeared not to be available. This has caused stress and anxiety and has cost thousands of euro."

The conference heard that the cost of independent legal assistance at the PPC stage for non-INMO members is €3,000-€5,000.

"Remember, you don't have to have done anything wrong to be referred to the PPC, nor do you have to have done anything wrong to be referred to a full hearing," Mr Mathews said.

The average cost of

representation by a solicitor only at a full hearing is €6,765 a day, he said and "few hearings go to just one day. Most are at least two and we've had a number of hearings in the past year that have run to six to nine days, so you can do the maths."

Legal expenses will reach almost €10,000 a day if a non-INMO member chooses to have representation by both a solicitor and legal counsel at a full hearing.

"The final message is that if you are referred to the NMBI you can be sure of one thing

– all of our members will be defended, you will not be left alone, you will not walk into that building on your own whether there's TV cameras there or not. You will never have to spend a penny and you will know that you are a member of an Organisation that has spent half a million euro defending its members in the past two years," said Mr Mathews. "We are standing together to make sure that the system works properly. We will be vigilant, we will let them away with nothing, and we will defend your interest to the last breath."

Independent living for older people a key priority

HELPING older people to live well and independently in their own homes for as long as possible should be a key priority for the incoming government, and must be bolstered by adequate resources to primary care and other home support services, the INMO has stressed.

Unanimously supporting a motion by the Offaly Branch calling on the government to fund these community-based services, annual delegate conference delegates were told

that years of forced austerity has crippled the health service and exacerbated the on-going emergency department overcrowding crisis.

"We want to support older people who wish to remain in their homes and live independently, so they don't need to come to hospitals. EDs will be less crowded, wards will be less crowded, staff will be less stressed, which will all help delivery of a better health service," said Neil Perry from the Offaly Branch

Practice nurses call for funding for CPD

THE INMO is calling on the Department of Health and the HSE to provide funding for the continuing professional education of practice nurses, many of whom are paying out of their own pocket to maintain and enhance their skills.

The conference heard that the role of the practice nurse is constantly expanding and currently includes a variety of services including respiratory/asthma care, diabetes care, cervical smears and wound care, all of which add to the

effectiveness of the general practice in terms of prevention and treatment.

"Practice nurses are calling on the Department of Health and the HSE to provide and fund the education needed to provide these services.

GPs are private practitioners; they have no obligation to provide this education, therefore practice nurses are paying for it themselves," said Anita Ruddy from the Dundalk Branch, who proposed the motion.



Essential to record extra time worked

IT IS very explicit under the Lansdowne Road Agreement that every minute worked by nurses and midwives should be recorded and compensated, delegates were told in a lively debate at the ADC.

A motion from the Clonmel Branch called for the INMO to stress the need for all nurses and midwives to record all time worked and to ensure they are compensated for additional hours worked.

"It would be interesting to publish the evidence of all additional time collectively accrued by all INMO members," Michael Dowling, Clonmel Branch, said in proposing the motion. He also pointed to the issue of not being paid for mandatory training outside of the 39 hour week and the time this took out of personal time. "For example, I have to do mandatory fire training next week at 10am. I will have to wait around from when I finish night duty at 8am for this mandatory session at 10am," he said.

Seconding the motion, Eamonn Cooney, Clonmel Branch, expressed what an hour later at work meant to his personal life: "An hour later going home at night because of the need to maintain the nurse ratio of 1:12; an hour



Delegates gave a resounding 'yes' to the call for the INMO to stress the need for nurses and midwives to ensure they were compensated for all additional time worked

later getting in after your kids are gone to bed; an hour later when you get a text from work checking something. An hour later going to bed, but an hour earlier getting up and it all starts over again. We really need to catch up on this loss of our time."

Geraldine Talty, INMO first vice president, said this type of motion comes up repeatedly but stressed: "It's very explicit in the LRA that every minute, every second that we work should and must be counted. We have to do this. Every hour extra at work is an hour lost to you and your work/life balance. I really cannot understand why we're not counting it. I know it is difficult when there are clinical nurse managers and DoNs telling us it must be sanctioned

– often by someone who isn't there when you're working late.

"We know we are not getting our breaks, so count them. We know if the ward is overcrowded, if the ED is overcrowded. If the ED nurse has 50 patients to hand over then the 15 minute overlap time is not enough to hand over 50 patients. And if it is that, you're not handing over your patients correctly, the clinical handover you are doing is not effective, and you're also accountable and responsible for that."

She urged delegates: "From this day forward, please count every second and every minute, which all add up to hours and eventually add up to money. This means you may need to come into work, possibly three days a week instead of four, or

four days instead of five. At the end of the day, it's all about our health and safety."

Some delegates reported that they had been told not to bother recording extra minutes worked because they would not be counted or compensated.

However, Martin Ward, South Donegal Branch, said he continuously stressed to staff in his workplace the need to document extra time worked that was necessary because of dependency levels etc. "I enforce this to my staff and when I'm doing rosters I note that staff must be given TOIL, but this instruction is often ignored."

The pros and cons of clocking in and out came up again and again at conference. It was pointed out that if a manager really wants to investigate, they can see what time you entered a department and what time you left through electronic scans and other machinery.

Breda Fogarty, North Tipperary Branch, said she took advice from a friend on this subject who said she supports a lot of charities but the HSE wasn't one of them. "So let's start thinking like that. Let's look for what we are entitled to and let's not take it any more."

The motion was carried.

Delegates demand zero-tolerance approach to bullying

THE government has failed to appropriately recognise the significant increase in incidences of physical and verbal hostility directed at nurses, midwives, and other healthcare staff, Sean O'Cealleagh from the Mullingar Branch told delegates during the annual conference.

Mr O'Cealleagh was proposing a motion directing the

INMO to demand zero-tolerance in relation to verbal or physical abuse of staff in all care settings, which was unanimously supported by the Organisation's annual delegate conference in Killarney.

"Nurses and midwives work to make a positive difference in peoples lives. We are not deserving of hostility.

We are, however, deserving of protection," Mr O'Cealleagh told delegates.

Most of the gathered delegates raised their cards when asked by Mr O'Cealleagh if they have had verbal or physical abuse directed at them during the course of their work.

He then asked them to keep their card raised if they

had reported or knew how to report the incidence. More than one-third lowered their cards at this point.

"We need the knowledge base to be able to report these incidences," he said. "We must as an organisation stand firmly together and highlight reports of attacks and threats to staff," Mr O'Cealleagh concluded.

Oluwayemisi Jegede of the International Section called on the INMO to back the call for the government to enact the Criminal Law (Hate Crime) Bill with immediate effect



Call for urgent action on Hate Crime Bill

A MOTION from the International Nurses Section calling on the urgent need for the government to enact the Criminal Law (Hate Crime) Bill to protect minorities in Ireland provoked a moving debate among delegates.

Speaker after speaker spoke of the trauma of hate crimes when backing the motion supporting the call for the Bill to be enacted with immediate effect, which was initiated by Action Against Racism, a project of The European Network Against Racism, Ireland.

"There is no rational or scientific evidence that one race is biologically or intellectually superior to another. Such an idea can be very destructive. It can be very demoralising, it can challenge your dignity which can lead to isolation," said Oluwayemisi Jegede from the

International Nurses Section, who proposed the motion. She reminded delegates that all people have the right to the core human rights principles such as dignity, fairness, equality, respect and independence.

Elizabeth Allauigan, International Nurses Section, said: "Everyone has the right to live safely and participate fully without fear in all aspects of life here in Ireland. The Hate Crime legislation makes a strong statement that we are an inclusive society where crimes based on the basis of a victim's identify are not tolerated.

"Hate crimes can lead to fear spreading through the community, especially when there is a poor response. In 2014 ENAR Ireland recorded 137 incidents of race crime in Ireland, compared to An Garda Síochána recording only 43. Having the

Hate Crime legislation in place will help ensure hate crimes are recorded for what they are and are taken seriously in Ireland."

Ireland, unlike most other EU countries, has no hate crime legislation, Ibukun Oydele, Dublin South West Branch told delegates. Some people still say racism is not a problem. It is a big issue. It is in our places of work, everywhere migrants go in Ireland there is always a race card. We are often told to go back to our country. I fear the government is not doing enough. We need to send a strong message that racism is not tolerated in Ireland.

Moira Wynne Craig, Executive Council, said: "As a group of workers, we particularly have to support this motion. We asked our international colleagues to come here to work and they need to be treated

the way we are in our country. They belong here now with us. Please support this motion."

Louise Devlin, Dublin South West Branch, said: "Every single person in this room has a beating heart. We all studied anatomy and physiology. We are made up of a musculoskeletal system. Take off the skin – we all look the same. Let's show racism the red card."

Jo Tully, Dublin South West Branch, told delegates: "Racism denigrates us all – not just those who are abused by it but our whole society. It cannot be tolerated. We are proud to stand with our overseas colleagues in the fight against racism. I do hope that our overseas colleagues understand that, when they are with us in our Organisation, in our hospitals and in our communities."

The motion was carried.



Funds from the table quiz and raffle held on the opening evening of the ADC amounting to €3,000 were presented to Pearl O'Connell (above left), who is a member of the Board of Management of Killarney Day Care Centre, Holy Cross Gardens. This centre caters for 100 people every week, providing hot meals, showers and other services. Claire Mahon, INMO President, presented the cheque to Ms O'Connell, who is also a member of the INMO Killarney local committee



INMO ADC 2016 Killarney local committee and branch members pictured at the ADC (l-r): Catherine O'Shea, local committee; Breda O'Sullivan, branch secretary, delegate and local committee; Sheila Dickson, local committee; Noreen Corcoran, chairperson of branch, delegate and local committee; Pearl O'Connell, local committee; Kate O'Sullivan, delegate; Trish Wright, local committee; Breda O'Connor, vice chairperson of branch and local committee; Eileen Breen, treasurer of branch and local committee



Students' supernumerary status is key

NURSES and midwives have vowed to support their student colleagues in the fight to protect their supernumerary status, which if not upheld will undermine their training and "the very lifeblood of the nursing and midwifery profession."

Delegates supported a motion calling for a clear definition of the role and working responsibility of the supernumerary student nurse and midwife, to include work extensions, in line with the 2012 Review of Undergraduate Nursing and Midwifery Degree

Programme, undertaken by the Department of Health, and the 2016 NMBI Nursing and Midwifery Registration Programme Standards and Requirements.

Proposing the motion, Aoife Kiernan, chairperson of the Student Section, said supernumerary status was a longstanding issue of contention for students and their mentors. Students have reported that, if their supernumerary status is not upheld, this can undermine their learning because their mentor is too busy or they are not able to work directly with

them. Mentors have expressed uncertainty about being able to meet their duty of care to patients and students.

"With the increasing demand on the nurses' role due to short staffing, our role is hindered, they don't have the time to teach us," Ms Kiernan said.

Mary Emery, Cork Voluntary/Private Branch, said: "All of us here in this audience owe it to our students to share with them the skills that we have. In the classroom they are learning extremely well and have the knowledge base, when they

come on the ward they need our support and we need them. They will be the staffers of tomorrow. They are the very lifeblood of the nursing and midwifery professions. I urge everyone to support these vibrant and brilliant students who come to us in the hospitals."

