pna Journal

VOL. 7 ISSUE 1 SUMMER 2009

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editorial

The most recent reports from the International Monetary Fund (IMF) and the Organisation for Economic Co-operation and Development (OECD) makes depressing reading. It also kills off the feeble attempt by the Irish Government to blame the international depression for our Irish problems. Other Countries in the western world are seeing the recession bottom out while we are facing another 2 years of the worst recession we have ever experienced ; and even when we do start to turn the corner, circe 2011 our growth will be at very small levels. These reports assert that:

- By the end of 2010 our economy will have contracted 13.5% in 2 years.
- Unemployment will reach 15.5% before the end of 2010.
- Our recovery will see an increase in GDP (Gross Domestic Product) of 1% in 2011 and will be followed by increases of 2.5% over the following 3 years.
- Tax Receipts will be significantly below what is needed to fund Public Services and Social Welfare will swallow a large chunk of that due to spiralling unemployment.
- Bank losses will total 35 Billion Euro.

Both reports call for further cuts in Government spending with the public service wage bill the main recommended target. This can only be done by either reducing wages or reducing employee numbers (or both)

Our members are hurting very badly from the so called Pension Levy and increased taxes. We are also being put to the pin of our collar to maintain services in an environment in which staffing numbers have been reduced , staff replacement is minimal and mileage for the provision of Community Care has also been targeted.

If the IMF and OECD reports are any way right we , as a country, are facing a long battle to get back to the way things were at the start of 2008. They say it will take as much as 8-10 years. In the meantime however we have to maintain services to our mentally ill and intellectually disabled; our ageing population must be looked after; and those with addictions will continue to need services; and if we are serious about improving our health service then a real commitment to a comprehensive Primary Care service is essential. However, in the current environment all the evidence points to continuing crisis management aimed at saving money today, irrespective of the consequences. There is no sense of a long term or even medium term plan. Senior managers acknowledge their orders are to 'slash and burn', do whatever is necessary to achieve savings : and to hell with strategy, to hell with patient need and patient care.

Clinical practice cannot take any more cuts. We need every temporary nurse in the system retained and appointed. We need our students employed. It is economic madness to continue paying overtime in an effort to maintain services rather than employ young nurses and abolish overtime. We need to be able to do our job and if that means maintaining historical mileage so be it; we cannot provide community care by sitting in an office.

The PNA has called on Government to reclaim responsibility for the Health Service, management by the HSE has been a disaster. Government must prioritise resources for clinical care before one penny is spent on so called support services.

In the meantime all PNA Branches must be ready to defend our patients and staff in the face of the incredible challenges now facing us.

Des Kavanagh
General Secretary

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Editor: **Des Kavanagh**

Psychiatric Nurses Association of Ireland
Station House Ireland, ,
The Waterways, Sallins,
Co. Kildare.

Current Issues - Industrial Relations

Directors of Nursing – Performance Related Pay (PRP)

A number of members have contacted us to say that either their PRP had not been paid or that it had been paid for 2008 but they were now being requested to return the money. We advised them to bank the money.

We have now discovered that a letter from Mr. Bernard Carey DOHC to the HSE is being used to withhold payments for 2008 and 2009. The Nursing Unions were not formally advised of this by either the DOHC or the HSE but found out when a DON came across a copy of the circular and forwarded it on.

We have written to the HSE concerning this agreement and if necessary we will process a claim through the normal channels. However some obvious questions arise : If Management have decided that they are entitled to walk away from agreements then what are the ICTU Leadership doing trying to cobble together a National Agreement by which only one party will be required to play by the rules? Why is one Public Service leader so emphatic that there will be a Public Service Agreement if the employers are treating existing agreements which such disregard? Are those Unions so disempowered, so weak?

Authorized Officers

Members will be aware that the Employers decided to 'go live' with the Authorised Officer Service from May 2009, despite the fact that no agreement had been reached with the Unions re same. It seems they rationalised that since it was a voluntary service based on the availability of trained volunteers who would be paid what they had determined was a fair price for the job, the Unions should not have any objection. They expressed absolute amazement when we objected. We are supposed to be in a process to resolve the outstanding issues but we have not met in weeks. We did submit a lengthy list of required clarifications to which we await a response. We will then consider our position.

A brief resume of our concerns is as follows : The Employers want to announce a guaranteed service to the public based on Officers who have completed the course volunteering themselves onto an availability list for which they are paid nothing unless they are called out to do a case. They will be unable to go out or have a drink in case they are called and if for some reason they are suddenly unavailable they are responsible for finding another sucker, sorry I mean Volunteer, to replace them. The Employer insists this service will account for 80+% of all Involuntary Admissions within a short time. We ask : Who will volunteer over Christmas and on Bank Holiday weekends etc?

