

# Institute of Community Health Nursing Christmas Newsletter

Volume 9, Issue 2

December 2010



Web address:

[www.ichn.ie](http://www.ichn.ie)

Email addresses:

[admin@ichn.ie](mailto:admin@ichn.ie)

Phone: 01 6602689

01 6349666

Fax No. 01 6602172



Photographs in this edition were taken at the Annual Conference in Galway in September, 2010 and can be viewed on 'ICHN Dublin' Facebook (Link on [www.ichn.ie](http://www.ichn.ie))

supporting this change and contributing to the debate on improving services and the delivery of safe and effective care in the community.

We are currently engaged in many projects with the HSE and we welcome this opportunity to represent our members in improving and developing new systems to ensure better and safer care. At a political level we have been engaged with elected TDs and Senators at Leinster House in presenting our submission on the new Nurses & Midwives Bill 2010. This year at our Annual Conference we also launched the 'Anne Flynn Memorial Fund' which will financially support our members in continuous professional development. In relation to child protection we have met with both voluntary and political groups to promote the role of the Public Health Nursing in both identifying and monitoring vulnerable families. On the subject of clinical governance in Public Health Nursing the Institute is pleased to have contributed and to host the launch of a CD on Policies Procedures & Guideline on December 14th 2010. The CDs will be available through the Directors of

## A Message from the newly elected President of the ICHN

Welcome to the Christmas edition of the ICHN Newsletter, 2010. This year we celebrated 25 years since the Institute was founded in 1985. To mark the occasion the President Mary McAleese opened our conference in September and paid tribute to the dedication and work of Public Health Nursing and the contribution they have made to individuals, families and communities. (Her speech is included in this edition). At the conference we also honoured the pioneering work that was done on behalf of the Institute by its founding members. As the landscape of our health care system is undergoing both a shift in delivery to Primary Care Teams and a concerted effort to deliver better outcomes at a reduced cost, the role and contribution Public Health Nursing will play, is well recognised.

As an Institute we are committed in

Public Health Nursing. In December also at the ICHN Professional Forum, we will be launching the establishment of Interest Groups. This year also we engaged with The School of Nursing & Health Sciences at UCD and the Primary Care Unit at HSE to develop an interdisciplinary Level 9 modular course in 'Clinical Leadership in Primary Care'. 2011 will see the production of a six part TV on Public Health Nursing series which the Institute have successfully secured with RTE and to be produced by GMTV.

As the newly elected President of the Institute of Community Nursing, I assure you of my commitment to continuously promote and advocate for Public Health Nursing, to ensure the service evolves to meet the needs of communities and that both Public Health Nurses and Community RGNs are supported in their work.

Wishing you and your families a peaceful Christmas.

*Anne Corridan, President ICHN*



President of Ireland Mary McAleese, ICHN President, Catriona Duignan and members of the executive council of the ICHN

# ICHN CONFERENCE 2010

## **CATRIONA DUIGNAN, ICHN PRESIDENT, 2008-2010.**

The Institute of Community Health Nursing celebrated the 25th anniversary of its foundation in style at the Grand Hotel, Malahide on September 18th, 2010.

I was very privileged to be the sitting President of the Institute for the occasion. As President I was simply the representative of a hard working Executive, Council, Professional Forum and staff of the Institute who were responsible for the planning and execution of the conference that proved to be a great success. We could not have managed without the services of Grainne Lynch, conference co-ordinator and her team, who did a very professional job that added to the making of a special day.

As President I was humbled to add my name to the list of past Presidents. It was wonderful that so many of them were able to accept our invitation to attend the occasion. We acknowledge the contribution of these Presidents and the Executive and Council members throughout the lifetime of the Institute. These people and all ICHN members past and present are responsible for



Cathariona Duignan ICHN President

the Institute's continuing standing as very important and respected Institute representing nurses in the community. These people were pioneers and displayed great foresight for the future of nursing in the community. I hope they are proud of today's Institute.

Maura Connolly, the first Professional Development Officer of the ICHN was in attendance. Maura's successor, Mary O Dowd, was the backbone of the September Conference. Her vision for the day was realised in a very professional conference with contemporary themes for the profession reflected in a great collection of speakers from home and abroad.

Those who attended the conference or followed up the presentations on the ICHN website will agree the standard of the presentations and the speakers was of a very high quality. The booklet, 'Reflections on the ICHN Conference', gives a comprehensive overview of the conference content. We are grateful to its authors, our academic colleagues, past and present, of UCC, for this valuable work.

There were a number of Special Contributors to the Conference on the day which added to the occasion. Dr John Bowman proved to be an excellent choice as Chairperson for the day and his professionalism and knowledge of the subject matter was noted by many. We were privileged to be entertained by the very lovely and talented Eleanor Shanley who added her own praise to the profession of which she had personal experience. Mr Fergus Finlay spoke at the Conference dinner and he acknowledged the valuable contribution that Public Health Nursing makes in the area of Child welfare and protection. Our very special guest, President of Ireland, Mary Mc Aleese, honoured us by officially opening the conference. Her address was very personal and she articulated a deep understanding of the role and contribution that nurses in the community make to the wellbeing of individuals, families in particular and communities as a whole. As described in the 'Reflections' booklet President Mc Aleese captured the core elements of public health nursing practice better than we can often articulate ourselves.

Overall, Community Health Nursing received a lot of positive reinforcement from a lot of people, how easily we forget the contributions we can and do make. As professionals we need to get over our self-esteem issues and keep our head high.

The Health Service is changing rapidly and faces many challenges. I trust the conference left members feeling upbeat and empowered to face those challenges and to articulate as professionals the contribution we can make to the profession as a whole and in turn to the people, families and communities we serve.

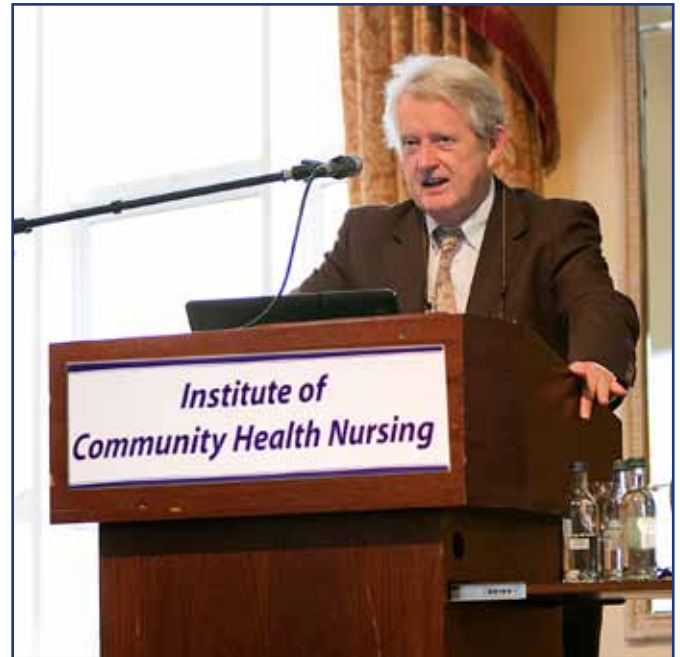
The Conference was followed by the Annual General Meeting of the ICHN.