Liam Doran, INMO general secretary, added: "More than ever we need to cherish the undergraduate student nurses and midwives of this country. We will never address our staffing crisis unless we make them feel that they belong."

Registration should note all qualifications

Dympna Fegan, Meath Branch, proposed a motion calling on the NMBI to acknowledge all additional qualifications on the registration documentation of nurses and midwives, in recognition of their ongoing professional development. This would include additional degrees, higher diplomas, masters and doctorates. The Executive Council proposed an amendment to this motion, stating that such annotation should be made by the NMBI without additional charge to the registrant. The amended motion was carried.

Clear educational pathway for CRGNs

The value of the community RGN to the primary care team must be more formally recognised through further investment in their continuing education to reflect their expanding scopes of practice. This was highlighted by a motion from the Roscommon Branch, which called on the HSE to introduce a clear educational pathway for CRGNs to strengthen their role within the primary care structure. The motion was carried.



Nurses and Midwives in the 1916 Easter Rising

Delegates gave a warm welcome to Mark Loughrey's fascinating presentation on the role played by nurses and midwives in the events leading up to the Easter Rising

Delegates demand protected study leave

DELEGATES at the INMO ADC issued a demand to health service employers to protect study leave for nurses and midwives so that they can meet their ongoing educational needs and continued professional development as will be required under the Nurses and Midwives Act 2011.

It was also proposed that these study hours could be accumulated to accommodate study days away from the service site.

Proposing the motion, Moira Wynne Craig, Executive



"Maintenance of expertise is not automatic, it must be facilitated and employers must be prepared to play their part," – Moira Wynne Craig, INMO Executive Council

Council, said that nurses and midwives are expected at all times to assess patient care and needs, and plan and deliver care on wards to best practice, and in keeping with best

available evidence.

Seconding the motion, Deirdre Munro, Executive Council, warned that nurses and midwives cannot achieve competence unless they get protected study leave to attend conferences and seminars, adding that she has observed a reducing number of nurses attending these events year-on-year.

"We need to maintain competence but we can't learn that by osmosis. Study leave has to be protected by our employers," said Ms Munro.

Support for motion to acknowledge CNEF role

THE appointment of clinical nurse education facilitators (CNEF) in neonate and paediatric hospital units should be prioritised by the Nursing and Midwifery Board of Ireland (NMBI), the HSE and all employing authorities.

That's according to INMO delegates who voiced their unanimous support for a motion calling for the CNEF role to be acknowledged, implemented and supported in these units throughout the country.

Proposing the motion, Eileen Tiernan of the National Children's Nurses Section, said that the clinical nurse education facilitator has a pivotal part to play in creating a quality clinical learning environment, providing support, and facilitating education at the bedside. "Real and meaningful learning can occur in real time and in context," she said.

Ms Tiernan added that the CNEF can reduce the theory/practice gap, promote quality, synergy and risk reduction, contribute



Eileen Tiernan of the National Children's Nurses Section addressing delegates during the ADC. Ms Tiernan proposed the motion that the appointment of clinical nurse education facilitators in neonate and paediatric hospital units should be prioritised by the NMBI, the HSE and all employing authorities

to the development of the unit-based clinical guidelines, and help disseminate evidence-based practice research in the clinical environment.

"There is a worldwide shortage of neonatal and children's nurses and our country has to compete with countries like the UK, Canada and Australia, which provide a variety of educational opportunities and support to their staff. We need to attract and retain these nurses to our units. The CNEF role is recognised as an important and essential staff retention strategy and also

ensures patient safety and quality of nursing care for our children," she stressed.

Seconding the motion, Anne McLaughlin, National Children's Nurses Section, said that 'Dr Google-informed parents' challenge and increase the workload of nurses today, and that the CNEF role is important in achieving the opportunity to upskill in a safe environment.

She highlighted the recent RN4CAST study, which found that there was an increase in mortality in patients under the care of nurses who were less educated.

INMO must fully back National Maternity Strategy

MATERNITY services must be co-designed locally with the women who use the service and the midwives who deliver the service, placing the mother and child at the core while facilitating new models of care and choice, annual delegate conference delegates agreed.

Supporting a motion from the Drogheda Branch that called for the INMO to fully back the implementation of the *National Maternity Strategy 2016-2026*, Deirdre Munro, Executive Council, told delegates that implementing the strategy also required a 'detailed and precise plan' which must deliver the appropriate number of midwives and support the needs of student midwives.

Proposing the motion, Mary Gaynor explained that the new strategy is based on the principle that childbirth is a natural physiological event and, at the same time, recognises that some women will have higher care needs. One model of care is proposed, with three separate care pathways.

"Our service must be responsive to all women's needs," she said. "Women should be offered choice regarding their preferred pathway of care, in line with their clinical needs and best practice. Insofar as possible, all care pathways should support the normalisation of pregnancy and birth and women should be encouraged, and supported, to make their individual experience as positive as possible."

When implemented, maternity care in Ireland will be provided in an integrated manner, by a multidisciplinary team, with women seeing the most appropriate professional, based on need.

"The intention is for the strategy to be driven by a National Women and Infants Health Programme, meaning there is a need for us to continue to engage with the Department of Health and the HSE to implement changes and developments as required," noted Ms Gaynor.

"It's essential that we agree the necessary measures, the staffing, infrastructure, the training and development of midwives to allow us to deliver this improved maternity service."

MedMedia competition winner

THE winner of the MedMedia competition for a €100 One4all gift card at the ADC was Gerri Ryan from Tipperary. MedMedia, the publishers of WIN, would like to thank participants for their comments about the journal, which included:

- "It is an important bond between secretariat,

- Executive Council, the members and all those who contribute, and makes me feel involved"

- "It ensures I see the very real work that the INMO does for nurses and midwives all around the country. It is a discussion topic at work with my nursing colleagues"
- "I love the variety of articles,

- the stock of the paper and the colour"

- "It covers everything a nurse wants to know"
- "It gives a realistic and honest perspective from nurses and midwives in practice on the important critical issues"
- "As always, it's the voice of Irish nurses."



Newly-elected president and vice presidents
New officers of the INMO Executive Council were elected in the closing stages of the 97th annual delegate conference. Pictured are incoming president Martina Harkin-Kelly (centre), with Mary Leahy, first vice president (left), and Margaret Frahill, second vice president (right). Next month's 'WIN' will have a full interview with the new president

Push for correct CPC/student ratios

AN IMMEDIATE review of the maintenance of the clinical placement co-ordinators to student ratios of 1:30 in nursing and 1:15 in midwifery was called for in a motion from the newly re-established Clinical Placement Co-ordinators Section.

These ratios were recommended by the NMBI in the new Standards and Requirements for nursing and midwifery education programmes published recently. "The NMBI also suggests that for those working in the community, the ratio should move towards those for midwifery," said Geraldine Burke, clinical placement coordinator with ID services in the southeast. "I call on the INMO to seek clarification on how this community ratio will be decided and will it include intellectual disability?"

Ms Burke outlined that currently she has a CPC to student ratio of 1:46, while covering five towns and said they were having huge difficulty in securing another post.

"We also call on the INMO to work with employers to actively pursue the recruitment of CPCs so that we can have the maintenance of the correct ratio. I have been asked to work using email, Skype and phone to maintain contact with my students. Think about where a student might be when you

ask them to take your call – in a nursing station or a CNM2's office perhaps. There's the issue of confidentiality and freedom of speech. We need to see a student to really know how they're doing. We also need to be visible in the clinical area to see their preceptors," she said.

Karen Clarke, Executive Council and CPC, stressed the importance of ensuring that adequate training and supports are in place for preceptors, who "play a crucial role in student supervision and education, and support guidance and assessment."

Stephen Woods, from the Student Section, pointed out that with staff shortages there is a lack of preceptorship on the ward and frontline, and therefore "the role of the CPC is crucial to the learning student on the frontline."

Madeline Spiers, East Coast Area Branch, told delegates that direct quotes from the Mid-Staffordshire report such as '*Cuts in staff and changes in skill ratio were motivated by the perceived need to save money*', could be said about any hospital in Ireland. In her work as a Trust in Care investigator, she said she is "appalled at what nurses have to put up with and at what patients have to put up with because management is '*too remote from the reality of the services they*

oversee', again a quote from Mid-Staffordshire."

Martina Harkin-Kelly, second vice president and specialist co-ordinator in nurse education, said: "Student nurses are charged with looking after vulnerable, sick, ill individuals. They have the lives of people in their hands. A ratio of 1:22 is being promised for national schools, we certainly need a target well below that for our student nurses. CPCs are the linchpins that take the burden off staff nurses/midwives within the clinical area and they ensure that the theory practice gap is avoided at all cost."

Louise Devlin, Dublin South West Branch, said: "If we don't teach our students with quality, time and consideration, what sort of nurses will they become? We are passing on tradition, education and standards. We need to look after our students because if we don't mind this generation of nurses, what will we have in 50 years time?"

Jennifer Wherity, fourth year intern in Our Lady of Lourdes Hospital, Drogheda said: "CPCs to us are absolutely invaluable. The nurses on the ground are far too busy. CPCs keep us on track and keep us from making mistakes. Without them we would be absolutely lost."

Following adoption of the motion by delegates, INMO general secretary Liam Doran

pointed out the issue was timely following the review of the undergraduate programme and the implementation body now in place to monitor it.

It is a core function of the NMBI to safeguard undergraduate training. "There is no excuse for the regulatory body not being strident about protecting the infrastructure that is required to deliver the undergraduate programme and as part of the work of the implementation plan. It is in our profession's hands to deliver these ratios – not in the government's hands. That is why the NMBI has got to step up to the plate very quickly."

He said research has found an average ratio of CPC to undergraduate of about 1:43 across the system and about 1:24 in midwifery. One hospital commented it was satisfied with its 1:37 ratio, which is at odds with the rules set down by the regulatory body.

"There are two things wrong here – the hospital presuming that it can decide what is right and the regulatory body being silent on this. It behoves us to ensure that the regulator protects its infrastructure. We lose the undergraduate ratio at our peril. If someone isn't there to support you when you need them, you can't grow from an experience and be a better nurse for it," he said.

Roscommon rep wins INMO award

Respiratory clinical nurse presented with Gobnait O'Connell award

MARY Freeman, a recently retired respiratory clinical nurse specialist at Roscommon County Hospital, received the prestigious Gobnait O'Connell Award at the INMO annual delegate conference in Killarney.

Ms Freeman was nominated for this award, which commemorates the late Gobnait O'Connell, by her nursing colleagues in the Roscommon Branch.

The award is presented annually in memory of Gobnait O'Connell, who died tragically in a car accident some years ago, in recognition of her contribution to nursing and midwifery in Ireland.

This award is given every year to a local representative who has given great service to the Organisation in a manner which seeks to enhance the interests and welfare of their local colleagues.

Ms Freeman is a long-time stalwart of the INMO's Roscommon Branch and is a most deserving winner. As those who know her will



Gobnait O'Connell Award 2015: Pictured (l-r) at the presentation of the award at the ADC were Claire Mahon, INMO president; Mary Freeman, respiratory clinical nurses specialist; and Liam Doran, INMO general secretary

readily agree, her energy is boundless, her enthusiasm never ending and her professionalism unquestionable

Ms Freeman received her award at the awards dinner during the ADC on May 5.