As lone workers a lot of questions arise regarding their personal and professional safety. The health risks are obvious but the professional risks equally great. After all any Authorized Officer who decides to make application to have someone admitted will have to account to the patients Tribunal for his/her decisions. The regulations state that the A.O. should decide on the least restrictive option of care. On the one hand you account to the Tribunal and on the other to the Coroners Court or some other Tribunal of Inquiry. And all for 350 Euro before Tax.

It is suggested, anecdotally, that a lot of those who have completed the course now realise how big a responsibility this is and have decided not to do the job. However, the PNA position is clear : We regard it as a very important position but it must be properly resourced, supported and remunerated. When our Minister and her Senior Managers were negotiating the Consultants Agreement the word Volunteer did not arise; their services were not paid for on a free on-call service and a small fee if called out for several hours to a potentially hazardous role for whch you would then have to account to a Tribunal !

Assisted Admissions

Following the implementation of the Compensation Scheme for Psychiatric Nurses Injured By Assault at Work the HSE have sought the co-operation of the PNA in facilitating our members return to the provision of Nursing Escorts/Assisted Admissions. The HSE's position arises from a number of perspectives :

- The cost of the Agency currently providing escorts in areas where the PNA has not returned to providing that service.
- The preference for a service provided by Nurses (mainly) from the local service.
- The recent Supreme Court Judgement which found that the existing arrangement as currently constructed is in breach of the Act which requires that the Assisted Admission be provided by staff of the Approved Centre.

A number of meetings have been held with the HSE EA in recent weeks for the purpose of agreeing protocols which the PNA would be prepared to accept as a basis for a return to Assisted Admissions and a withdrawl of our Embargo (which operates in all services except 6 who voted previously for a return to escort duty on the basis of the previous offer).

Managements proposed policy document has been available to Branch Officers and has been the subject of considerable debate. We have submitted an extensive list of questions for clarification. Most of our concerns relate to role clarification, health and safety issues, restatement of our absolute insistence that the service must be provided on a voluntary basis, current staffing issues and our concern to ensure that controls will be in place to ensure neither the greed of the few, or their gerrymandering of the system will result in wards being stripped to provide Assisted Admissions.

We have also sought agreement re :

- A protocol governing the care of the Nurse injured by assault.
- A review of Fees.
- A protocol to ensure Savings are retained in the Mental Health Service.
- Recruitment of staff where there are shortages which would prevent a return to providing Escorts / Assisted Admissions. Copies of the relevant documentation are available on request from Head Office.

Members will be kept advised via the Website and by Circulars to branches.

Monaghan and Cavan Branches Challenge the Cutbacks

Much of St. Davnetts Hospital is now closed , Acute beds in Cavan and Monaghan are reduced to a minimum, the service is now predominantly community based.

Indeed, many members will have heard of the glowing reports of

Cavan Monaghan

Mental Health Services as being the ideal, a blueprint for the future shape of mental health services everywhere, national and even internationally. The Service boasts :

- Small Acute Units in Cavan and Monaghan.
- Home based teams.
- Assertive Outreach Teams.
- Community Addiction Teams.
- Community based service for Psychiatry of Later Life.
- Community Based Child and Adolescent Service.
- Community Mental Health Nursing Services.
- Two Continuing Care Units.

Because the service is predominantly community based it depends on nurses and other team members being able to travel to people's homes as frequently as their conditions dictate and to attend clinics across both Counties. When a 15% cut in travel (miles) was announced it was extremely difficult to cope, many nurses maintained services by travelling the miles anyway but were not paid for those miles hit by the cut; then the 15% turned out to be 18%; Now that cut is an additional 25%.

On top of that there has been no recruitment. Large numbers of staff retiring are leaving gaps in teams. The fledgling Child and Adolescent Service has 7.5 staff when according to Vision for Change it should be 22.5. Children 16to 18 are still managed by the Adult Service. Many very ill people are maintained in the community only because the Teams have guaranteed the GPs and the Families as well as the patients that a comprehensive and responsive service will be available e.g. All were assured that anyone in crisis would be seen within 2 hours.

The Service is now being dismantled by non-filling of posts and imposition of cuts in travelling.

The PNA held a Press Conference in Monaghan on Monday 15th of June to highlight our concerns. Seven Nurses spoke with great passion and eloquence of the pride they have in the service they want to provide and with real sorrow and anger about the manner in which this service is being dismantled.