There were a number of changes to the Executive Committee of the Institute.

Margaret McLoughlin, who has served as an excellent Secretary of the Executive for a number of years resigned from the position. I wish to acknowledge her contribution to the Institute and thank her for all her hard work and dedication.

Sr. Elizabeth Mc Nicholas was elected to replace Margaret as Secretary. Sr. Elizabeth has been an active Institute member for many years and has been a representative on Council up to this nomination. I wish her every success.

Mary O Malley from Mayo, a Vice President of the Institute and committed Institute member through the



Dr John Bowman

years, accepted the post of Treasurer of the Executive. I wish her every success in the position.

Marianne Healy was nominated and elected to a position of Vice President.

Anne Corridan has worked tirelessly as Treasurer of the Executive for a number of years through lean and leaner financial times but always managed to keep us out of the red. Anne travels religiously from Kerry to the capital to attend Institute meetings without fail. Anne has resigned her position as Treasurer but I am very pleased to announce that she is now the new President of the ICHN.

I have resigned from the position of President after two years in post. I would like to take the opportunity to thank, en-masse, the Executive and Council members, Dorothy and Mary O Dowd for all their support and assistance during my period as President. I also wish to extend that thanks to all ICHN members. I was lucky to meet many members along the way. I am very proud to be a Public Health Nurse and a member of The ICHN and I was privileged to represent you.

A special word of thanks to my PHN management and colleagues in Sligo/Leitrim/West Cavan who facilitated my attendance at meetings and ICHN events and supported my position as President.



Dr Breda Howley and Dr Amanda Phelan, School of Nursing and Health Science UCD

## Remarks by President McAleese

**at the Institute of Community Health Nursing  
25th Anniversary Conference, Malahide,  
18th September 2010**

Dia Dhibh a Chairde and thank you very much for your very warm welcome. I am very pleased to be here with you today as the Institute of Community Health Nursing celebrates its 25th anniversary. I would like to thank your President, Catriona Duignan and your conference co-ordinator, Gráinne Lynch for inviting me to address you on this very special occasion.

Today we are celebrating the silver anniversary of the foundation of the ICHN but, of course, the history of community-based nursing goes back much further, at least as far as 1876, when Lady Plunkett founded St. Patrick's Home for District Nurses in Dublin. In those days the district nurses were obliged to 'live-in' while they were training. They were well-known in the community and easily recognisable with their blue uniform dress, white starched apron and a navy blue coat that often billowed in the wind as they traveled from house to house on their bicycles. And long before them, our communities had the tradition of unofficial community nurses and midwives, local women who through circumstance and inclination became skilled in delivering babies or caring for the ill.

Nursing and midwifery in the 21st century have transformed to meet the current healthcare needs of society and community nursing has certainly come a long way from the early days of the district nurse on her bike. The profession is no longer exclusively female. The focus has shifted to a primary care strategy, an emphasis on keeping people well and supporting people with chronic disease so that they can live in the community rather than in institutional care. Whether it is changing a wound dressing, attending a home birth, offering advice and reassurance to anxious first-time parents, helping patients and their families deal with chronic illness or providing the palliative care that allows people choose to spend their final days at home rather than on a



President Mary McAleese addresses the delegates

hospital ward, you provide a life-enhancing service that puts the individual human person right at the heart of the healthcare system. Your help gives people hope that they can cope and that there is effective, professional, accessible help available to them.

Of course, this continuing shift from hospital to community-based care has placed you all at the centre of care delivery for large numbers of patients. As a result, you have a wonderful opportunity to promote, advance and influence quality and safety in the community as part of dynamic, patient-focused, multi-disciplinary teams. You work in partnership with individuals, families and communities and are well-placed to deliver interventions aimed at improving the health and social well-being of the local population. Many of you deal with our most vulnerable communities. Such a level of interaction has to be personally demanding and at times draining of your resources of patience, stamina and compassion. Yet it is the good that you do, even in the most difficult of circumstances, which time and again renews your vocation and reenergizes you as you see revealed over and over the positive difference your presence and only your presence is capable of making.

Over the past 25 years, the Institute of Community Health Nursing has developed into a strong professional Organisation whose members have a common goal of healthcare development. You are in a privileged position in that, in the majority of cases, you care for your patients and clients in their own homes. You, therefore, have an almost unique opportunity to provide nursing care in a family setting and, from that “hands on” experience; you are very well qualified to advise on what are the most effective ways of supporting patients in the home.

The theme you have chosen for your conference “Achieving Quality and Safety in the Community” reflects not just your priorities but crucially those of your clients for it is their welfare that is your core vocation and they come in all ages, genders and conditions and whoever they are they look to you for the reassurance, guidance, assistance and care that your name promises. To enter their homes, to offer that care in their homes is to establish a very special familial relationship very different from many other institution based forms of health care. You become a

friend, trusted, welcomed, and looked forward to. You are their conduit and guide through the maze of problems and changes they face and of course, to be able to do that to the highest standards of professional care, you have to be fully up-to-date. So not only do you have to look after your patients but you have to look after your own professionalism well too – taking care of it, upskilling, developing, growing, and innovating. New initiatives like the Advanced Nurse Practitioner posts in the community are born out of the scholarly research and reflection on your everyday experiences as community nurses. Here at this Conference your sharing of those experiences will distill into a new level of insight and

wisdom from which will come the next steps towards even better services.

Your anniversary coincides with the 150th Anniversary of the first publication of Florence Nightingale’s Notes on Nursing and the Centenary of her Death (1820 – 1910). We know how she revolutionized nursing but we also know that her work was only beginning. The starched white apron has given way to the single-use latex gloves in line with today’s infection control protocols but the professional insistence on offering the



best possible care remains the same because the curiosity about how that care can be improved remains as intense today as in her day.

May this conference be an opportunity to enjoy each other’s company, to learn from each other and to return to your work with renewed enthusiasm, fresh ideas and new networks through which to develop even better practice in the years ahead. I thank you for making such a difference to the lived lives of so many in our community and I wish you well as you continue to dispense excellent healthcare along with human comfort and compassion, with or without a prescription! Go raibh míle maith agaibh go léir.