Speaking on Ms Freeman's win, INMO general secretary, Liam Doran said: "Mary is one of the most loyal and dedicated members of the

INMO and it has been my privilege to meet her. She is a true professional, portraying a calm demeanour and has always made herself available to listen to members. She has been a steadfast member of the INMO who worked quietly behind the scenes for members.

"She has shown incredible commitment to the

Organisation and to the members she represented. The award is a fitting tribute to Mary who has just retired from nursing. She truly deserves this award and I thank her sincerely, on behalf of all of us in the INMO, for her sterling work for both members and patients. She will be missed by all who knew and worked with her."

CJ Coleman Award 2016



CJ Coleman Award 2016: This award was presented to Anne Murray, a midwife at Portiuncula Hospital, Ballinasloe, for her research entitled 'Neonatal pulse oxygen saturation levels (spO2 AND heart rates) for the first ten minutes of life following delayed umbilical cord clamping (DCC)'. Pictured (l-r) were: Liam Doran, INMO general secretary; Michelle Barrett, CJ Coleman; Anne Murray, midwife, Portiuncula Hospital, Ballinasloe, and Claire Mahon, INMO president

Preceptor of the Year 2016



INMO's 'Preceptor of the Year' for 2016: This award went to Melissa McGinley who works in the emergency department at Mayo University Hospital. Ms McGinley was nominated by Bridget Ryan, a student from Galway-Mayo Institute of Technology, Castlebar. The award is kindly sponsored by Cornmarket. Pictured (l-r) were: Bridget Ryan, student Galway-Mayo IT; Ivan Ahern, Cornmarket; Melissa McGinley, Mayo University Hospital; Claire Mahon, INMO president; and Liam Doran, INMO general secretary

The logo for INMO ADC 2016 is centered at the top. It features the word 'INMO' in blue, 'ADC' in white on a red ribbon, and '2016' in blue on a white banner. The logo is set against a white semi-circular background with a black outline.

INMO ADC 2016



ADC reporting by
Tara Horan and Eimear Vize

All photos by Lisa Moyles

The recent report on missed care highlights the urgent need to develop a community nursing workforce capable of meeting growing needs



INMO members unite in call for action on community nursing (l-r): Catherine Rotte-Murray, chair of the INMO PHN Section; Mary Leahy, Galway PHN and newly-elected INMO first vice president; and Siobhan Devine, education officer for community RGNs

Call for urgent action

THE grim findings of the recent INMO/UCD research into missed care in community nursing are of little surprise to those working on the frontline who deal with this reality every day, especially since recession hit Ireland in 2008. This was reiterated by several public health nurses and community RGNs at the recent launch of the report in INMO HQ.

"The crude moratorium on recruitment has had a devastating effect on community nursing, a service that has been denied any reform since the 1970s and is now breaking under severe pressure. There has been no review of caseloads, which have multiplied in numbers and complexity. There is no workforce planning on the needs of the predicted 60% increase in over 80 year olds in the next decade, the increase in obesity and associated co-morbidities, and the growing birth rate," said *Mary Leahy, Galway PHN and newly-elected INMO first vice president.*

"The number of PHNs has fallen significantly behind exploding population needs and growth. In 2009 there were 1,690 PHNs employed by the HSE; this figure is now at 1,490. A small increase in the intake of student PHNs is not even keeping up with retirements. So in effect, we are running to stand still. It is simply astonishing that politic rhetoric focuses so much on primary care when we see that 15% of all UK nurses work in the community compared to just 5% in Ireland. The effects of these worrying statistics are extremely evident in practice. PHNs and CRGNs are fighting all of the time to deliver care, which, due to pressures on time, is often rushed and left incomplete.

"A key issue is that lack of direction at a very senior HSE level is causing gross confusion with who is and is not entitled to our service. We are advised not to refuse care yet we don't have nearly the resources to provide a universal service which is what we are being expected to provide.

"The massive economic and health

contribution to the nation is lost as the PHN service is evolving into a reactive, curative one, losing the ability to prevent illness and reduce admission to the overburdened acute services," Ms Leahy said.

Catherine Rotte-Murray, chair of the INMO PHN Section, agreed: "It is no wonder that there are instances of missed care in community healthcare delivery, given dramatic demographic changes. However, we do ourselves and our patients a disservice by increasing our already overstretched workload without adequate staffing levels and sufficient resources across all workplaces. Ours is the only service in primary care that does not operate a waiting list and, as a result, expectations are high and we strive to meet them by seeing patients as soon as a referral is received.

"The research highlights the prioritising of our work, which is largely driven by a marked increase in early hospital discharges, complex cases, essential clinical care, and obligatory legislation such as child notification visits and child protection. It also highlights the areas of missed care in family support and child health for older children, with potential for key developmental delay. In older adults, surveillance of vulnerable and disadvantaged groups and health promotion are the key areas of missed care," Ms Rotte-Murray said.

Lack of administrative support, reduction or absence of all but mandatory continuous professional development, ad hoc IT support with many PHNs and CRGNs having no computer or internet access, and inadequate cover for sick leave or annual leave, all lead to missed care.

"I had hoped that with economic recovery we might see an end to these practices. However, the recent reinstatement of a recruitment embargo by the HSE changes everything. If this embargo is not lifted immediately, it will lead to the situation worsening and place community services under further strain," she said.

"The missed care report emphasises the socio-economic benefits of a well-resourced community nursing structure that can deliver comprehensive care and contribute to the increasing demands and expectations of people in today's society. Improved communication between hospital and community to ensure optimum patient care, and provision of administrative and technical support to facilitate this are crucial. The eligibility of patients to access community nursing needs to be addressed as the current requirement of a full medical card is incompatible with the demands on the primary care team and puts undue pressure on PHNs and CRGNs who can't deliver care to those who are ineligible for some, yet eligible for other services," Ms Rotte-Murray concluded.

Siobhan Devine, education officer for community RGNs, said: "As a community RGN, I find I have to regularly prioritise my care and delegate my workload to meet essential calls. In doing so care is being delayed or postponed. This is due to no communication, or poor or fragmented communication from the acute section and the multidisciplinary team or lack of care and equipment needed on discharge in to the community. Delayed written documentation on care given is often the norm and I have found myself staying behind after hours to complete paperwork or alternatively writing it up days later. This can lead to poor continuous care."

Ms Devine stressed the importance of recording delayed and omitted care and of filling out INMO Statements of Concern to highlight concerns.

Call for a national commission

The report makes 16 recommendations and calls for a national commission to examine the role of community nursing and midwifery, and consider issues such as structures, governance, skill mix, career advancement pathways, as well as the demand for service expansion.

– Tara Horan



Bulletin Board

With INMO director of industrial relations Phil Ní Sheaghda



Query from member

I am currently employed as a CNM1 in a voluntary hospital. I have just been successful in securing a position as a CNM2 in a HSE hospital. I want to resign from my current post at the end of the month and take four weeks' holiday before commencing my new position. Will I start on the 10% pay cut which was introduced a few years ago? Is this seen as breaking my service?

Reply

The 10% pay cut was applied to all entry grades who entered

the public service for the first time on or after January 1, 2011.

The entry grade in nursing is the staff nurse grade. A revised staff nurse salary scale was introduced in November 2013, which merged the 2010 and 2011 salary scales. Staff nurses entering the public health service for the very first time, having never worked in the Irish/EU public health service before, will be placed on the merged staff nurse salary scale. Since you are being appointed to the CNM2 grade, the staff nurse salary scale does not apply to you.

A break of service which exceeds more than 26 weeks can have implications on your pension, ie. you would be considered a new entrant and would become a member of the Single Public Service Pension Scheme.

Query from member

I work night duty, week on week off. My mother passed away during my rest week. Can I carry my compassionate leave day forward and take it when I am due back at work?

Reply

Unfortunately, you can't carry your compassionate leave forward. Compassionate leave may be granted but you must be rostered for duty. Compassionate leave may not be granted at a later date. It is granted to cover the time associated with the death of a relative and subsequent funeral.

Query from member

I have applied for one-day parental leave per week and have been refused twice by my employer. Is my employer obliged to grant this leave to me on the third application?

Reply

An employer can postpone the granting of parental leave for up to six months. However, parental leave in reduced hours is not an automatic entitlement, you only have statutory entitlement to 18 weeks in full or in blocks of a minimum of six weeks. So your employer may refuse your reduced hours (one day per week) on your third application.

Know your rights and entitlements

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

Contact Information Officers Catherine Hopkins and Karen McCann at

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Email: catherine.hopkins@inmo.ie, karen.mccann@inmo.ie

Mon to Thur 8.30am-5pm; Fri 8.30am-4.30pm

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



Quality & Safety

A column by
Maureen Flynn



Comprehensive Geriatric Assessment

Comprehensive Geriatric Assessment (CGA) is an organised approach to assessment, designed to determine an older person's medical condition, mental health, functional capacity and social circumstances. Its purpose is to develop and implement a co-ordinated and integrated plan for treatment, rehabilitation, support and long-term follow-up.

CGA is based on the premise that a full evaluation of a frail older person by a team of healthcare professionals may identify a variety of treatable health problems resulting in a co-ordinated plan and delivery of care, thus potentially leading to better health outcomes. The benefits of a CGA include:

- Improved diagnostic accuracy
- Optimised medical and rehabilitation treatment
- Enhanced health and functional outcomes
- Facilitation of effective discharge planning.

A CGA assists in developing individualised care plans and the avoidance of the potential complications of hospitalisation. It can be developed locally depending on the members and seniority of the multidisciplinary team (MDT). The assessment should consist of the elements depicted in *Figure 1*.

When is a CGA indicated?

The National Clinical Programme for Older People recommends that all older adults identified as being frail or at risk of frailty should have a timely comprehensive geriatric assessment performed and documented in their permanent health record.

When an older person is identified as being at risk of frailty (see *Table 1*) they should be considered for a CGA. Substantial evidence shows that in hospital, those who receive an inpatient CGA on specialist geriatric wards are more likely to return home, are less likely to have functional decline and have lower mortality rates than those who are admitted to general wards.¹

The content of the assessment may vary depending on different settings of care (eg. home, clinic, hospital, nursing home). A key

Table 1. Possible approaches to identifying frailty

Presence of frailty syndromes	Validated frailty assessment tools
• Falls, eg. collapse, legs gave way, 'found lying on floor'	Rockwood Clinical Frailty Scale
• Immobility/decreased mobility, eg. sudden change in mobility, 'gone off legs', 'stuck in toilet'	PRISMA 7 questionnaire
• Delirium, eg. acute confusion, 'muddled', sudden worsening of confusion in someone with previous dementia or known memory loss	Timed up and go test
• Incontinence, eg. change in continence, new onset or worsening of urine or faecal incontinence	Groningen Frailty Indicator questionnaire
• Susceptibility to side effects of medication, eg. confusion with codeine, hypotension with antidepressants ⁴	Edmonton Frail Scale

element of a CGA is that the environment in which it is delivered is gerontologically attuned.²

If indicated, a CGA should be initiated as soon as possible after admission to hospital by a skilled, senior member of the MDT, and used to identify reversible medical problems, target rehabilitation goals and plan all the components of discharge and post-discharge support needs.³

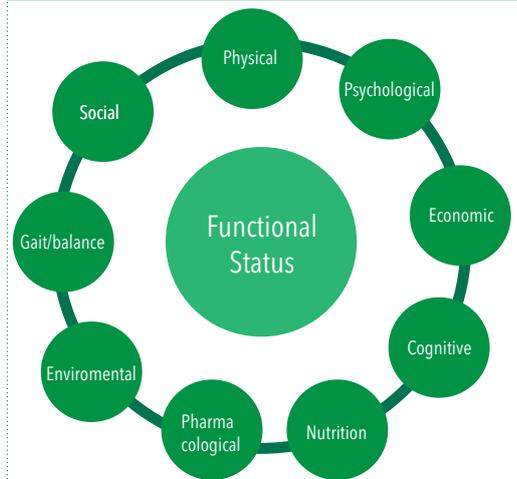
Who should carry out a CGA?