Des Kavanagh asserts 'I have great pride in our nurses. I was honoured at that Press Conference to say that I represent such professionals. But where are all those who see themselves as overseeing the service nurses provide when those nurses are being prevented from providing that service? Where is An Bord Altranais ? I haven't noticed a newspaper advert supporting them or criticising those who are compromising the care of the mentally ill of Cavan Monaghan? Where is the Mental Health Commission ? Surely this is a case that requires a Tribunal of Investigation ?'

He continued: 'We know that a small minority of patients who do not receive services or withdraw from services often end up in tragic events, for themselves, for their families or for others. Then we have all sorts of public condemnation followed by the obligatory Inquiry to find a scapegoat. This time there will be no nurse scapegoat. If there is a tragedy the responsibility rests elsewhere, somewhere between the Minister who takes responsibility for nothing and the managers who impose her cuts with zeal!'

PNA Branches everywhere must highlight the impact of the cuts on patients and ensure those responsible take full responsibility!

Mileage Rates

Re: Motor Travel Rates

Mr. S. McGrath, National Director HR HSE has advised that following Government instruction, existing rates for travel are reduced with effect from 25th March 2009. All travel expenses incurred by employees from that date are reduced accordingly. Fixed travel allowances and other allowances derived from travel and subsistence allowances should also be reviewed accordingly.

The revised rates are shown in mile and kilometre format below. Payment of the rates authorised in the Circular is subject to the general regulations governing such payment and any other instructions that are in force from time to time.

Rates per mile effective from 25th March 2009

Official Motor Travel in a calendar year	Engine capacity up to 1,200cc	Engine capacity 1,201 to 1500cc	Engine capacity 1,501 and over
Cent	Cent	Cent	
Up to 4,000 miles	64.54	76.94	97.95
4,001 and over	34.91	39.14	47.36

Rates per kilometre effective from 25th March 2009

Official Motor Travel in a calendar year	Engine capacity up to 1,200cc	Engine capacity 1,201 to 1,500cc	Engine capacity 1,501 and over
	Cent	Cent	Cent
Up to 6,437 km	40.11	47.82	60.88
6,438 and over	21.70	24.33	29.43

Motor Cycle Allowance

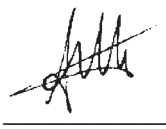
Rates per mile effective from 25th March 2009

Official Motor Travel in a calendar year	Engine capacity up to 150cc	Engine capacity 151-250cc	Engine capacity 251-600cc	Engine capacity 601cc plus
	Cent	Cent	Cent	Cent
Up to 4,000 miles	23.29	32.34	38.16	46.01
44,001 and over	15.07	21.42	24.61	28.31

Rates per kilometre effective from 25th March 2009

Official Motor Travel in a calendar year	Engine capacity up to 150cc	Engine capacity 151-250cc	Engine capacity 251-600cc	Engine capacity 601cc plus
	Cent	Cent	Cent	Cent
Up to 6,437 km	14.48	20.10	23.72	28.59
6,438 and over	9.37	13.31	15.29	17.60

The circular states that:
"Line managers should continue to ensure that only essential travel is undertaken and that the number of staff travelling on any official journey is kept to the absolute minimum".



Seán McGrath,
National Director of Human Resources

Moratorium on Recruitment and Promotions in the Public Service

Circular 015 - 2009 is reproduced in full below

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Office of the National Director of Human Resources
Health Service Executive
Dr. Steevens' Hospital
Dublin 8
Tel: (01) 635 2319
Fax: (01) 635 2486
E-mail: nationalhr@hse.ie

HSE HR Circular 015/2009 **15th May, 2009.**

To: **Each Member of Management Team, HSE;**
Each Assistant National Director, PCCC, HSE;
Each Assistant National Director, HR, HSE;
Each Hospital Network Manager, NHO, HSE;
Each Local Health Manager, PCCC, HSE;
Each CEO of directly funded Voluntary Hospital / Voluntary Agency.

Re: Moratorium on Recruitment and Promotions in the Public Services – Revised Employment Control Framework for the Health Services

1. Introduction

1.1. Further to HSE HR Circular 010/2009, the employment control framework for the health services is being revised effective from this day to give full effect to the moratorium on recruitment and promotions in the Public Service as notified by Government effective from the 27th March 2009. The moratorium is a central feature of the required implementation on savings measures on public service employment.

1.2. The Government decision has been modulated to ensure that key services are maintained insofar as possible in the health services and delegated sanction will apply to some specified grades and activity as set out in this circular. It should be noted there is no exemption for the health services from the moratorium. Some revisions to the current employment control framework as set out herein gives effect to the delegated sanction from the Department of Health and Children/Department of Finance.