# THE ICHN RESPONSE TO THE NURSES AND MIDWIVES BILL, 2010.

*A flavour of the discussions held in Leinster House.*

**Patricia O'Dwyer RGN, RM, RPHN, NT, M.Sc.(Nurse ed.) Public Health Nursing Consultant.**

The Institute of Community Health Nursing's (ICHN) written response to the Nurses and Midwives Bill, 2010 was presented to Dail Deputies and Senators, recently, in Leinster House. The opportunity to make the presentation was timely as it preceded the debate of the Bill by the Select Committee on Health and Children on November 4th 2010. The purpose of the presentation was to raise awareness amongst members of both houses of the Oireachtas of the substantive issues in the Bill that are of concern to community nurses. The substantive issues raised in the discussion with the deputies related to Registration and Practice, Education and Training and Maintenance of Professional Practice. These issues were discussed in the context of the purpose of the legislation, and the changing health care environment.

The primary purpose of the Bill is to protect the public and the corollary is also true that nurses and midwives need to be enabled to protect the very same public. The legislation seeks to ensure that nurses and midwives are educated to the standards set down by the regulatory authority and that there are safeguards in place to protect the public. The maintenance of professional competence is also important, for building a culture of patient safety, in a rapidly changing health care environment and high patient expectations.

The selection of appropriate and clear language for the proposed piece of legislation is critical. A requirement to maintain professional competence that is not clearly stated in legislation is less likely to be complied with and is a barrier to enforcement. This section (Maintenance of Professional Competence) of the Nurses and Midwives Bill, 2010 differs from the Medical Act, 2007 which places a statutory duty on registered medical practitioners to maintain their professional competence. Good quality patient care, requires that each nurse and midwife can demonstrate that they are competent practitioners. The audience responded to the issue of competence and the necessity

to ensure a culture of patient safety. The counter argument expressed was that, the legislation, as currently composed does not go far enough in this regard.

It was also raised with the audience that the Bill needs to be reflective of a progressive health care system. As such, the proposed legislation must be forward looking. This view raised most discussion and comment particularly in the context of the link between the registration and the status of advanced nurse practitioners and advanced midwife practitioner posts. The ICHN position is that membership of the advanced nurse register should not be tied in any way to employment status. To legislate, thus, would be unprecedented in this jurisdiction and elsewhere. It is the case that Minister Harney has had many submissions from other interested parties (An Bord Altranis, the Health Service Executive and the Irish Association of Directors of Nursing and Midwifery) on this issue and the relevant provisions in the Bill are most likely to be amended by the Minister.

Returning briefly to the issue of the Bill as a modern piece of legislation, the ICHN proposed that while the legislation itself cannot be overly prescriptive, neither can it be so broad that the legislative provisions taken as a whole do not enable the effective implementation and transformation of the health care system. That concluded a lively discussion on the substantive issues in the Nurses and Midwives Bill, 2010 from the perspective of community nurses. I wish to acknowledge the support of Senator Ann Ormonde and Ms. Sheila O'Malley Chief Nursing Officer, Policy Division, at the Department of Health and Children in facilitating the discussion.

## **For the sake of completeness I include this addendum.**

The Debate on the Nurses and Midwives Bill, 2010 by the Select Committee on Health and Children held on Thursday November 4th 2010 can be accessed at <http://debates.oireachtas.ie/HES/2010/11/04/00003.asp>

## Monitoring - Is it child protection?

**Susan Kent**

The term 'Monitoring' is used in the care of children at-risk, however the clarity of the meaning is vague and does not encapsulate the role played by the PHN. Within the Children's First<sup>1</sup> legislation, all practices with families within the child protection system should be overt. PHNs are notorious for calling on families under the guise of child health screening rather than for child protection issues. Many have written on this topic stating that we do not wish to ruin the 'friendly face' we have with our families and the community<sup>2,3</sup>. PHNs dislike the policing and checking up on the mother and child role of monitoring. We need to question this practice as it may violate the rights of a child to perform screening when it is not necessary and also to not be honest about the reason for the house visit. This does not take away from the role of the PHN in doing spontaneous, opportunistic visits where screening for a clinical need is performed outside of the identified time periods<sup>4</sup>. Some PHNs have the time to call frequently to families and can use the opportunities to check up on the children. Other PHNs are too burdened by workload to have the opportunities to visit families frequently. The practice is unclear and not standardised nationally.

Historically, the public health nurse (PHN) was involved in monitoring since the 1940s, when visiting children who were 'boarded out' now known as fostering<sup>5</sup>. Within Ireland there exists since 2002 the Child Protection Notification System (CPNS)<sup>1</sup>. This is similar to the child protection register in the U.K. All children referred to the social worker are discussed with the social worker management meeting and decision is made whether to assess the child or not. After the child conference and if found at risk, the child is placed on the system and reviewed every 6 months. Notification of the child in the PHNs area is delivered through the assistant director of PHN for notification only. No structure is in place for the PHN to alter her practice in any way because a child is on the system.

In an Irish study, PHNs highlight the difficulties surrounding the roles health professionals play in child protection<sup>6</sup>. They were certain that their role was not to monitor children identified as at risk. This belief was

also reinforced by the poor feed back received from social workers in such cases<sup>5-7</sup>. This mismatch of actual and perceived roles between professionals leads to practices that undermine child protection. This can be seen by PHNs who visit children at-risk but within their own guidelines of practice and not as a monitor for the social worker. There appears to be a considerable lack of clarity in the exact practice of the PHN in the child protection role delivered by PHNs. This is concerning as they are statutory bound to be involved in the care of children in child protection<sup>8</sup>. Dissatisfaction still lingers around role boundaries and who is responsible for what in child protection. This leads to a service where all parties are 'doing their own thing' for the child. However in many cases of child abuse and neglect this practice has shown to not provide protection for the children<sup>9-11</sup>.

Hanafin<sup>12</sup> in scrutiny in the report of the Kelly case<sup>11</sup>, states that even at primary and secondary prevention



Mr Fergus Finlay CEO Barnardos Ireland Anne Corridan  
incoming President ICHN IMG\_9142

level there are problems with the involvement of the PHN at case conferences. It appears that little value is placed on the role of monitoring by other professionals unless pre determined at case conference. PHNs believe the role of monitor is as a result of a shortfall in the social worker work force. A similar belief is known also to health visitors in the U.K.<sup>13</sup>. Monitoring occurs after the child has been assessed at secondary level. PHNs must acknowledge that their skills and experience at tertiary care of child abuse cases will not protect children, as monitoring is not child protection<sup>12</sup>. She also suggests that involvement should be placed within certain timeframes to avoid prolonged risk of danger to the child and prevent delay in monitoring deviance from an acceptable situation. PHNs are not educated to care for families in this situation. Although there are financial restraints to training and study days there appears to be time to deliver study days on care of the elderly and mentoring of home carers in the home. PHNs need to know that when they stand in the court room to defend the decisions they make in their practice in relation to child protection, they will stand alone and will answer for their action alone and not in relation to any shortfalls in the system.

### Future practice

As PHNs we need to define our role at all levels of child protection and at national level. If the policy makers are to take notice of the distaste the PHN has for practicing a role that is not protecting children, then they must provide defined roles for the professionals who work in this area of service provision. We are educated to work with families at primary preventative role and should pursue that role in practice. Therefore by delivering prevention we avoid the need for protection.