Members of the CGA multidisciplinary core team should include experienced individuals drawn from medical, nursing and health and social care professions. This MDT is responsible for the co-ordinated assessment, discussion and recommendation or implementation of treatment plans.

At your next ward, unit or team meeting you might like to talk about how you care for older people. Consider what assessments you make in partnership with older people and their family, and more importantly, if these are comprehensive.

See www.hse.ie/eng/about/Who/clinical/natclinprog/olderpeopleprogramme/ for further information or contact Deirdre Lang, director of nursing, National Clinical Programme for Older People at email: deirdrelang@rcsi.ie or Carmel Hoey, NMPD officer/NCPOP at email: carmel.hoey@hse.ie

Figure 1. Elements of a CGA



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

Acknowledgement

A particular thanks to Deirdre Lang and Carmel Hoey for sharing the information on CGA and preparing this column

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Add to your value with CPD

CPD courses will strengthen your chances of getting the job you really want after qualifying, writes Dean Flanagan

CONTINUING professional development (CPD) – the dreaded phrase that student nurses and midwives avoid more than they avoid getting down to writing assignments. CPD has become exclusively associated with qualified nurses and midwives but it is also something that should be considered by student nurses and midwives.

Finding employment

It's increasingly obvious that employers want an applicant to have more than a straightforward degree. Employers are more likely to look at you as a potential employee if you can show evidence of enthusiasm and motivation to continue developing your professional education.

As I neared the end of my internship I started searching for ways to widen my knowledge on different aspects of emergency nursing so as to have the upper hand when searching for potential employers; the moratorium was in place at the time.

It was then that one of my colleagues, an INMO representative in Sligo, told me about the ECG interpretation programme run by the INMO Professional Development Centre. This seminar really helped bring my understanding of ECGs up another level and shortly after I attended the Tools for Safe Practice course which was an excellent course for interview preparation. If you are serious about standing out from the crowd, then these courses can really be your opportunity to showcase your commitment to nursing and midwifery and to further expanding your professional development.

CPD is valuable to all professionals and students alike. It is good to get into the habit of continuing to extend your knowledge so you are ready for when you qualify as a nurse or midwife. CPD ensures that your practices are in line with the most recent standards of care. CPD also helps to keep you interested and motivated within your career.



Pictured (l-r) at the annual delegate conference in May were: Dean Flanagan, student and new graduate officer; Bridget Ryan, student nurse, Galway-Mayo Institute of Technology, Castlebar; Melissa McGinley, ED staff nurse, Mayo University Hospital; and Regina Durcan, industrial relations officer, Galway office. Ms McGinley won the INMO preceptor of the year award for her help to motivate and inspire student Bridget Ryan who nominated Ms McGinley

For those of you who are close to qualifying, revalidation is only around the corner – it's time to gather your CPD evidence early.

Preceptor of the year

I would like to extend my congratulations to Melissa McGinley who is the winner of the INMO Preceptor of the Year award 2016, which was presented at the annual delegate conference.

Ms McGinley is a staff nurse in the emergency department at Mayo University Hospital and was nominated by Bridget Ryan who is a student in Galway-Mayo Institute of Technology, Castlebar. Well done to the two of them and I hope all students will continue to enter the competition next year after so many heartfelt entries to this year's awards.

Annual delegate conference motions

The Student Section committee was well represented at INMO annual delegate conference last month. The following motions were presented to conference and both were unanimously accepted by the delegates, this means that the INMO will now ensure that these motions are carried out.

The Student Section put forward a

motion calling for a clear definition of the role and working responsibility of supernumerary student nurses and midwives to include work exclusions, in the context of the 2012 Review of Undergraduate Nursing and Midwifery Degree Programmes by the Department of Health, and the 2016 NMBI Nursing and Midwifery Registration Programmes standards and requirements.

In another motion of interest to students and new graduates, the Dublin Youth Forum Conference called on the NMBI, the HSE and all related national universities to standardise the national undergraduate nursing programme. The aim of this is to prevent the existing discrepancies in training, including in placement hours, scope of practice and module content.

Internship pay rates

At this stage, all internship students should be receiving their correct pay rates. Some areas have taken longer than others to implement these and the slower areas have been contacted. If there are any students not receiving the new pay rate, please contact me at email: dean.flanagan@inmo.ie

Dean Flanagan is INMO student and new graduate officer

Radical rethink of health and safety in EDs



INMO organiser **Albert Murphy** focuses on recent activities aimed at enhancing the structures and supports offered to members throughout the country

UNDER the WRC emergency department agreement, each ED is designated as an employment in its own right and therefore all EDs are required to have a health and safety representative.

The role of the health and safety representative is enshrined in health and safety legislation. This legislation confers a number of rights and functions on safety representatives. However, it is clear that the responsibility for ensuring that the workplace is healthy and safe rests with the employer and each employer is required to have a designated safety officer with responsibility for ensuring employees' health and safety.

The INMO has designed a new health and safety training course specifically in relation to the recent WRC ED agreement. The Organisation held its first training course on health and safety for ED reps in INMO HQ last month, which was attended by 12 of the ED representatives.

Dave Hughes, INMO deputy general secretary, gave a presentation to attendees on the importance of the health and safety reps in the context of the new agreement.

Mr Hughes said: "This is a radical rethink by the INMO in relation to health and safety in EDs. For far too long EDs have treated the abnormal as normal and this needs to be changed. An important step in this is the appointment of safety reps working in EDs who will have the experience and knowledge of their own EDs. The



Fergus Whelan (back row, far left), ICTU; Albert Murphy (back row, far right), INMO organiser; and Dave Hughes (back row, third from left), INMO deputy general secretary, pictured with ED reps at the inaugural INMO health and safety training course. The course was specifically designed by the INMO in relation to the recent WRC ED agreement

INMO intends to invest in training of ED reps to ensure the safety of staff in these departments. This course is a new departure as it focuses on the health and safety of employees as well as of the patients."

A presentation was also given by Marian Geoghegan, senior training and industrial relations officer with the Financial Services Union. She spoke on health and safety legislation and the role of the safety rep.

Finally Fergus Whelan, industrial relations officer, Irish Congress of Trade Unions, gave a presentation on risk assessment and a talk on how it was used in the construction industry to improve health and safety. There was a lively debate among the attendees on the course and it is intended to have a further course for the remaining INMO ED reps in the near future.

ADC recruitment and retention

At this year's annual delegate conference the recruitment and retention stand proved a big hit with delegates and we are glad to report that James Geoghegan, outgoing

member of the Executive Council, won the prize for a weekend for two following the draw held for delegates who completed an application form for a new member.

Delegates had the opportunity to meet Alastair Foley from Group Scheme who was able to assist members in relation to the INMO Group Scheme. The Group Scheme also ran a competition for a voucher for €300 for SuperValu. It is hoped that delegates will actively recruit new and existing nursing staff to the INMO, which is the voice of the nursing and midwifery in Ireland.

Upcoming training courses

A basic reps training course will take place in Letterkenny on Thursday, July 14 and Friday, July 15 in Mount Errigal Hotel, starting at 2pm on Thursday and continuing for a full day on Friday. Another rep training course will take place in Galway in September. The dates for this course will be confirmed shortly.

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

Is your INMO membership up to date?

In difficult times the INMO will be your only partner and representative.

If you are not a fully paid up member, you cannot avail of the Organisation's services and support in such critical areas as: Safe practice, fitness to practise referrals, pay and conditions of employment, other workplace issues and continued professional development.

Please advise the INMO directly if you have changed employer or work location

Contact the membership office with any updates through the main INMO switchboard at Tel: 01 6640600 or email: membership@inmo.ie

Important message from the INMO

Parkinson's disease

Continuing the continuing professional education series, Catherine Lewis, Nina Thirlway and Gerry Morrow discuss management of Parkinson's disease



PARKINSON'S disease is a chronic, progressive neurological condition that currently has no cure. James Parkinson, whom the disease is named after, described the condition in a paper entitled *An essay on the shaking palsy* in 1817.¹ It affects around 9,000 people in Ireland, which equates to one in 500 of the population.² While Parkinson's disease is a common condition in older people, one in 20 people who are diagnosed are under the age of 40.²

Parkinson's disease results from the loss of the dopamine-containing cells in the *substantia nigra* section of the brain. Dopamine is linked to movement, thinking and emotion, hence the range of symptoms caused by a loss of dopamine.

Parkinson's disease is the most common form of Parkinsonism. This is an umbrella term for the clinical syndrome which involves slowness of movement plus at least one symptom of tremor, rigidity and/or problems with posture. Other causes of Parkinsonism include medical conditions such as strokes, Lewy-body dementia, supranuclear palsy and also medications.

It is often not possible to distinguish between Parkinson's disease and Parkinsonism caused by medication. However, Parkinsonism caused by medication usually presents with symptoms that are rapid in onset and affect both arms and legs. These patients often have no rigidity or resting tremor, but they have an 'action' tremor (a tremor on movement). Drugs that can possibly cause Parkinsonism include antipsychotics, anti-emetics and, more rarely, antidepressant medications.

Parkinson's disease is usually slowly progressive but the prognosis varies between individuals. People with early-onset disease may have a later onset of motor (movement) complications and cognitive impairment. The mortality rate for older people with Parkinson's disease is two to five times higher than for people of a similar age who do not have Parkinson's disease.³

Suspecting Parkinson's disease

Signs and symptoms of Parkinson's disease include:

- Bradykinesia – this is a slowness in

initiation of movement with reductions in speed and ability to perform repetitive actions, such as finger or foot tapping

- Hypokinesia – this is an overall decreased movement, eg. reduced facial expression, arm swing while walking, or amount of eyelid blinking
- Difficulty with fine movements such as buttoning clothes and opening jars, or small, cramped handwriting (micrographia)
- Slow, shuffling, gait (rapid, small steps), or difficulty turning in bed

In addition, the person typically presents with at least one of the following motor signs of the disease:

- Stiffness, rigidity with or without tremor felt when a limb is flexed by someone examining a patient
- Resting tremor – this tremor usually improves when the patient moves, with mental concentration, and during sleep. This may affect the thumb and index finger ('pill-rolling'), the wrist, or the leg. It may also affect the lips, chin and jaw, but rarely involves the head, neck or voice
- Postural instability suggested by the 'pull test' – a tendency to stumble backwards after a sharp pull on both arms from the examiner.