1.3. The general moratorium on recruitment, promotion and the payment of acting up allowances does not apply to the following specified grades; Medical Consultants, Speech and Language Therapists, Physiotherapists, Occupational Therapists, Clinical Psychologists, Behavioural Therapists, Counsellors (Mental Health and Disability Services), Social Workers, and Emergency Medical Technicians. It is Government policy, in the case of Medical Consultants, to move to a consultant delivered service, and in the case of the other grades to increase their numbers in order to meet the requirements of integrated care delivery and address community and primary care needs particularly in respect of children at risk, the elderly and those with disabilities.

1.4. The Circular operationalises the moratorium in the health services and it has full application across the HSE, Voluntary Hospitals and Voluntary Agencies encompassed by the approved employment ceiling. A separate communication from the National Directors of Primary Community and Continuing Care, and National Hospitals Office will be sent to the funded agencies within their respective areas. Notwithstanding this, changes in procedures and processes as set out herein are the general principles that will be applied in the Voluntary Sectors encompassed by the approved employment ceiling.

1.5. Decision-making, monitoring, reporting and control requirements on matters arising from the application of the moratorium in the health services will be exercised primarily through the Area HSE HR Circular 015/2009 Page 2 of 7 Employment Monitoring Groups (AEMGs) established in 2008, and with appropriate linkage to the Voluntary Hospitals through Network Managers and to the Voluntary Agencies in PCCC, through Area Assistant National Directors, PCCC.

2. Purpose of the Moratorium

The Government moratorium on recruitment and promotion requires the health services to use its resources better through the redeployment/reassignment of staff, and by reducing

the employment levels in management/admin grades during 2009 by 500 WTEs. The moratorium will operate within an initial overall employment ceiling of 111,800 for the public health sector as approved by Government.

3. Key Actions

3.1. The application of the moratorium requires adherence to a number of key actions as listed herein:

a With effect from the 27th March 2009 and until further notice there will be a general moratorium on recruitment, promotion and acting appointments to all management and administrative grades and all other grades in the health sector (including temporary positions), except for those grades as outlined later in this Circular – see paragraph 6 below.

b When vacancies arise, work and/or staff should be reallocated, or reorganised both within and across institutions and pillars and the budget for that staff member will also be reallocated. Key focus in implementing the moratorium in the health services will be on the redeployment or restructuring of existing staff and work with a resulting reduction in numbers employed.

c The employment ceiling of 111,800 will be reduced by 940 WTEs and a further 95 WTEs in the staff category of management/admin, when functional responsibility for Social Welfare Allowance (SWA), Domiciliary Care and Respite Allowance is transferred from the HSE to the Department of Social and Family Affairs later in 2009.

d The redeployment of some 2,000 staff from the National Hospital Office and HSE Corporate to the Primary, Community and Continuing Care (PCCC) pillar is required by the end of 2009 to facilitate the development of integrated health care. This action will be required irrespective of the creation of a single national operations function.

e As Clinical Risk is an ongoing management challenge for Clinical, Service and Line/Operational Managers in the delivery of services for patients and clients, the focus of decision-making by such managers will be on ensuring maintenance of front-line services where possible, and minimising the impact on patients and clients. Clinical nursing/midwifery leadership in key areas of care should also be considered and prioritised where possible.

4. Promotions

4.1. No promotions can be sanctioned until further notice unless approval is granted by the Minister for Health and Children/Minister for Finance and this only in exceptional circumstances. Any such requests will require the endorsement of both the National Directors of Human Resources and Finance in addition to the National Director initiating such a request. Such requests will be submitted by the AEMGs using a Request to Hire Form A (1), through NEMU to the Department of Health and Children/Department of Finance.

4.2. No requests to upgrade or evaluate posts will be considered for the duration of the moratorium. All such requests are suspended with immediate effect. All evaluations in process and/or completed are deferred until the end of 2010 at the earliest.

5. Sanction of payment of acting and responsibility allowances

5.1. The moratorium rescinds the authority of managers to sanction the payment of acting allowances or additional payment for additional responsibilities for the duration of the moratorium. No such new payments will be sanctioned from the 27th March 2009. Existing payments for those in acting positions will continue. However when the allowance comes up for review, there is a HSE HR Circular 015/2009 Page 3 of 7 requirement for clinical/line/operational managers to ensure the appropriateness of this allowance and cease it if the need no longer is required. Where there are requirements for staff to act up all steps should be taken to redeploy or reorganise work to minimise requesting staff of a lower grade to assume the role of a higher substantive post. Other than the specified grades as outlined in paragraph 6, the payment of acting allowances will be allowed only in exceptional circumstances and the prior approval of the Department of Health and Children/Department of Finance will be required in each such instance.