Further and ongoing education should be provided to standardise the practice of the PHN nationally. In this way an equitable service will be provided to our children and families by appropriate skilled professionals. As per recommendations in several reports development of specialist roles should be encouraged in this area by PHNs so as an educated expert can emerge from public health nursing that would inform their colleagues of professional and up to date practice in this area<sup>14-15</sup>.

Contact: susan.kent@hse.ie

Mobile: 086 8151245.

### Reference List.

1. Department of Health and Children (1999). Children First National guidelines for the Protection and Welfare of Children. Dublin: The Stationery Office.
2. Butler, S.(1996) Child Protection or professional preservation by the baby nurses? Public Health Nurses and child protection in Ireland. *Social Science in Medicine*. **43**, 303-314.
3. Marcellus, L. (2005) The ethics of relation: public health nurses and child protection clients. *Journal of Advanced Nursing*. **51**(4). 414-420.
4. Denyer, S., Thornton, L. and Pelly, H. (1999) Best Health for Children. Improving screening and surveillance services for children in Ireland. *Journal of Health Gain*. **4**(2), 3-6.
5. Skehill, C., O'Sullivan, E. and Buckley, H. (1999) The nature of child protection practices: an Irish case study. *Child and Family Social Work*. **4**, 145-152.
6. Kent (2007) The perceived role of the public health nurse in preschool child health. Unpublished thesis. Trinity College Dublin.
7. Hanafin, S. and Cowley, S (2003). Multidisciplinary communication in the Irish public health nursing service: a study. *British Journal of Community Nursing*. **8**(12), 544-549.
8. Department of Health and Children (2000). Job Description of the Public Health Nurse. Circular 41/2000. Dublin: Department of Health and Children.
9. Government of Ireland (1995) Report of Inquiry; Kelly: A child is dead. Report of a committee of Inquiry. Government Publications, Dublin.
10. Department of Health. (2003) The Victoria Climbié Inquiry report of an inquiry by Lord Laming. The Stationary Office. England.
11. Health Service Executive (2010) Report of Inquiry team to the Health Service Executive. Roscommon Child Care Case. HSE publications.
12. Hanafin, S. (1998). Deconstructing the role of the Public Health Nurse in Child Protection. *Journal of Advanced Nursing*. **28**(1): 178-184.
13. Appleton, J. (1994) The concept of vulnerability in relation to child protection: health visitor's perceptions. *Journal of Advanced Nursing*. **20**, 1132-1140.
14. Government of Ireland (1998) Report of the commission on Nursing- A Blueprint for the future. Dublin: Stationery Office.
15. National Council for the Professional Development of Nursing and Midwifery (2005). Agenda for the future development of Public Health Nursing. Dublin.

# Professional Certificate in Clinical Leadership in Primary Care

September – November 2011

Prof. Philip Larkin, Dept. of Health Science UCD

- Do you hold a leadership position in Primary Care?
- Do you have a project that you would like to develop to support the roll-out of the Primary Care Strategy?
- Would a short academic course help you to develop and reflect on your leadership knowledge and skills?

## The Professional Certificate in Clinical Leadership in Primary Care may be for you

UCD School of Nursing, Midwifery and Health Systems in conjunction with the Institute of Community Health Nursing are pleased to offer this single 15 ECTS credit module leading to the award of Professional Certificate in Clinical Leadership in Primary Care. The module will recommence in September 2011.

The course is designed to provide the opportunity for people working in a leadership role in primary care to broaden their knowledge and understanding around leadership and management with respect to the Primary Care strategy and with an emphasis on transformational leadership.

The first programme commenced in September 2010 and 7 students will shortly complete the course. The module is open to any discipline working in Primary Care leadership and the current students include Public Health Nursing managers and professionals with a background in Occupational Therapy and Psychology.

## Who are we looking for?

**Practitioners who are in a position to effect change in Primary Care at a strategic level**

## About the programme – teaching and learning to improve excellence in Primary Care

The Professional Certificate in Clinical Leadership in Primary Care is a Level 9 award of the National Framework for Academic Qualifications. This means it is equivalent to the 1<sup>st</sup> year of a Masters degree. Participants currently share some sessions with students undertaking a Masters level module on Clinical Leadership within the School, supported by specific tutorials and seminars related to Primary Care. Topics covered include models of primary care practice, population health, clinical excellence and organisational culture. The module runs over 12 weeks ( 6 weeks of which are shared with the larger group), currently on a ½ day morning per week



Carmel McNamee Catherine Curry Miriam McNamee  
Anne Flynn Memorial Launch

(Mondays). The module is examined through course work, on-line discussion boards, and a project which is the final assessment of the programme. Each student develops this project during their studies with a view to being able to implement this within three months of completion of the academic programme. Students receive 1:1 support for the development of their project idea from the teaching team, academic and clinical experts in leadership and primary and community care.

### Entry requirements

Applicants from any discipline are encouraged to apply. You must hold a Primary degree or equivalent qualification. You should also be able to demonstrate evidence of recent academic study. You should be working in a leadership role in Primary Care and in a position to commit to a ½ day class contact time per week\*. Course fees for 2010 were €1682.00. For individual queries regarding eligibility, please contact Professor Philip Larkin as indicated below.

There are a maximum of **15** places on this programme.

\* To be confirmed for 2011

### Why should I do this programme?

Currently, there is no other academic programme which looks at the specific leadership needs in Primary Care. As the overall numbers are small, those who are returning to academic study will find significant levels of support to help them in their learning. Taking a short programme such as this may be of interest to people wishing to gain an academic 3<sup>rd</sup> level qualification but who are unable to commit to a longer period of study. In many cases, the credits awarded for this module may be ‘banked’ for transfer to other higher academic programmes ( such as a Masters in Clinical Leadership) in the future. A 15 credit academic module is intensive and the workload reflects this fact. Students need to plan for a minimum of 6 hours work per week. The informal evaluations of the programme to date have been very positive and although there will be some changes to the programming based on the feedback from the 1<sup>st</sup> student group, we do expect to run the programme in 2011.

For all inquiries regarding entry requirements and the programme, please contact Professor Philip Larkin, UCD School of Nursing Midwifery & Health Systems at 01 7166438 or [philip.larkin@ucd.ie](mailto:philip.larkin@ucd.ie)



Senator Anne Ormonde, Dr John Bowman ICHN, 25th Anniversary Conference



Eleanor Shanley at ICHN Conference 2010

# National Guidelines for the Management of Pre-Gestational and Gestational Diabetes Mellitus



Office of the  
Nursing & Midwifery  
Services Director

Diabetes mellitus is a significant health problem in Ireland. The number of people affected by diabetes in Ireland is increasing. It is estimated that at least 4.7% of adults in the Republic of Ireland have diabetes (diagnosed or undiagnosed) and this is expected to rise to 5.6 % of the population by 2015 – a 37% increase.