These clinical features are usually unilateral in early disease, but may become bilateral in later disease.

Depression, anxiety, fatigue, reduced sense of smell, cognitive impairment, sleep disturbance and constipation may also be present in early disease and may precede the movement (motor) symptoms and signs described above.

Complications of Parkinson's disease

People with Parkinson's disease may develop a range of motor and non-motor complications.

Motor complications (often as a direct result of anti-parkinsonian medication) include immobility, slowness, communication difficulties, involuntary muscle movements, impairment of muscle movement, freezing of gait and falls.

Two-thirds of people with Parkinson's disease fall each year, and most people

with Parkinson's disease will eventually fall, but early onset of falls may indicate an alternative cause of Parkinsonism such as progressive supranuclear palsy. Falls are usually caused by many factors. These can include freezing of gait, postural instability, postural hypotension, cognitive impairment and environmental factors.

Non-motor complications include depression, anxiety, apathy, psychosis, dementia, sleep disturbance, constipation, postural hypotension, dysphagia and weight loss, excessive salivation and sweating, bladder and sexual problems, and pain. These may be symptoms of Parkinson's disease, complications, or side-effects of anti-parkinsonian medication. Most people are affected by non-motor problems as late complications of Parkinson's disease.

Depression is very common in people with Parkinson's disease, and may affect up to 50% of people. It is thought that depression is underdiagnosed as some clinical features of Parkinson's disease, including reduced facial expression, sleep disturbance and cognitive impairment, overlap with symptoms of depression. Family or carers can provide valuable information to help make the diagnosis of depression.^{4,5}

The risk of dementia is two to six times higher in people with Parkinson's disease than in healthy people.⁴ About one-third of people with Parkinson's disease have some cognitive impairment at diagnosis, and it is estimated that 24-31% of people with later Parkinson's disease have Parkinson's disease dementia.^{4,5}

Excessive daytime sleepiness and dozing affects 15-54% of people with Parkinson's disease. Sleep disturbance is thought to be caused by degeneration of sleep regulation centres in the brainstem as well as physical complications such as being unable to turn over in bed, restless legs and vivid dreams related to anti-parkinsonian medication.^{4,5} People who have sudden onset of sleep without awareness or warning signs should be advised not to drive and to think about avoiding other potential hazards in their daily lives, such as climbing ladders.

Swallowing difficulties may affect up to 95% of people with Parkinson's disease. Excessive salivation or drooling occurs in 70-80% of people with Parkinson's disease and may be more common in men.^{4,5} Referral to a speech and language therapist should be made promptly for full assessment and swallowing advice.

Up to 75% of people with Parkinson's develop urinary symptoms. Nocturia, daytime urgency, frequency and urge incontinence are common. Alteration of antiparkinsonian medication or adding an antimuscarinic drug such as oxybutynin, may help symptoms.

Erectile dysfunction is more common in men with Parkinson's (affecting 60-70% of men) than in age-matched controls (38%).⁴ Men with Parkinson's disease may also experience sexual dissatisfaction and premature ejaculation. Dopaminergic drugs can also induce hypersexuality, even when there is erectile dysfunction. In women, difficulties with arousal, low sexual desire, and anorgasmia are common.^{4,5}

Pain occurs in up to 60% of people with Parkinson's disease and often worsens during the course of the disease. Musculoskeletal pain, pain on movement and neuropathic pain are all common. Pain can be managed with simple analgesia or referral to physiotherapy or pain management services as appropriate. Pneumonia is a leading cause of death in the later stages.

Anti-parkinsonian medication

Anti-parkinsonian medication such as levodopa is used to replace the dopamine lost in Parkinson's disease and provide symptomatic relief. A dopa decarboxylase inhibitor such

as co-beneldopa or co-careldopa is usually given with levodopa to reduce some of the potential side-effects caused by levodopa. Anti-emetics should be avoided as they can cause or exacerbate Parkinsonism.

The benefits of anti-parkinsonian medication can reduce over time, which can lead to rapid fluctuations in symptom relief due to changes in response to the treatment. This usually occurs after several years of use.

Anti-parkinsonian medication should be initiated on the advice of a Parkinson's disease specialist. A regular medication review should be undertaken and should include asking about problems with medication and any adverse effects. Adverse effects of anti-parkinsonian medication in addition to nausea include dizziness, drowsiness, hallucinations and abnormal movements.⁵

Referral and management plans

People with suspected Parkinson's disease should be referred urgently, and untreated, to a specialist in movement disorders for confirmation of the diagnosis. In the UK, the NICE recommends that people with suspected mild Parkinson's disease are seen within six weeks, and people presenting with later, complex disease are seen within two weeks. The aim of a quick referral is to reduce potential psychological distress caused by a delay in diagnosis.

If Parkinson's disease is suspected, but the person is taking a drug known to induce Parkinsonism, the drug should be reduced or stopped if possible. Referral should not be delayed to assess the response.

A person with confirmed Parkinson's disease should be managed by a specialist multidisciplinary team including a

Parkinson's disease specialist nurse who will monitor the person and help manage symptoms and complications.

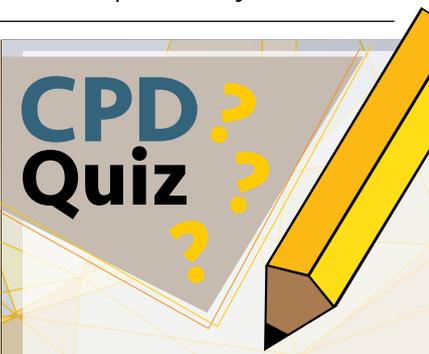
Referral to speech and language therapy, physiotherapy, occupational therapy, adult social care, community nursing, continence and urology specialists, and psychology and mental health services, should be considered for each person affected. The needs of any carers should also be assessed, and the option of respite care discussed. For people with end-stage Parkinson's disease, end-of-life discussions should be offered, including advance care plans and advance decisions.

If the person drives at the time of diagnosis and if there is a change in their clinical condition, they should be advised to inform the Road Safety Authority and their car insurer. It is helpful to provide people with Parkinson's and their family/carers with sources of information such as www.parkinsons.ie and www.hse.ie/eng/health/az/P/Parkinson's-disease/

Catherine Lewis is a clinical author at Clarity Informatics, Nina Thirlway is a senior information analyst, and Dr Gerry Morrow is editor and medical director at Clarity Informatics

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CPD Quiz

There may be more than one correct answer to questions listed here. The correct answers are those deemed most appropriate by the authors in the context of this CPD article.

1. Parkinson's disease results from:

- A) Loss of dopamine
- B) High levels of dopamine
- C) High levels of serotonin
- D) Loss of serotonin

2. Symptoms of Parkinson's include:

- A) Difficulty buttoning clothes
- B) Small, cramped handwriting
- C) Slowness in moving
- D) Reduced facial expression

3. Complications of Parkinson's include:

- A) Falls
- B) Reduced vision
- C) Dementia
- D) Sleepiness

4. Over a long period of time, anti-parkinsonian medication usually:

- A) Becomes more effective
- B) Becomes less effective
- C) Remains consistent
- D) Needs to be doubled in dose

5. Referral to the following services should be considered for people diagnosed with Parkinson's disease

- A) Speech and language therapy
- B) Occupational therapy
- C) Community nursing
- D) Physiotherapy

After reading this article you may wish to reflect on what you have learned, how this might be applied to your own work and to make a note of this in your portfolio.

Answers for the CPD multiple choice quiz appear in the inverted text box below.

For further information and resources: www.clarity.co.uk



Critical career pathway in paediatrics

Despite the challenges, Elaine O'Rourke finds working in a paediatric ICU extremely rewarding. She spoke to Ann Keating about her career to date

ELAINE O'Rourke is a clinical nurse facilitator at the paediatric intensive care unit (PICU) at Our Lady's Children's Hospital, Crumlin (OLCHC). The PICU is a 23 bed unit split over two floors and is one of the largest in Europe. In the unit, Elaine has a varied and dynamic role which she really loves.

"We care for children from birth to 16 years of age from all specialties including cardiac surgery, haematology/oncology, burns, ENT, sepsis and shock", she said.

Elaine did her training in University College Hospital Galway and worked there for three years completing her BSc in nursing, before heading to Australia for a short period as an agency nurse. On her return she moved to Dublin to undertake the higher diploma in children's nursing course through UCD and OLCHC.

With nine years working in the PICU now under her belt, Elaine says the career pathway and supportive environment in the unit encourages progression of nursing skills and there is constant encouragement to develop your PICU skillset. This was developed and is facilitated by a robust education team, which she is now a part of herself. All new nurses undergo a six-week PICU orientation divided into two weeks theory and four weeks supernumerary periods working with a preceptor. Education programmes to promote staff development within PICU include basic and advanced ventilation study days, a nine-month level 8 PICU foundation programme accredited through UCD, the level 9 graduate diploma in critical care nursing (children's), access to paediatric life support (PLS) and advanced paediatric life support (APLS) courses, haemofiltration training programme and extracorporeal life support (ECLS) training programme. In addition there is a varied timetable of training days such as tracheostomy care, breastfeeding and haematology/oncology study days run through the Centre of Children's

Nurse Education (CCNE). This gives staff many opportunities to specialise within the PICU.

This support and encouragement has seen Elaine progress from staff nurse through this PICU career pathway, initially completing the Foundation Programme in PICU. She went on to achieve a distinction in the graduate diploma in paediatric critical care in UCD in 2010. In 2012 she did APLS training. In 2014 she again achieved a distinction in her research masters in the RCSI where she completed a study on the pain/distress scale (COMFORT-B) for paediatric critical care patients funded by the National Children's Research Centre. She presented her study at the 5th Congress of the European Academy of Paediatric Societies in Barcelona, Spain.

Her current post in PICU is divided between PICU and the newly formed Irish Paediatric Acute Transport Service (IPATS). Her primary role is as a clinical nurse facilitator, supporting the educational needs of existing and new staff, and she also works as a staff nurse delivering bedside care to PICU patients reflecting the resourcefulness and dynamism required from nursing currently.

Set up in October 2014, IPATS is part of the National Transport Medicine Programme (NTMP). It is a dedicated team of specialists who support the transfer of critically ill infants and children who require PICU admission, providing expert care for the child throughout the process. Being out in the ambulance is very different from working in the PICU where you have an entire team behind you. Commitment, clear communication, professionalism and expertise are whole heartedly required. It is an exciting collaborative project aiming

to achieve the best patient outcome. IPATS transfer critically ill infants and children to the PICU in OLCHC and Temple Street Children's University Hospital.

Elaine believes being a staff nurse in PICU is challenging and compelling but above all else the most rewarding job you could possibly ask for. "It is difficult to express the trauma critically ill children and their families experience and it is a huge task to meet their complex needs. Care, compassion, commitment and motivation for excellence in nursing are among the many skills that are needed to provide the highest level of care to PICU children". In OLCHC there is a diverse team who work incredibly hard together to provide the best care for the most vulnerable children. Elaine is "very proud" to work as part of this team.

Elaine is newly married and would not rule out further education in the future. With such a busy work environment, she relaxes on her time off with walking, Pilates and visiting family and friends, with a little bit of baking thrown into the mix! Elaine wants to thank her amazingly supportive education and nursing colleagues in PICU, her managers Lorraine O'Reilly and Tracey Wall, her IPATS coordinators and team and the former OLCHC research nurse Claire Magner for all their constant encouragement and support throughout her career to date.