5.2. A review of long-term acting up arrangements/associated payments has commenced and the outcome may provide a further opportunity to streamline the existing situation where widespread acting up arrangements are currently in place. The review when completed should result in a reduction in the overall level of long term acting arrangements currently in the organisation.

5.3. Where a clear clinical risk is identified by the non-renewal/sanction of a paid acting-up arrangement/associated payment, the service manager will have the authority to resolve the matter in line with the emergency provisions outlined in paragraph 7 below. The position will subsequently be regularised by way of application to the relevant AEMG for consideration and for onward transmission to the Department of Health and Children/Department of

Finance for their approval. Any such approvals will need to conform to approved budgets and ceilings.

5.4. In the event of a decision to cease a current payment of an allowance, staff will be advised in advance of the cessation of the payment and in consultation with their staff representative as appropriate.

6. Delegated Sanction for specific grades.

In order to meet the requirements of integrated health care delivery and particularly to address needs in the community in respect of care of the elderly and people with disabilities, delegated sanction is hereby given to the filling of vacancies that arise post the date of the moratorium, and the creation of additional front-line posts in the grades listed in this section, subject to the conditions specified herein. The delegated sanction will also apply to decisions on promotions, the continued payment of acting allowances, for those grades specified, subject to ongoing justification for doing so and to the renewal of non-permanent contracts where the provision of ongoing service delivery so warrants. In addition, new staff in these specified grades may be recruited in either non-permanent or permanent contracts, within the specified limits, dependent on the service and funding provisions.

6.1. Hospital Consultants – As indicated by the Minister for Health and Children in the context of the Estimates, there is a need to rebalance numbers between Non-Consultant Hospital Doctors and Hospital Consultants to provide for a consultant delivered service and to free up resources to contribute to the cost of this service. Any new post of hospital consultant will therefore generally be created by the suppression of 2 non-consultant hospital doctor posts (some variation may be allowed to this ratio to meet particular local circumstances). This suppression of 2 NCHDs for each new consultant post may require suppressions across hospitals and networks. Further instructions will issue from the Consultants Appointments Unit (CAU).

6.2. Specific Grades in Health and Social Care Professionals – The HSE has been given delegated sanction to fill current vacancies in existing posts in the grades listed in this sub-paragraph. These may be filled in line with procedures already outlined for the operation of the AEMGs as set out in paragraphs 5 and 6 above. Provided that the HSE is satisfied in each case that there is no scope to redeploy an equivalent post from the NHO to/or within PCCC, new additional posts at basic level may also be created in these grades to meet primary and community care needs and particularly those of the elderly, and people with disabilities, mental health and primary care.

The National Director, PCCC will set out the necessary details with regard to the service development, location, grade and WTE value and forward to the National Director, Human Resources who will issue a primary notification to give initial approval to the recruitment of additional posts as set out here:

a Speech and Language Therapist, Occupational Therapist, Physiotherapist – Up to an additional 450 therapists.

b Clinical Psychologist, Behavioural Therapist, Counsellor Therapist – Up to 250 new posts.

c Social Worker - Up to an additional 270 Social Worker posts.

d Further specialist grades, on a replacement basis only, where the option of redeployment is not available and due to the impact of a non- filling on front-line services, may be added to this delegated sanction but will require Department of Health and Children/Department of Finance formal approval to add such grades to the list above.

6.3. Emergency Medical Technicians (EMTs) - Where it is necessary to support the reconfiguration of emergency services between hospitals and there is no scope to meet the needs arising from the redeployment of existing Emergency Medical Technicians up to 30 further posts may be created and filled. The National Director, NHO will set out the necessary details with regard to the service development, location, and WTE value and forward to the National Director, Human Resources who will issue a primary notification to give initial approval to the recruitment of additional EMT posts

6.4. A post or posts with an equivalent salary value will be suppressed in non-priority areas to meet the cost of each new front-line post created under this section. The moneys allocated for the salary and related costs of the suppressed posts will be reallocated from the budget holder of the suppressed posts to budget holder of the new post

6.5. All requests to hire for additional posts under this delegated sanction will be initiated through Requests to Hire Forms A and forwarded to NEMU prior to being processed, through the relevant AEMG. The Request to Hire Form A must identify the live vacancy to be suppressed in advance of the filling of the post.

6.6. Adjustments to the approved employment ceiling and associated budget of the appropriate Hospital/Local Health Office, Voluntary Agency, Ambulance Centre will be adjusted once the new post is activated on payroll and a corresponding reduction of ceiling will be applied to the location where the

suppression is made to allow the creation of these additional posts in the grades listed above.