The impact of diabetes in pregnancy for both mother and baby can be far reaching, thus it is essential that every effort is made to achieve optimum obstetric outcomes and prevent long term disease.

The development of HSE national *Guidelines for the Management of Pre-gestational and Gestational Diabetes Mellitus from Pre-conception to the Postnatal period* is designed to support standardisation of care and encourage best clinical practice.

As part of the HSE efforts to improve healthcare, it is hoped that these national guidelines will assist all clinicians in the decision making process and help to standardise the management of diabetes and pregnancy at primary, secondary and tertiary levels.

## Pre-Gestational Diabetes Mellitus (Type 1 and Type 2)

The incidence of pre-gestational (Type 1 and Type 2) diabetes and pregnancy is increasing. The incidence of type 2 diabetes mellitus is increasing in younger people, including women of child bearing years. Women with type 2 diabetes mellitus are more likely to have additional risk factors for adverse pregnancy outcomes, such as obesity, increased parity and age and are more likely to present late in pregnancy.

Maternal morbidities associated with pre-gestational diabetes mellitus in pregnancy include pregnancy induced hypertension, pre-eclampsia, obstructed labour

and shoulder dystocia. Pre-existing complications of diabetes such as diabetic retinopathy and diabetic nephropathy can worsen in pregnancy.

Fetal morbidity and mortality is increased in babies born to women with pre-existing diabetes due to increased risk of birth injury and stillbirth. Macrosomia (increased birth weight) is increased 6-10 fold compared to the non-diabetes population.

Off spring of diabetic pregnancies may have an increased risk of diabetes in later life, thus optimal management and care of diabetes pre-conceptually and during pregnancy has far reaching implications for the mother, baby and society. It is crucial that women with pre-gestational diabetes are informed as to the importance of pregnancy planning to ensure optimal blood glucose control and diabetes management at conception and throughout pregnancy.

## Gestational Diabetes Mellitus

Gestational diabetes may be defined as any form of diabetes or glucose intolerance with onset or first recognition during pregnancy. Gestational diabetes is associated with fetal macrosomia, thereby increasing the risk of birth injury to mother and fetus. Clinical risk factors attributable to gestational diabetes include:



Anne Marie Ryan Chief Education Officer An Bord Altrnais,  
Helen Mulcahy UCC

overweight/obesity, increased age, family history of diabetes and ethnicity. In terms of number of cases seen, gestational diabetes mellitus is more common than pre-gestational diabetes mellitus.

While there is universal agreement that pre-gestational diabetes increases the risk of adverse pregnancy outcomes; the level of glucose intolerance associated with a significantly increased risk of adverse outcomes has yet to be established. Recently a number of large international clinical trials have demonstrated that diagnosis and intensive management of gestational diabetes are associated with decreased maternal and fetal morbidity and mortality.

Screening for gestational diabetes remains controversial. To date, the American Diabetes Association, the International Diabetes Federation and the National Institute for Health and Clinical Excellence recommend selective screening for gestational diabetes.

The HSE guidelines currently advocate selective screening for gestational diabetes mellitus.

Women with gestational diabetes mellitus are at high risk of developing type 2 diabetes mellitus later in life. This risk may reach 50% in the decade following pregnancy. Therefore, follow up of women with a history of gestational diabetes mellitus provides an opportunity for screening and possibly preventing type 2 diabetes mellitus and its long-term complications.

To download a copy or to read more, the guidelines are available on the following web addresses:

[http://hsenet.hse.ie/Library/HSE\\_Publications/](http://hsenet.hse.ie/Library/HSE_Publications/)

<http://www.hse.ie/eng/services/Publications/>

<http://www.hse.ie/eng/services/Publications/topics/Diabetes/>

<http://www.lenus.ie/hse/handle/10147/112890>



Dr Siobhán O'Halloran, Speaker



Prof Linda Olson Keller Keynote Address



# PRIMARY CARE PALLIATIVE CARE



*Progress on the work of the National Steering Committee Primary Care Palliative Care Nov 2010*

## PROGRAMME AIM

The Irish Hospice Foundation, in partnership with the HSE and Irish College of General Practitioners, are undertaking a programme of work to identify and support palliative care initiatives that will support staff working in primary care to respond to adults with life limiting diseases who are expected to die within 12 months.

## CONTEXT

Approximately 90% of care provided to people who are facing death is delivered by staff in primary care, yet there are very few formal systems to support staff working with people with life limiting disease in the community.  
Specialist Palliative Care (SPC) Services provide direct support those people with advanced progressive disease who have complex care needs (approximately 20% of deaths per annum). The SPC services also have a role in providing advice and support to those working in primary care to care for those who are dying who do not need direct input from SPC.

## PROGRAMME TIME LINES

This work commenced at the end of 2009 and the initial phase of this work is exploratory, with the expectation that its findings will lead to an implementation phase commencing in 2011.

## MEMBERSHIP

Mary Bowen	IHF Hospice Friendly Hospitals Programme
Mary Ferns	Irish Cancer Society
Dr Paul Grogan - Chairperson	Irish Palliative Medicine Consultants Assoc
Liz Hoctor	Irish Pharmacy Union
Dr Emer Loughrey	Irish Council of General Practitioners
Marie Lynch	Irish Hospice Foundation
Dr Brian Maurer	Irish Heart Foundation
Michele Megan	Directors of Public Health Nursing
Edith McMahon	Milford Hospice at Home Service
Pauline Newman	Dir of Nursing SPC National Group
Dr Kevin O'Doherty	HSE Primary Care
Eileen O'Leary	HSE Palliative Care
Dr Eve O'Toole	Cancer Control Programme
Ms Lorna Peelo-Kilroe	HSE Primary Care
Dr Ailis Quinlan	Personal Capacity
Anne Tan	Irish Association of Palliative Care
Grainne Tipping	Irish Palliative Pharmacy Group

## SUMMARY OF PROGRAMME ACTIVITIES SO FAR

### CONSULTATION MEETINGS

5 consultation meetings were held over the summer in Cork City, Tullamore, Dublin (2) and Letterkenny. In total 127 health care staff participated in these sessions and there was a good cross section or representation from GPs, nursing personnel, pharmacists, allied health professionals and specialist palliative care.

The issues that were common from these meetings included:

- Enhancing existing communication systems, between primary, secondary and out-of-hours services
- Guidance & support to assist planning with patients and families in advance
- Guidelines and enhanced access for palliative medication and specialist equipment
- Clarity re approach to take for patients with non malignant disease
- Service directory and information for patients and staff
- Education and training

### SURVEY

A questionnaire has been compiled, based on the information gathered at the consultation meetings, and will be circulated in November to a selected number of primary care teams around the country. The aim of the questionnaires is to further clarify issues that present in this area, as well prioritising a range of initiatives that have been identified from the consultation phase and emerging work in this aspect of service delivery internationally.