Ann Keating is INMO media relations officer



Elaine O'Rourke presenting to the 5th Congress of the European Academy of Paediatric Societies in Barcelona, Spain

A hidden trauma

Keeping it secret – Sylvia Murphy Tighe and Joan G Lalor explore concealed pregnancy in 21st century Ireland

CONCEALED pregnancy as a social issue remains a contemporary problem in Ireland and internationally. It is a complex process which involves hiding a pregnancy and can lead to maternal or neonatal morbidity or mortality.¹

Many still believe that women and young girls conceal their pregnancy because of the stigma related to pregnancy before marriage, but it is much more complex than that. Understanding why women conceal a pregnancy will help in offering responsive care to women and may have a positive impact on consequences such as birthing alone or neonatal abandonment. Concealed pregnancy is a complex phenomenon, where a woman is aware of her pregnancy and copes by keeping it secret and hidden.¹

Prevalence rates of concealed pregnancy (see Table 1) are difficult to establish because of the nature of the phenomenon and the way in which countries collect population-based data. The Confidential Enquiry into Maternal Deaths² and Serious Case Reviews of infant deaths in the UK have identified some of the risks of concealing a pregnancy, including unassisted birth, maternal death, neonatal death, newborn abandonment and neonaticide.¹

The Keeping it Secret (KISS) Study

Our research, funded by the Health Research Board, the Keeping it Secret (KISS) Study involved exploring the nature and impact of the experience of concealed pregnancy for women. We have interviewed 30 women up to three times who were concealing or had concealed a pregnancy in the past.

Definitional confusion around concealed pregnancy and what it is and is not is problematic.^{1,3,4,5} This ambiguity has hindered the development of responsive services to support women concealing a pregnancy and their choices. Consequently, one of the aims of the KISS study was to generate a new definition for concealed pregnancy and the characteristics of the process to assist understanding (see Table 2).

Concealed pregnancy is a complex, multidimensional and temporal process where a woman is aware of her pregnancy

Place of study	Prevalence rate	Methodology
Ireland (rural area)	One in 146 (20 weeks gestation)	IPA and quantitative retrospective case control study ⁴
Ireland (rural area)	One in 403 (20 weeks gestation)	Case study ³
Ireland (urban area)	One in 625 (20 weeks gestation)	Case study ³
Germany	One in 475 (until birth)	Case study ⁵
US	One in 516 (20 weeks gestation) One in 2,500 (birth)	Exploratory retrospective medical record review ²⁰
Wales	One in 2,500	Retrospective population-based study over 11 years ²¹

Antecedents	Attributes	Consequences
<ul style="list-style-type: none"> Aware of pregnancy Fear (of others or for others) Compares own situation to societal norms and expectations Context - relationship/finances/culture/religiosity Perceives a lack of support or mechanism to mother infant 	(Internally or externally mediated) <ul style="list-style-type: none"> Secrecy Hiding Daytime story (cover story) Staying away Avoidance 	Woman <ul style="list-style-type: none"> Maternal death Self harm/suicide Mothering/termination of pregnancy - forced or voluntary Recurrence Infant <ul style="list-style-type: none"> Neonatal death Abandonment/neonaticide Fostering/adoption Parented Society <ul style="list-style-type: none"> Increased child surveillance Anonymous birthing Baby hatches

and copes by keeping it secret and hidden. Behaviours such as avoidance, hiding, using a daytime story, staying away and secrecy are key characteristics of a concealed pregnancy. Fear (of others or for others) is central to the process and an interaction with another antecedent, eg. context/culture or a perceived lack of support to a mother and her infant, leads to concealing a pregnancy. It is a difficult and traumatic experience for the woman. Variations in the duration of concealed pregnancy exist and recurrence may feature in this process.¹

The Ann Lovett and Kerry babies cases are perhaps the most publicly known examples of concealed pregnancy in Ireland. However, more recent incidences include a case in July 2013, when a newborn infant

was found dead in Cork after being born in a toilet.⁶ The following year in 2014 the media reported on a newborn infant's body that was found in a bin,⁷ and again recently a newborn infant's body was found in Wicklow, likely abandoned after a concealed pregnancy. Last year, a newborn (baby Maria) was found on the roadside in Dublin.⁸ The media captured pleas made by a Garda and a social worker asking Maria's mother to come forward, and although reassurances were given that the mother was not in trouble, this was at odds with images of Garda checkpoints searching for the mother seen on TV and in newspapers.

Lest we believe that this phenomenon is peculiar to Ireland, such cases have also occurred in Wales and Australia.^{1,9}

In 2014 in Australia a newborn baby was found alive but hidden in a storm-drain,¹ also following a concealed pregnancy. At the same time, a second case emerged which involved a young Irish backpacker in Australia who gave birth alone and then concealed the body of her stillborn baby.¹¹ She revealed the situation to friends days later and was charged by police for concealing a birth. The response to charge this young woman with a criminal act and subsequently incarcerate her, demonstrates a serious lack of understanding of the process of concealing a pregnancy and will do little to encourage women who are distressed and traumatised by being pregnant to come forward to access help.

These tragic cases serve to highlight that concealed pregnancy remains problematic today. As a nation we might wish to forget our dark history of mother and baby homes, Magdalene laundries and forced adoptions.^{12,13,14,15} However, concealed pregnancy is real, is happening today and needs an effective response if we are to mitigate the worst possible outcomes.

Who conceals a pregnancy?

The notion that only young women and girls conceal pregnancy is a fallacy.^{1,2} Concealed pregnancy crosses many boundaries and in fact a woman may be in a relationship, married with children and financially secure. As pregnancy outside of marriage is now generally accepted, concealment is sometimes viewed as an abnormal response to a crisis pregnancy.

Although women who experience a concealed pregnancy report it is a distressing time where they often have no support,¹⁶ it is still the case that some authors approach this event as being related to a pathological disorder such as psychosis or mental ill health.^{17,18,19} The potential exists for women who conceal a pregnancy to become pathologised and stereotyped as mentally ill, despite little evidence to support this.¹

Women have described the time when they were concealing a pregnancy as a bleak, desolate and lonely period in their lives.^{1,3} Women in the KISS study were fearful of the pregnancy becoming known and many sought antenatal care late in their pregnancy, if at all. One participant in the study said: "To this day, the official story I tell my family is that I did not know I was pregnant." This woman was aware of her pregnancy but reported she felt disconnected, shut down and paralysed by fear. Another participant who hid her pregnancy said "my plan was to show up, have the baby, hand it over and walk away", as she

feared others would influence the outcome.

It must be recognised that women who experience a concealed pregnancy may have had no healthcare or support during their pregnancy, and some have had traumatic experiences in their lives such as domestic violence, child sexual abuse or a sexual assault.¹ Contemporary society imposes expectations on pregnant women that discourages the expression of ambivalent or conflicted feelings. The silence and lack of discussion around conflicted feelings about a crisis pregnancy is problematic.¹

Key learning points for midwifery and nursing practice

- Women can experience such intense levels of paralysing fear while concealing a pregnancy that they may risk their own lives and that of their infant
- Women may conceal a pregnancy if they fear significant others will dictate the outcome, eg. forced termination, forced adoption or forced mothering
- Some women in the KISS study who concealed a pregnancy had experienced pre-pregnancy trauma such as child sexual abuse, sexual assault or were in a relationship characterised by violence
- It is essential that concealed pregnancy is viewed as a trauma rather than through a biomedical lens that presumes mental ill health is a causative factor
- Some women report that a concealed pregnancy is a life-altering experience with major consequences including depression, self-blame, complicated maternal-infant attachment, self-harm and suicidal ideation and intent
- Accessible integrated care pathways are urgently required so women can obtain antenatal care and privacy and confidentiality to make an informed decision regarding themselves and their babies.

Critical need for support

Midwives may meet women who are concealing their pregnancy in advanced gestation or during labour. It is critical that midwives are compassionate, non-judgemental and provide empathic listening. Sensitive enquiry about support available to the woman may reveal a hidden story.

The therapeutic relationship at the heart of midwifery care is essential when working with a woman who is experiencing a concealed pregnancy. Recognising that concealed pregnancy is still occurring is the first step to preventing abandonment, neonaticide and negative outcomes for women.

Online information about concealed pregnancy, telephone helplines providing

a listening service and non-directive and therapeutic counselling are essential. Integrated care pathways for women are urgently required in order to decrease missed opportunities for engagement with women who conceal a pregnancy. If midwives do not recognise that concealed pregnancies still occur, healthcare systems will continue to fail women and their babies.

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Focused interventions for injecting drug users

Marcus Keane and Sereena Hogarty discuss the need for supervised injecting facilities as a safer alternative to addicts injecting in public

SINCE 2012, the introduction of supervised injecting facilities in Ireland has been a strategic priority of the Ana Liffey Drug Project, which works with more than 2,500 injecting drug users in Dublin, the Midlands and the Midwest.

In 2015, following work with the Voluntary Assistance Scheme of the Bar of Ireland, the Ana Liffey Project presented draft legislation to then Minister of State, Aodhán O'Riordáin, that, if enacted, would create a framework for supervised injecting facilities to operate in Ireland. Last December, Leo Varadkar, Minister for Health, brought the matter before Cabinet and a decision was taken to introduce the legislation calling for supervised injecting facilities.

What are supervised injecting facilities?

Supervised injecting facilities are a subset of drug consumption rooms. They are places where injecting drug users can inject drugs in a clinical space, under medical supervision. They are often conflated with other types of intervention, so it is useful to set out what is meant by supervised injecting facilities and how they are conceptualised.

Supervised injecting facilities should not be confused with heroin assisted treatment, which involves the prescription of heroin and its supervised use to entrenched users. Supervised injecting facilities do not prescribe or otherwise provide drugs to users, but rather users bring their own (often illegally obtained) drugs to the centre.

These injecting facilities focus specifically on injecting drug use. While drug consumption rooms more broadly can (and often do) permit drug use by other routes of administration, supervised injecting facilities are

restricted to injecting drug use.

These injecting facilities are not standalone facilities. They are a focused intervention aimed at a particular cohort of hard-to-reach drug users who are often isolated from mainstream services. Such facilities need to have strong links and referral pathways to other, higher threshold, services.

Finally, supervised injecting facilities are primarily clinical services. The focus is on ensuring addicts use drugs in the safest manner possible, that there is medical support and overdose monitoring immediately available onsite.

How do injecting facilities operate?

As with any service, there is more than one model of service provision available, and supervised injection facilities operate in different ways around the world. Regardless of the exact model used, facilities tend to follow the same basic footprint.

Users first enter into a reception area, where they either undergo a brief assessment (if it is their first time using the service) or confirm their identity (if they've used the service before). Basic information concerning the addict's recent drug use and intended use in the centre can be relayed to staff in the injecting space. Following this, they move through into the injecting space. This is typically a nurse-led space where users can access clean injecting equipment and harm reduction advice. There are also injecting booths, where client can sit to prepare and use their drugs.