7. Emergency interventions to maintain critical front-line services.

The implementation of the moratorium in the health services has no impact to current emergency interventions/processes to maintain critical front-line services. Staff and local management must continue to work in an environment where they are confident that they can address emergency clinical risk issues where and when they occur. In the first instance Clinical/Nursing/Operational/Service Managers should address such emergency situations by short term redeployment of existing clinical staff and/or other a ctions, pending a longer term solution being achieved through the role of the AEMGs. Local Health Offices and hospitals should have contingency planning in place to deal with emergency staffing situations. Use of agency/overtime/short term acting arrangements to deal with key emergency vacancies in critical front-line posts as a stop-gap can be actioned in accordance with current instructions issued by the National Directors of PCCC and NHO.

8. Modifications to the Recruitment Function

8.1. The focus of recruitment activity in both the HSE and wider health services, from the application of the moratorium will move to maximising the capacity to redeploy staff within and across functions and agencies to areas of greatest need in accordance with the HSE's service plan priorities, with the objective of minimising the impact on front-line services.

8.2. Recruitment activity which may continue in the context of the revised employment control framework within the HSE, will move to the National Recruitment Services (NRS), Manorhamilton, Co Leitrim, while the Area recruitment function will focus and support the Area Employment Monitoring Groups (AEMGs) and Corporate Employment Monitoring Group (CEMG) in effecting redeployment of existing staff. Separate instructions will issue from this office on the implementation of moving existing recruitment functions and activity to NRS and separate discussions will be held with the relevant trade unions in this regard.

9. Role of Area Employment Monitoring Groups (AEMGs) and Corporate Employment Monitoring Group (CEMG) and delegated sanction.

9.1. The four AEMGs and the CEMG are the key groups required to ensure adherence to the moratorium on recruitment and promotions across the health services. Front-line service managers and CEOs of Voluntary Agencies/hospitals will input through the relevant Network Manager and Assistant National Director, PCCC. The chair of the Group will alternate between the two service functions pending the appointment of Regional Directors. Critical to the operation of the Groups is the ability to fill vacant posts through redeployment of existing staff on a priority basis. The roles of the Groups also extend to the Voluntary Hospital Sector in the NHO and Voluntary Agency Sector of PCCC and redeployment may extend across functions and agencies where appropriate. A specific set of instructions will issue separately to ensure consistency of application across the health services and ensure timely approvals to recruit where required.

9.2. A process will be put in place to re-assign ceilings to the four administrative areas and to provide for further re-assignment of ceilings to LHOs, Hospitals, Voluntary Agencies and Corporate functions. The allocation of ceilings will have regard to the requirement to implement the key actions outlined in paragraph 3 and the requirement for re-deployment of some 2,000 staff to facilitate the implementation of the integrated care model and expansion of priority services in PCCC as set out in sub-paragraph 3.d above.

10. Contracts of Employment – non permanent/Fixed-term and Specified Purpose

10.1. The moratorium also applies to temporary appointments on a fixed-term or specified purpose basis and to the renewal of such contracts.

10.2. A review of all non-permanent contracts of employment on a case by case basis will be undertaken over the next two months. The review takes into account the necessity, on the one hand, to protect front-line services and on the other to ensure resources are deployed as efficiently as possible and to achieve a permanent structural reduction in numbers employed. This review will ensure compliance with legislation and also to facilitate appropriate engagement with staff representative bodies at Area and local level.

10.3. Any exceptions to the moratorium, other than the specified grades listed in paragraph 6 above, which will arise in very limited circumstances only, will require the prior sanction of the Minister for Health and Children and the Minister for Finance and must comply with approved budget and ceilings at Area, Agency and local level. This sanction will only be forthcoming where it can be demonstrated that the post is essential to the delivery of a public service or performance of an essential front-line function, and that every effort has been made to fill the post by redeployment.

10.4. In instances, where approval or otherwise to extend a fixed term or specified purpose contract

(and/or replace with a contract of indefinite duration), is being sought due to the critical nature of front-line service being delivered by the contracted employee and the immediate impact of termination of the contract on service delivery, such contracts may be extended on an interim basis by the relevant AEMG for a period of no more than 40 days to allow sanction or otherwise to be given by the Department of Health and Children/Department of Finance.

10.5. In the event of a decision to terminate a non-permanent contract, staff will be notified in line with standard notification of termination of contracts and in consultation with their staff representative as appropriate.