### ENGAGEMENT

Throughout the project direct links have been made with a wide range of professional groups and community based services that are involved in the care of people with life limiting chronic disease, to seek their views and suggestions re potential areas for service development in this area.

### WHATS NEXT .....

**Following analysis of the questionnaire an interim report will be published in early 2011. This will identify initiatives that will be developed as part of the implementation phase of this project.**

**For more information contact Marie Lynch**

[marie.lynch@hospice-foundation.ie](mailto:marie.lynch@hospice-foundation.ie) Ph: 01 673 0063 [www.hospice-foundation.ie](http://www.hospice-foundation.ie)

# CervicalCheck – The National Cervical Screening Programme

CervicalCheck – The National Cervical Screening Programme became available to over 1.1 million eligible women aged 25 to 60 on 1 September 2008. CervicalCheck provides free smear tests to women aged 25 to 60. A smear test is a simple procedure that only takes minutes and is the most effective way to detect changes in the cells of the cervix.

The overall aim of CervicalCheck is to reduce the incidence rate of cervical cancer by detecting cell changes before they become cancerous. Over time, a successful national, quality assured cervical screening programme in Ireland has the potential to significantly reduce mortality rates in the screened population. In Finland, mortality rates have dropped by 80 per cent over the last four decades.

Screening is recommended every three years for women aged 25 to 44 and following two consecutive ‘no abnormality detected’ results at three yearly intervals, every five years for women aged 45 to 60, in line with best international practice. A woman can choose to have a free smear test with any registered smearer (GP or Practice Nurse), in any location of her choice, such as GP practices, Women’s Health, Family Planning and

Well Woman Clinics. Over 4,150 GPs, practice nurses and medical practitioners in over 1,400 locations are registered to take smear tests as part of the Programme.

Since launched on 1 September 2008, CervicalCheck has proved very successful.

The response from women nationwide to the Programme has been exceptional, with uptake remaining consistently high. In 2009 alone, almost 281,000 women received a CervicalCheck smear test.

## The CervicalCheck Register

CervicalCheck has developed a register (list) of eligible women nationwide aged 25 to 60 through up-to-date information received from the Department of Social and Family Affairs and also from women who have self-registered.

CervicalCheck sends an invitation by post to all women on this list during each three year screening round.

## Women who have never had a CervicalCheck Smear Test

Women who have never had a CervicalCheck smear test need a letter of invitation from CervicalCheck to



Catriona Duignan & Sheila O'Malley



Kathleen Griffin, and Patricia O'Dwyer

have a free smear test. With an invitation letter, women can have a free smear test with any smertaker that is registered with CervicalCheck.

### **Women who Have Not Had a Smear Test in the Last Three Years**

Any woman who has not had a smear test in the last three years can self-register and request an early invitation letter from CervicalCheck by registering online at [www.cervicalcheck.ie](http://www.cervicalcheck.ie) or completing and returning a Freepost self-registration form or by calling

Freephone: 1800 45 45 55.

### **Cervical Screening and Pregnancy**

Having a smear test during pregnancy may be psychologically difficult or inappropriate for women. The same can be said of having a smear test shortly after pregnancy.

**Women do not need to have a cervical smear test postnatally unless they are due to have one within a usual call, re-call period.** The call, re-call period is every three years for women aged 25 to 44 and every five years for women aged 45 to 60.

Women who are pregnant and who have gone three years without having a smear test and who have not had an abnormal smear test result can have their smear test deferred. The smertaker will complete a deferral form and send it to CervicalCheck. CervicalCheck will advise the woman when her next smear test is due.

If a woman receives a letter of invitation from CervicalCheck to have a free smear test and she is pregnant the smear test can also be deferred and again a deferral form will be completed by the smertaker and sent to CervicalCheck.

If a woman had a previous smear test that had an abnormal result and in the interim becomes pregnant the test can be taken mid trimester unless there is a medical reason not to take the smear test.

### **The Screening Promotion Team**

CervicalCheck has a designated team of Screening Promotion Officers based in different areas across the country. Individual team members are based in Cork, Dublin, Galway and Limerick. The Screening Promotion team is available to work Public Health Nurses and Community RGNS who would like to collaborate in order to increase awareness and reduce barriers which prevent women from accessing the Programme. If you have a query in relation to the work of the Screening Promotion team or if you would like to contact the Screening Promotion Officer in your area please email [screening.promotion@cancerscreening.ie](mailto:screening.promotion@cancerscreening.ie)

For further information

[www.cervicalcheck.ie](http://www.cervicalcheck.ie) Freephone: 1800 45 45 55

For promotional leaflets, self registration forms and posters contact

[screening.promotion@cancerscreening.ie](mailto:screening.promotion@cancerscreening.ie)



Mary McDermot, Claire Alcott, Mary Powell, Brenda Horgan, Dr Breeda Howley, Dr Amanda Phelan, Sylvia Kennedy,

# Elder Abuse: Results from an Irish National Prevalence Study

**Dr. Amanda Phelan, Lecturer School of Nursing, Midwifery & Health Systems, Director, National Centre for the Protection of Older People**

Elder abuse is a significant issue for global societies. However, understandings have been hampered by definitional confusion, categorical difficulties and theoretical instability. The Irish definition is adapted from the World Health Organisation's (2002) definition. In *Protecting our Future* (DOHC 2002:25), elder abuse is defined as:

*'A single or repeated act or lack of appropriate action occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person or violates their human and civil rights'*

There are five types of abuse which are generally agreed upon: psychological abuse, physical abuse, financial abuse, sexual abuse or neglect (commission or omission). Although self-neglect was not included under the rubric of elder abuse, the HSE (2009) indicated that severe self-neglect cases would be reviewed according to the protocols for elder abuse. In a recent Irish prevalence study undertaken by the National Centre for the Protection of Older People (Naughton *et al* 2010), 2,021 older people were interviewed regarding their experience of elder abuse. The prevalence rate over the previous year was 2.2 percent and when this is applied to the general population, this suggests that 10,201 older people have been abused in some way in the last 12

months. If the experience of elder abuse was expanded to include neighbours and acquaintances as perpetrators, the prevalence figure goes up to 2.9 percent in the last year. When figures are expanded to the experience of mistreatment since the age of 65 years, the prevalence rate increased to 4 percent (18,764 people).

Financial abuse (giving money or property to someone in a position of trust) was found to be the most common form of abuse (1.3%), with psychological abuse next (1.2%), physical abuse (0.5%) and neglect (0.3%). In addition, 25 percent of older people experienced more than one type of abuse, while 14 percent reported three or more forms of abuse. In this study, women were more likely to report abuse, whilst increasing age was found to increase risk of abuse. Older people who were separated, widowed or divorced experienced a greater level of abuse than those who were single (never married) and living within intergenerational families demonstrated a higher risk of abuse. In terms of education, older people who had higher levels of education were seen to be subject to lower levels of abuse and those who had incomes lower than €220 per week demonstrated a great propensity to abuse. In addition, older people who identified their health as poor or very poor and those with poor levels of community support experienced more abuse. For example, those with below average physical health scores were three times more likely to report abuse, whilst those with below average mental health scores were nearly six times more likely to report abuse. Older people reported that they would most likely disclose the abuse to other family members (41%) or to their General Practitioner (11%). In terms of the perpetrator, the adult child was the most likely abuser (50%), followed by another relative (24%), spouse/partner (20%), friend (4%) and home help (2%). The findings revealed that most abuse perpetrations had a serious impact on the older person's life.