Clients are monitored for medical issues including overdose and/or paradoxical reactions, and the injecting space is equipped to deal with such issues. There

is no report of a death from overdose in a supervised injecting facility anywhere in the world. Once the user is finished in the injecting space they move through to a more social space, where social care staff can offer advice, onward referral to other services and other support.

Injecting facilities have been shown to improve both health related indicators for drug users and broader environmental indicators such as the reduction of unsafely discarded paraphernalia.

In its *European Drug Report 2015*, the European Monitoring Centre for Drugs and Drug Addiction noted that: "The benefits of providing supervised drug consumption facilities may include improvements in safe, hygienic drug use, especially among regular clients, increased access to health and social services, and reduced public drug use and associated nuisance. There is no evidence to suggest that the availability of safer injecting facilities increases drug use or frequency of injecting. These services facilitate rather than delay treatment entry and do not result in higher rates of local drug-related crime."¹

Similarly, a report commissioned by the Joseph Rowntree Foundation in 2006 found that there is no evidence that such services either increase or decrease an individual's drug use, or that they act as a magnet for drug users. However, they were associated with a reduction in injecting in public places and a reduction in discarded used syringes and drug-related litter.² For example, in Barcelona, a fourfold reduction was reported in the number of unsafely disposed syringes being collected in the area from a monthly

average of over 13,000 in 2004 to around 3,000 in 2012.³ Other positive findings include evidence that supervised injecting facilities can be a successful gateway to treatment⁴ and can reduce ambulance call-outs for drug overdoses.⁵

As noted earlier, it is important that such facilities are provided, not as standalone services, but as a response that is integrated into current service provision. The European Monitoring Centre for Drugs and Drug Addiction states that: "In settings where there is a demonstrable need for drug consumption rooms, their development and the extent to which they can achieve their objectives is tempered by the broader social and policy context. A qualitative assessment of the literature suggests that drug consumption rooms can only be effective if they are:

- Integrated into a wider public policy framework as part of a network of services aiming to reduce individual and social harms arising from problem drug use
- Based on consensus, support and active cooperation among key local actors, especially health, police, local authorities, local communities and consumers themselves
- Seen for what they are, that is, specific

services aimed at reducing problems of health and social harm involving particular high-risk populations of problematic drug users and addressing needs that other responses have failed to meet."⁶

It is beyond doubt, particularly in Dublin, that such supervised injecting facilities are much needed and, despite our best efforts, existing services do not meet the health needs of injecting drug users.

A 2005 study showed that 68% of 66 homeless intravenous drug users reported injecting in a public place in the previous month.⁷ A client survey carried out by the Ana Liffey Drug Project in 2008 found that of the 16 respondents who reported where they had injected 30 days prior to interview, nine respondents (56%) stated that they had used in public places.⁸

In 2014, Merchants Quay Ireland reported that 44 (14%) people from their sample who used the needle exchange service generally injected in public places.⁹

At Ana Liffey, there is an assertive case management team tasked with working on a street outreach basis with the most marginalised and hard to engage people. Through this service, the project currently case manages over 40 individuals, the

majority of whom inject in public.

The Ana Liffey Drug Project could improve drug users' health and service engagement greatly by being able to provide a safe space where users could inject with medical supervision.

Marcus Keane is head of policy, Ana Liffey Drug Project and Sereena Hogarty is an RGN working with the Ana Liffey Drug Project

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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.

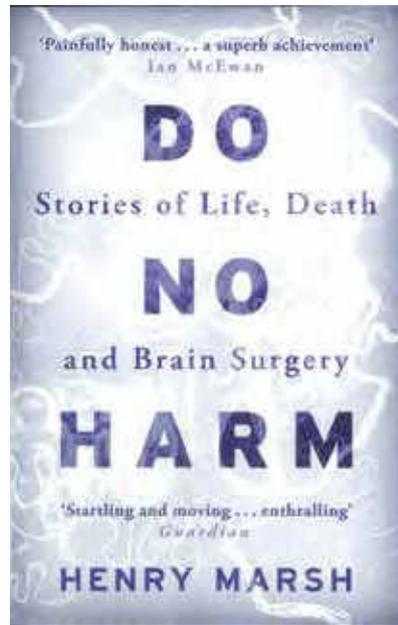
'First, do no harm...'

Henry Marsh, in his *Do No Harm, Stories of Life, Death and Brain Surgery*, chose to use part of the well known expression *Primum non nocere*, or 'first, do no harm' for the title of this book of atonement. The phrase, most commonly attributed to Hippocrates of Kos, can also be found, if not in the exact words, in the Hippocratic Oath – an oath historically taken by all physicians.

I call this a book of atonement because while the book contains many stories of intriguing, fascinating and extraordinarily complicated (at least to the lay person) brain surgeries, it is foremost an honest account of the life of a brain surgeon.

In Henry Marsh's own words: "I have made many patients very happy with successful operations, but there have been many terrible failures and most neurosurgeons' lives are punctuated by periods of deep despair."

While I will not remember the complex terminology, such as choroid plexus papilloma, neurotmesis, hubris, anaesthesia dolorosa or haemangioblastoma, I will remember the feelings revealed through the patient encounters Henry Marsh describes. He doesn't hide from failure, nor does he dwell on them. Like any surgeon,



he has had to learn from the 'occasionally awful consequences'.

Henry Marsh is not only an accomplished neurosurgeon, he is also an incredible storyteller. *Do No Harm* is a compassionate account of a professional life spent in a job that has huge highs and desperate lows. The stories are moving,

compelling and sometimes raise tears.

Perhaps Henry Marsh's ability to write such an absorbing piece of work can be explained by his background. His career path didn't start in medical school, rather he ended up on this path after spending many years doing English, Latin and Greek, and studying politics, philosophy and economics.

He took a break in his studies and spent six months as a hospital porter in a mining town in the north of England, where he spent his spare time writing what he describes himself as 'second-rate, self-obsessed poetry'. And then, "having spent six months watching surgeons operating I decided that this was what I should do", and that is what he did.

Many will be grateful Henry Marsh ended up in a career as a neurosurgeon, others will perhaps not. Either way, his memoir is a brilliant piece of work that deserves all the praise it gets. It is without doubt the best work of non-fiction I have read so far.

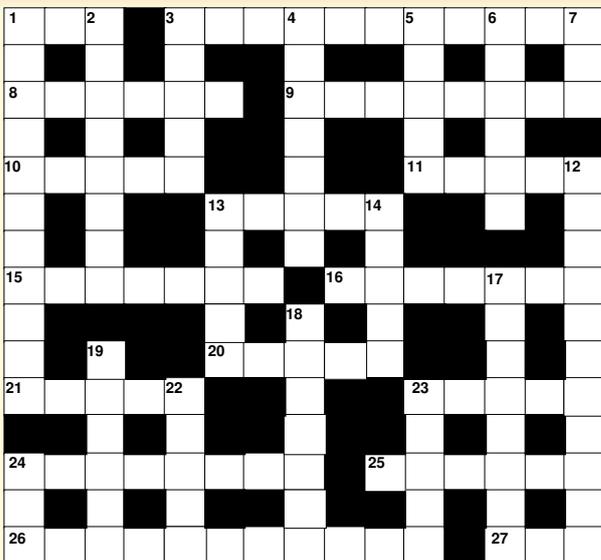
– Sonja Storm

Do No Harm, Stories of Life, Death and Brain Surgery is published by Weidenfeld & Nicholson. RRP €14.20 ISBN 978-1-7802-2592-0

Crossword Competition



WIN A €30 BOOK TOKEN



Across

- In what way is that a hot sound of pain? (3)
- Office machine (11)
- A professor is a handsome chap (6)
- Give the name of someone or something (8)
- River which flows through Rome (5)
- Laws, regulations (5)
- Part of a jacket (5)
- Vote back into power (7)
- Stir it up (7)
- Give the prisoner an Ulster river (5)
- Bird with black plumage (5)
- Parts of the skeleton (5)
- Happen at the same time as (8)
- Make something from nothing (6)
- Outlaws featuring in the strange 'deep roses' ad (11)
- Small drop of alcohol, or a little child (3)

Down

- It's an unhealthy sign to have earth-moving make a little noise (5,6)
- Honeysuckle (8)
- Abbot's deputy (5)
- Muscle will rip itself asunder (7)
- Possessor (5)
- Frozen appendage (6)
- Sunbeam (3)
- Accountants' tool or part of the instructions for making the bed? (11)
- In the neighbourhood (5)
- Behold, travel north to make use of the internet (3,2)
- Plentiful (8)
- One as brainy as Humpty Dumpty? (7)
- Dodges make the diva so distressed (6)
- A nook or shelf (5)
- Makes the sound of a dog (5)
- Seafish (3)

Solutions to May crossword:

Across:

- Wan
- Rescheduled
- Italy
- Executed
- Frank
- Respond
- Captain
- Motel
- Spare
- Dared
- Rap music
- Odds on
- Tracheotomy
- Owe

Down

- Waiting room
- Nitrates
- Rocky
- Cheddar
- Decor
- Did
- Dinner dance
- Funds
- Knave
- Al fresco
- Manx cat
- Utopia
- Laugh
- Dodgy
- Rat

The winner of the May crossword is:
Theresa Gould, Montenotte, Cork

Name:
Address:

The prize will go to the first all correct entry opened.

Closing date: Tuesday, June 21

Post your entry to: Crossword Competition, WIN, MedMedia Publications, 17 Adelaide Street, Dun Laoghaire, Co Dublin

Obituary: Mary Walsh



IT IS with great sadness, and deep sorrow, that the INMO learned of the death on May 12, 2016 of our friend, colleague and stalwart member, Mary Walsh from the Sligo Branch.

Mary was a member of the outgoing Executive Council and had been active, in various roles, in the Sligo Branch for many, many years.

"Mary was known for her quiet, solid and steadfast commitment, to members and the ideals of the INMO, and will be

deeply, deeply missed. Our thoughts and prayers are with Mary's family and friends, at this sad time, as we have all lost a lovely, caring lady and colleague," said INMO general secretary Liam Doran.

Mary retired from her staff nurse post in Sligo General Hospital last year, where she had been an INMO rep for many years. She served several terms as a member of the INMO Executive Council, on which she used every means available to her to assist members with workplace issues. Writing in *WIN* last year, Mary said that safety, health and welfare at work was her top priority.

May Mary Rest in Peace.



At the recent Intensive Care Unit Nursing Conference in Tallaght were: Maire Gilmartin (left), physiotherapist, St Vincent's University Hospital; and Eimear Fitzgerald, ICU nurse, Mater Hospital. The conference was addressed by experts in the area of critical care nursing and included topics such as subarachnoid haemorrhage, tracheostomy management and updates on organ donation. Ms Gilmartin facilitated a session on rehabilitation post-critical illness and Ms Fitzgerald facilitated a session on emotional and psychological support post-discharge to the ward and onwards

INMO celebrates international day of the midwife

THE INMO, as a member of the International Confederation of Midwives (ICM), the worldwide body for midwives, celebrated the International Day of the Midwife on May 5. The theme for this year's International Day of the Midwife was '*Women and newborns: The heart of Midwifery*'.

Every year, May 5 is dedicated to recognising that millions of women and newborns around the world are cared for by skilled midwives every day. Midwives have a central role in reducing maternal and newborn mortality and ensuring universal access to healthcare services.