11. Redeployment of existing staff and/or Reorganisation/Reallocation of existing work

A central feature of the moratorium is the focus on redeploying existing staff and grades to address the filling of critical front-line vacancies and to reduce overall employment levels. In addition such redeployment should provide employment scope to give effect to increased employment in specific grades as set out in paragraph 6 above. Area Recruitment Managers and their teams will move their focus from recruitment to redeployment for the duration of the moratorium on recruitment and promotion.

11.1. HR support to redeployment and reassignment. The Area Redeployment Teams will provide direct support to the operation of the AEMGs in the redeployment options for the filling of HSE HR Circular 015/2009 Page 6 of 7 critical front-line posts. Once a decision is made on redeployment of staff, the Area Redeployment Team will effect such a decision. If there is no immediate capacity within an Area to redeploy, the Area Redeployment Manager will liaise with other Area Redeployment Managers and NRS in Manorhamilton to fill through the National Transfer panel. Redeployment will not attract any additional remuneration. Training and development support should be provided to staff being redeployed as required.

11.2. Criteria to be used in redeployment of existing staff:

a Redeployment should be pursued proactively on a voluntary basis.

b Redeployment will generally be on a grade for grade like basis.

c In the case of specialist posts, the staff member to be redeployed must meet the agreed prescribed specialist qualifications for the specialist post.

d The priority will be to examine existing skills to meet business pressures.

11.3. Re-deployment of some 2,000 staff from NHO and HSE Corporate to Primary Community Continuing Care is a key action for implementation as part of the Government decision. The reconfiguration of services will involve the re-deployment and re-assignment of staff as well as providing a far greater level of flexibility across and between grades and functions/agencies on working arrangements and responsive service delivery. The AEMGs will be required to oversee the implementation of these arrangements. Each AEMG will establish a process to address the issue including arrangements for engagement with Unions and staff associations as appropriate. Monthly reports will be made available to HSE Corporate for communication to the Department of Health and Children/Department of Finance.

12. Clinical Placements, rotations, training posts and pre-registration requirements

12.1. The filling of these posts are critical to the workforce planning requirements of the health services and are to be maintained at current agreed levels. All such appointments should be on the basis of "one-for-one". If, as at the 27th March 2009, a future filling of a post under this section would result in increased employment levels over an above the level as at the said date, such increases need to be offset prior to the activation on payroll by suppressing a similar number of live vacancies for the duration of the placement, rotation, pre-registration period or filling. It should be noted that a Training Post is a post recognised by the relevant; statutory body, training body, and the HSE for training purposes.

12.2. In accordance with the agreement with the nursing unions and the Commission on Nursing, regarding student nurse placements from the start of 2009, staff nurse employment levels must be displaced at a 2:1 ratio. In essence this requires a reduction of 700 staff nurses from the 2008 census outturn for the duration of these placements. When student nurse placements cease on completion of their 36 week placement later in 2009, and assuming that the complement of staff nurses was reduced to give effect to the 2:1 replacement ratio, additional staff nurses may be given employment on a fixed term basis for the period between student nurse placements. 13. 3% Reduction in payroll for Management/Admin grades and reallocation of approved employment ceilings at Local Health Office/Hospital and Voluntary Agency level.

These will be the subject of separate HSE HR Circulars as referenced in HSE HR Circular 01/2009. A further 95 WTEs in this staff category will need to be suppressed in 2009 arising from the transfer of functions from the HSE to the Department of Family and Social Affairs.

14. Incentivised Scheme for early retirement

Details on this scheme and how it will be applied to the health services, in the context of the employment control framework, is the subject of a separate circular.

15. Reporting.

15.1. Each AEMG, must submit to NEMU a monthly report no later than the 6th day of the following month, the following information items;

a The number, and location of front-line posts filled in the month in question by
- Redeployment,
- Recruitment,
- Promotion,
- Salary savings including cumulative savings to date,
- Staff returning off career-break,

b With regard to the specific recruitment decisions arising from the review of non-permanent (temporary) contracts, full details will be forwarded monthly through NEMU to the Department of Health and Children / Department of Finance for their necessary approval or otherwise to extend beyond the 30 days as set out in paragraph 10 above.

c In addition a copy of all requests to hire forms approved by an AEMG will be sent immediately to NEMU.

d NEMU will maintain a database on all such employment activity.

16. Miscellaneous Provisions

16.1. 2009 Service Development Posts. Recruitment for these additional 225 WTEs as set out in the National Service Plan 2009 in the three programmes; National Cancer Control (NCCP) – 100 WTEs, Disability Services – 90 WTEs and Mental Health Services – 35 WTEs are as set out in HSE HR Circular 01/2009.