Global prevalence studies have indicated that elder abuse predominantly occurs in the home. This concurs with the fact in Ireland only five percent of older people live in long-term care. Consequently, elder abuse is a significant concern for community nurses. However, like



Margaret Daly, Cora Williams, Mary Rose Day, Speaker

other forms of interpersonal violence, abuse is difficult for a number of reasons. Research has shown that issues such as practitioner time constraints, attitudes and lack of knowledge about the topic influences recognition and subsequent decisions. As a taboo topic, practitioners describe being uncomfortable addressing it. In assessing older people, there can be some assumptions which render sensitive discrimination of the ageing process and abuse difficult. Furthermore, the fact that the home is a private space wherein families have their own realities can present a problem as families 'act' in a different way when surveyed by external bodies, for example, community nurse. In tandem with this, older people value family privacy and often do not want their 'dirty laundry aired in public'. For older people, disclosure is difficult. Very often the perpetrator is a family member which the older person has deep emotional ties to. The experience of negative and unsupportive attitudes

towards both old age and the experience of abuse have been shown to prevent disclosures. Other issues relate to the fact that if the older person dependency is high, there may be a tacit acceptance that the abuse is warranted due to the caregiver burden. Also, there may be a perception that if the abuse is disclosed, the older person may have to be admitted into a nursing home as the perpetrator may be the primary caregiver. However, despite these difficulties, community nurses can play an active role in addressing abuse and reporting to the elder abuse officers, particularly as older people do not have time on their side nor do they have mandated social contacts, such as schools, community links or employment, which can trigger suspicions in other age groups

**For further information on this study and the topic of elder abuse see [www.ncpop.ie](http://www.ncpop.ie)**

---

## **Development of an e-learning program to support the use of specialist assessment tools in clinical practice**

Following the development of the Older Persons' Record and the implementation of the Common Summary Assessment Record (CSAR's), the public health nursing services in PCCC, Mayo identified the need for further education around the utility of specialist tools in assessing the care needs of older persons. A similar need was identified by staff in residential services for older persons following HIQA Inspections.

To address this need the NMPDU West/Mid-West and NCNM have agreed to co-fund a national project aimed at developing an e-learning program on the use of specialist assessment tool in clinical practice. To facilitate a national approach to the development of the program, representation from nursing services, NMPDU's, INMPDA and CNME's have come together to form a National Steering Committee. The role of the Steering Committee is to provide professional guidance and leadership from a governance perspective. The structure, content and presentation of the e-learning program will be developed by multidisciplinary working

groups in collaboration with Mr Pat Kenny and the HseLand design team. The Working Groups will build on work initiated in this area by Mayo PCCC Public Health Nursing Services.

Exploratory meetings have taken place to scope out the overall aims of the Project and following agreement on a Project Plan by the Steering Committee, structured work on the Project should commence in January 2011. It anticipated that the e-learning program will be completed by May 2011. On completion this educational resource will be available to all healthcare staff on the [hseland.ie](http://hseland.ie) website.

**If you wish to contribute to the Project or for further information on the Project contact:**

Teresa Moore Project Officer at  
Teresam.moore@hse Tel:087-9830592)  
or Ann Boland Chair of the Steering Committee at  
Ann.Boland@hse.ie Tel: 094-9022333

## Caring Together in Challenging Times – Public Health Nurses and Family Carers: is there a need for change?

Caring is a fact of life, we may all be called on to provide care to a family member and we will all need care. The family continues to be the strongest and most reliable source of care<sup>1</sup>. Family carers are people who provide unpaid care to someone with a chronic illness, disability or other long lasting health or care need, outside a professional or formal framework. Currently, up to 80% of all care is provided in the community.

In 2006 (CSO) there were 160,917 people providing care in the home, 62% were Female and 11% were over the age of 65 years, 40,883 provided full-time care and 90,544 were combining paid working and caring. The European Foundation for the Improvement of Living and Working Conditions found that 25% of female carers and 15% of male carers reported that care limited their employment opportunities.

Caring is a major source of strain and psychological distress,

23% of family carers find the work of caring completely overwhelming at times.

70% find caring a financial strain

73% score poorly on a General Health Questionnaire.<sup>2</sup>

Research has shown that up to 47% of family carers have no major source of help with their caring duties resulting in social isolation.

Public Health Nurses are the main providers of support to family carers, providing advice, information and referral to other services. There is a greater need to provide practical assistance in the form of home care and flexible respite care services which are critical to enabling people to continue to be cared for at home. "The obligation of caring for vulnerable populations cannot rest with the family alone. The burden is too great and the resources are too few, not everyone is capable of providing care and not everyone has family members or friends available to do so". (WHO,2002)

Family carers are largely seen as a resource by service providers and as a consequence support mechanisms have been inadequately developed. The main aim of this support has been to ensure that they continue in their role with little attention given to the changing demands they face.

Do families have a choice whether or not to care? The Eurocarers 10 Guiding Principles states 'People should have the right to choose freely whether they want to be a carer.' Exercising a choice not to care is increasingly difficult due to the strong moral imperative to care, the implicit pressure that is put on people to care,

the rapid throughput from hospital settings and the lack of alternative arrangements. Fortunately most wish to care, but it is essential that they are adequately prepared and supported throughout the caring process. This means providing a more holistic model of carer support, thinking clearly about intended goals and actively promoting a more equitable relationship.

Given the challenges presented by resource constraints and pressure for early discharge from hospitals, there needs to be a cognitive shift in the way that professionals perceive family carers.<sup>3</sup> Interventions still focus on the patient/client need, there is now a greater to work collaboratively with family carers, whilst also recognising the needs of the carer and their family members. There is need to assess and respond to carers needs providing information and support proactively rather than waiting until it is sought and this process needs to extend through the continuum of care.

Responding to the needs of family carers should be a primary objective of health and social care policy; with the aim of enabling carers to continue to care for as long as they, or the service user, wishes, without detriment to the carers health and inclusion in society.

To meet this aim, policies which promote partnership and empowerment should be developed. If this is to be achieved, there is a need for considerable remedial action, requiring among other things, a consensus on the nature and purpose of carer support and the development of practical approaches to realising a partnership model which responds to carers changing needs over time. Now more than ever there is a greater need for a Carers Strategy to be developed to provide a framework in which family carers will be recognised and valued for the contribution they make to their families and to society.