The ICM, in celebrating the day, has

launched the annual campaign to highlight the important contribution that midwives make globally.

The INMO Midwives Section works closely with the ICM to promote, support and drive the strategic direction of midwifery practice and celebrate the value of midwives. The International Day of the Midwife is an occasion for every individual midwife to reflect on the difference midwifery makes globally and make new contacts within and outside midwifery.

INMO president Claire Mahon said: "The INMO has warmly welcomed the recent launch of Ireland's first National Mater-

nity Strategy, by the Minister for Health, entitled *Creating a Better Future Together: National Maternity Strategy 2016-2026*. It maps out how Ireland can improve maternity and neonatal care in the years ahead, ensuring that it is safe, standardised, of high-quality and offers a better experience and more choice to women and families.

"A national women and infants health programme is to be established, to drive forward the implementation of the strategy. The strategy must lead to a positive transformation, of maternity services in Ireland, with much improved staffing levels."

International Nurses Day: Improving health systems

THE INMO celebrated International Nurses Day on May 12. The theme for this year was *Nurses: a force for change – improving health systems' resilience*, which reflects the International Council of Nurses' (ICN) commitment for action to strengthen and improve health systems around the world.

ICN president Judith Shamian and ICN CEO Frances Hughes said: "It is imperative that we identify in our organisations and in ourselves, opportunities to strengthen and develop resilience. By promoting the nursing voice, we can help guide improvements in the quality of health service delivery and inform health systems' strengthening. Nurses' input into health

sector policies will help ensure that supportive work environments for practice are taken into account when policies are reformed."

In saluting nurses at home and abroad, INMO deputy general secretary Dave Hughes said:

"The theme for International Nurses Day underpins the simple, but vital, message that nurses play a central role in the provision of healthcare and have an important task in improving health system's resilience. For this to happen, governments must understand that a high-quality health service cannot be achieved without an adequate number of appropriately educated, empowered

and autonomous nurses. The nurse is, without doubt, the health professional closest to the population they serve and therefore must be centrally involved in making decisions for strengthening health services.

"At our annual delegate conference, members called for a universal healthcare service, funded by progressive taxation, which is efficient, effective and which treats everyone equally, with access being determined by need and not ability to pay. In this regard, we look forward to meeting with the new Minister for Health to discuss, along with other stakeholders, the development of a 10-year plan for the health service."

MONEY & MATTERS

Finding the right motor insurance

Marc Evans advises INMO members on choosing the best motor cover for their needs

MORE than one-third of Irish drivers have seen their insurance premiums rise by up to 30% this year. This is due to the increasing frequency of motor insurance claims, in particular, third party injury claims, in the market as a whole.

With premium increases across the market, a lot of drivers need to choose between the level of cover and the premium they can afford to pay. When looking for motor insurance it is important to make sure that you include the benefits that are important to you.

What type of benefits should I look for when buying a motor insurance policy?

No claims bonus protection

Your no claims bonus is a discount that is applied to your motor insurance policy in the event that you don't make a claim each year. Typically, you receive a 10% discount for each year you are claims free, normally up to a maximum of 50%. So when you are purchasing a policy, make sure to check the level of cover you are getting is adequate to protect this discount. Insurers often give you the option to choose between full or step-back no claims bonus protection:

- **Full no claims bonus protection:** With full no claims bonus protection you can ensure that in the event of a claim you retain your full no claims bonus discount. In some policies, you may have the option of two unlimited claims within a three-year period without affecting your discount
- **Step-back no claims bonus protection:** Step-back bonus protection will generally protect part of your no claims discount in the event of a claim. For example, if you had a 50% no claims bonus discount and were at fault for a claim, your provider may step back the bonus to 20%. The step back element prevents you losing your full discount.

Breakdown cover

For those unfortunate times when your car breaks down or won't start, breakdown assistance/cover is an important component of your car insurance policy. Normally



breakdown assistance comes within an hour with free roadside labour and a towing service to the nearest approved repairer also. It is always good to know you are covered for these unexpected situations.

Using your car for work

Many nurses and midwives working in the community and others use their car for work. If you are one of these people, it is important that your policy includes employer indemnity cover. Insurance companies who are not as familiar with the insurance needs of INMO members may charge additional fees and place limitations on the number of business miles you can clock up in a year. Make sure you are covered for unlimited business miles as standard.

Driving other cars

This benefit allows you to drive another person's private motor vehicle, so long as you are not the registered owner of the car. This can come in handy when helping out a friend or popping down to the shops in someone's car. The common level of cover when driving another person's car is third party only, but some insurance policies can offer comprehensive driving of other cars. Make sure to ask if you have the benefit and what level of cover you will have.

If I claim, does it cost me anything?

If you are claiming for an accident where you are at fault, you will generally have to pay in the region of €200–€500 towards the cost of the claim. This amount is known as the excess. When purchasing a

policy, choosing a higher excess will reduce the cost of your premium and opting for a reduced excess will in turn increase your premium fee.

Take the time to decide if reducing your premium weighs up favourably against the amount you would need to pay with an increased excess in the event of a claim.

Reducing a motor insurance premium

It is important to call and review your policy to make sure your details are accurate and up to date. Certain factors can reduce premium for some insurance providers for example:

- **Your annual mileage:** Make sure this is accurate. Often insurance rates can reduce for low mileage. So it's important to ask what mileage is stated on your policy and ensure that it is accurate
- **The right number of drivers:** Often people can have insured drivers named on their policy who do not use the car or may be able to drive other cars on their own policy, so be sure to review who is covered on your policy and then check what the price would be with just the necessary drivers
- **Second car discount:** Some insurers will reduce the cost of your car insurance premium if there is a second car in the household. Normally this option only applies when the drivers on the policy are you and your spouse/partner but if this applies to you, make sure to mention this when you are next getting a quote or renewing your policy.

Marc Evans is a director of Cornmarket Group Financial Services Ltd

The nurses and midwives car insurance scheme can offer INMO members and their partners three levels of cover: gold, silver and bronze. Join the 16,000 INMO members insured with this scheme by calling Cornmarket at Tel: 01 470 8042. The nurses and midwives car insurance scheme is devised and administered by Aviva Insurance Limited. Aviva Insurance Ltd, trading as Aviva, is authorised by the Prudential Regulation Authority in the UK and is regulated by the Central Bank of Ireland for conduct of business rules. Cornmarket Group Financial Services Ltd. is regulated by the Central Bank of Ireland. Cornmarket is part of the Great-West Lifeco group of companies, one of the world's leading life assurance organisations. Telephone calls may be recorded for quality control and training purposes

June

Thursday 9

ODN Section meeting. INMO HQ. From 6pm. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Saturday 11

Midwives Section meeting. 2pm. University Hospital Galway. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Wednesday 15

Director of Nursing/Midwifery/Public Health seminar from 12.30pm. Open to all directors of nursing and midwifery. See page 14. Booking essential. Please contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details or see www.inmoprofessional.ie

Friday 17

Emergency Nurses Section meeting. INMO HQ. 12pm-2pm. All interested members welcome to attend. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Tuesday 21

Care of the Older Person Section meeting. From 10am-1pm. Session on Tools for Safe Practice. Booking essential to obtain CEUs. Log onto www.inmoprofessional.ie or contact helen.oconnell@inmo.ie to confirm your free place

Friday 24

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

Saturday 25

Third Level Student Health Nurses Section meeting. UCD. From 9.45am-1.30pm. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

July

Monday 4

Wicklow Branch meeting. 4.45pm in Newtownmountkennedy Health Centre. Contact Lorraine Heeley at Tel: 01 6640629 for further details

Tuesday 12

Dublin East Coast Branch meeting. 7.30pm in the Sunroom, St Columille's Hospital. Contact Lorraine Heeley at Tel: 01 6640629

Thursday 14

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

Thursday 14/Friday 15

Rep training course. Mount Errigal Hotel, Letterkenny. 2pm Thursday continuing for a full day on

Friday. Contact Martina Dunne at martinadunne@inmo.ie

Wednesday 27

CPC Section meeting. INMO HQ. 10.30am-12.30pm. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

September

Tuesday 6

Care of the Older Person Section meeting. INMO HQ. Session on pensions with Denis Brophy, financial consultant. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Wednesday 7

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

Saturday 10

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

Saturday 10

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

Thursday 15

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

Saturday 24

School Nurses Section meeting. 10.30am. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Wednesday 28

Telephone Triage Section Annual Conference. Castletroy Park Hotel, Limerick. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

October

Saturday 8

ODN Section meeting. 11.30am Cavan General Hospital. Contact jean.carroll@inmo.ie for further details

Thursday 13

All Ireland Annual Midwifery Conference Crowne Plaza Hotel, Dublin. Contact jean.carroll@inmo.ie for further details

Conference

- ❖ A special one-day conference on maternal morbidities will take place on Tuesday, November 8, 2016. The conference theme is 'Minding Mothers with Morbidities'. See www.trinityhirc.com

INMO Professional Development Centre Library Opening Hours

June
Monday-Thursday: 8.30am-5pm
Friday: 8.30am-4.30pm

For further information on the library and its services, please contact:
Tel: 01-6640-625/614
Fax: 01-01 661 0466
Email: library@inmo.ie

INMO Membership Fees 2016

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

Congress

- ❖ The 7th Congress on Women's Mental Health will take place from March 6 to March 9, 2017 in the RDS, Dublin and will coincide with International Women's Day on March 8. The Congress theme will present cutting-edge research in four thematic areas: The importance of gender sensitive mental health services, young women and mental health, reproductive and maternal mental health and violence against women. The main objective of the Congress is to create a space for rights and evidence-based exploration of women's mental health in Ireland and internationally.

This Congress will be an excellent networking and learning opportunity for healthcare professionals to discuss best practices and innovative developments to improve women's mental health.

For further information see www.iawmh2017.org/wp/ or contact Jacqueline Healy at email: jacquelineh@nwcii

Condolences

- ❖ The INMO extends its sympathy to Helen Rouine, early years inspectorate Tusla and formerly HSE and INMO official mid-west, on the recent loss of her father, John Joe Rouine. RIP
- ❖ The INMO extends its sympathy to the family and colleagues of Nano Quinlan who passed away in February. Ms Quinlan was a nurse at the Community Hospital of the Assumption Thurles and a former INMO rep. May she rest in peace

Training programme

- ❖ One-day ear irrigation training programmes with Category 1 NMBI approval and four continuing education units will be held on June 16, September 22 and November 17, 2016 in the Education and Conference Centre, Royal Victoria Eye and Ear Hospital, Adelaide Road, Dublin 2. For further details contact Sabrina Kelly, nurse tutor at Tel: 01 6644652 or email: sabrina.kelly@veeh.ie

INMO CONFERENCES 2016



Occupational Health Nurses Section

Wednesday, 11 May 2016
Maryborough Hotel, Cork



Telephone Triage Nurses Section

Wednesday, 28 September 2016
Castletroy Park Hotel, Limerick



All Ireland Midwifery Conference

Thursday, 13 October 2016
Crowne Plaza, Santry, Dublin



RNID Nurses Section

Tuesday, 1 November 2016
Dublin

For information on attending any of the above conferences, please contact
Jean Carroll, Section Officer, by email: jean.carroll@inmo.ie
www.inmoprofessional.ie