Presented by Brigid Barron, RGN RM RPHN FFMRCISI.

Innovation & Programme Manager, Caring for Carers Ireland.

### Notes

- 1 Carers Charter, Caring for Carers Ireland 1991
- 2 Prof. E O'Shea, Director, Dept. Social Gerontology NUIG 2006
- 3 Nolan M. Working with family carers: towards a partnership approach Review in Clinical Gerontology 2001 11, 91-97

## Report from Professional Development Officer, Christmas 2010

**Anne Flynn Memorial Fund:** This fund was launched by at the ICHN conference in September. Catherine Curry on behalf of the ICH invited Anne nieces, Miriam and Carol to launch the Fund. The fund is administered by the Professional Forum and funding applications are approved by the ICHN Council. This year there were 10 applicants who were offered 23% of cost of fees and there were 2 applications for Research projects. On completion of their research or study the applicants give a commitment to provide ICHN a report on their study /research and to acknowledge the ICHN funding in any published papers or posters. It is hoped to continue this fund in 2011 and applications will be accepted in the New Year.

**Documentary on Public Health Nursing:** The ICHN in association with GMarsh Productions have secured a contract with RTE for a six part documentary for transmission viewing in Autumn 2011. The Communication Department in HSE have through the Directors of Public Health Nursing agreed 5 sites and filming has commenced.

**Launch of Policy/Procedures/Guidelines CD:** To support a culture of patient safety within the public health nursing profession and the values underpinning the vision for an Irish health service (DOHC 2008) the National Director of Public Health Nursing Group commissioned a project team to collect, collate and to advise on dissemination, training and governance in relation to clinical policies, procedures protocols and guidelines (PPPGs) for public health nursing teams which will be printed in CD format and housed on the HSE website. The rationale for this project is to compile a current list of national PPPGs which may be used or adapted for use by PHNs nationally but an acknowledged limitation is the fact that this is a once off exercise and therefore does not provide a pathway for future PPPG upgrade. This CD compilation is separated into the following seven sections

1. Introduction, Explanatory Memo and Governance
2. Family and Child Health
3. Adult Health
4. Health and Safety
5. Infection Control
6. Practice Management
7. Publications, PPPG Template and Policy on Policies

The ICHN was represented on the project team and the CD will be launched on 14th December 2010 and

will be available through the Directors of Public Health Nursing.

**Clinical Leadership in Primary Care:** The ICHN in association with the Department of Nursing & Health Science in UCD agreed a 12 week programme which commenced in September 2010. The Co-ordinator of the programme Professor Philip Larkin has further information on the course in this edition of the newsletter.

**Fergus Finlay, CEO Barnardos:** Further to a meeting with ICHN on the subject of PHN role in Child Protection, Mr. Finlay kindly met with members of the ICHN Council and Professional Forum in October 2010 on the subject of promoting the ICHN to be a stronger and influential voice for members. He further agreed to develop a communication plan when the ICHN have developed a new plan for promoting the Institute.

**Population Health Information Tool: (PHIT):** The ICHN are members of a group convened by Dr Siobhan O Halloran, Nursing Services Director HSE to consider the resource requirements to introduce the PHIT for use in Primary Care.

**Parent Held Record (PHR):** A new group has been reconvened by Dr Siobhan O Halloran, Nursing Services Director HSE to examine the progress of the use of the PHR. The ICHN are represented on the group which met in November 2010.

**ICHN Interest Groups:** Following the ICHN conference in September 2010 members expressed an interest in setting up National ,Regional and Local Interest groups, At the Professional Forum meeting on December 14th 2010 the ICHN plan to introduce 4 Interest Groups to advocate for better systems and processes in the delivery of Community Nursing Services. The groups are

- Child and Family Health
- Care of the Older Person
- Population Health
- Leadership in Community Nursing

If you wish to get further information on the development of these or wish to include another group contact maryodowd@ichn.ie

**Nurses & Midwives Bill 2010:** The ICHN prepared a submission and presented it to An Bord Altranais, the Nursing Division in the DoHC. Patricia O Dwyer did a presentation on behalf of the Institute to an all party group in Dail Eireann in October. Further information on the submission is included in this edition of newsletter.

**Mary O Dowd, ICHN Professional Development Officer**  
maryodowd@ichn.ie Mob: 086 0266728

## Council Members elected at Institute of Community Health Nursing AGM, September 2010

President: Anne Corridan, ADPHN, Kerry	Vice Presidents: Annette O Gara, PHN Donegal
Past President: Catriona Duignan, A/ADPHN, Sligo	Patricia Marteinsson, PHN Offaly
Secretary: Sr. Elizabeth Mc Nicholas, PHN, Sligo	Marianne Healy, DPHN,
Treasurer: Mary O'Malley, ADPHN, Mayo	Dublin North West



## Unite/CPHVA Annual Conference 2010,



## Harrogate, International Centre, Harrogate.

Mr Gavin Fergie on behalf of Unite/CPHVA issued an invite to ICHN, to attend their annual Conference. Harrogate is located in the Yorkshire Dales and is renowned for the delights of 'Betty's Tea Rooms'.

This year's conference has 2 main themes: the economic and demographic impacts on practitioners and sustaining positive change in the community: flourishing not failing families. In the UK the Coalition Government is committed to increasing the number of health visitors and to maximising the potential of their role to support children and families and in addition to building and using the resources of local people and communities to improve health and well being. Specifically they wish to see the development of a programme to increase the number of health visitors to:

- Provide increased support to families
- Provide and /or enable access to additional tailored care packages/support to family needs

- Develop community capacity and utilise that capacity in providing a wide range of services and choices to local people.

A NHS/Department of Health consultation document 'Service Vision for Health visiting in England' was launched at the conference. It outlines how health visitors improve health outcomes for families and describes the universal prevention and early intervention pathway from pregnancy to 5 years.

The overall message from the conference was the political commitment and the recognition of the role of the health visitor in supporting families and communities. The slides and recorded presentations from the conference can be accessed on [http://www.uniteunion.org/sectors/health\\_sector/professional\\_groups\\_\\_assoc/cphva/slides\\_and\\_recorded\\_presentati.aspx](http://www.uniteunion.org/sectors/health_sector/professional_groups__assoc/cphva/slides_and_recorded_presentati.aspx)

**Mary O' Dowd, PDO**

**ICHN Office Tel: 01 6602689 Email: [admin@ichn.ie](mailto:admin@ichn.ie)**

**The Professional Development Officer can be contacted on**

**mobile 086 0266728 or e-mail [maryodowd@ichn.ie](mailto:maryodowd@ichn.ie)**

Royal City of Dublin Hospital  
18 Upper Baggot Street  
Dublin 4



Phone: 01 6602689  
Fax: 01 6602172  
Email: [admin@ichn.ie](mailto:admin@ichn.ie)

The Institute is most grateful for all your submissions.