16.2. Flexible Working. The moratorium proscribes the granting of any additional hours to existing flexible working contracts of employment, unless offset by reductions elsewhere

16.3. Maternity leave cover. AEMGs are required to examine all such requests. Maximum use of redeployment and/or reorganisation/reallocation of work are to be applied in such instances.

16.4. Return from maternity leave. In the case of employees who have a legislative entitlement to return from maternity leave, AEMGs must ensure these increases in employment are either offset by the termination of the fixed term/specified purpose contract of employment put in place to cover for such leave or alternatively by suppression of other live vacancies.

16.5. Return from career-breaks. Only when a live vacancy, where it is deemed critical to fill from a front-line service perspective, has been identified at an appropriate grade, can approval be granted through an AEMG for the return from career-break of existing employees of the HSE/Health Services. Due regard has to be given to the statutory timeline obligation for staff to resume employment in the health services under the career-break scheme. The option of redeployment across functions, hospitals, agencies may be considered when dealing with such requests to return from career-break.

Queries in relation to this Circular should be directed to Mr Frank O'Leary, Head of the National Employment Monitoring Unit (e-mail frank.oleary@hse.ie) phone 045 880454 or Ms Eíbhlín Smith (e-mail Eibhlin.smith@hse.ie) phone 045 882522, or Mr Paddy Duggan, Recruitment Manager National Policy and Standards (e-mail paddy.duggan2@hse.ie) phone 045-882541.

Séan McGrath,

National Director of Human Resources.

Unions Unite to Issue Directive to all Union Members following HSE Moritorium and Recruitment Embargo

The Union Directive

In order to maintain safe standards of care, protect employment and protect existing terms and conditions, all health service unions are issuing this directive to members.

Where employers introduce cutbacks and/or staffing restrictions, without agreement, **all members of the unions listed below**, are directed to adhere to the following subject to the basic care needs of patients being met:

1. Advise the employer that they are in breach of their existing agreements and contractual obligations and are, as a consequence, fully responsible for any impact on patient care.

2. All members are instructed not to undertake duties, roles, tasks or responsibilities of vacant posts, or where a post holder has been let go and not replaced.

3. All members should refuse to act up or take up added responsibility in any voluntary or informal arrangement, as an alternative to the normal acting up arrangements which provide for payment for the added responsibility.

4. All members should resist attempts to redeploy or be reassigned and refuse to accept any redeployment, or outsourcing other than those agreed with trade union representation.

5. In any case where it is proposed to terminate the employment of temporary staff, or reduce numbers, call for an immediate risk assessment by the appropriate service manager and confirm your request in writing.

6. If you are left short of staff to a point where the safety of staff or patients is undermined, you may be instructed by your branch or national executive to report for work but not to go on duty.

7. Any union member who breaches a HSE directive in order to act in the interests of the patient, client or service user will be fully supported by their union.

8. All members should refuse to co-operate with the opening or expansion of new or existing services while other services are being curtailed or suspended because of the cutbacks and/or moratorium on recruitment.

9. All members should resist attempts to have any member of staff work on an overtime basis (including un-rostered hours) without appropriate agreed payment for such duties.

CRAFT GROUP OF UNIONS

IMO

IMPACT

INO

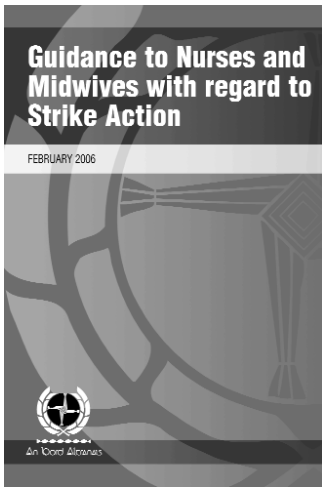
Irish Dental Assoc

MLSA

PNA

SIPTU

Des Kavanagh responds to Mr. E. O'Donoghue CEO An Bord Altranais Re: Guidelines sent to All Nurses regarding strike action following Sligo dispute



Des refferred to An Bord Altranais letter, 12/06/09, in relation to Strike Action, and indeed the advertisement recently taken out by An Bord in the National Newspapers.

He went on to state that Nurses regularly find themselves in ethical and moral distress as a result of decisions by Managers which impact on safe care and practice. Many of those Nurses phone An Bord Altranais and are advised to phone their trade union for support and representation. You see no role for An Bord in the "promotion of high standards of professional practice and conduct" in such cases.

In some cases the Union succeeds in winning cases at third parties or indeed agreement in direct negotiation which are then ignored by Managers, including Nurse Managers, in pursuit of cutbacks. Again you see no role for An Bord.

If Nurses, as advocates for patients then take action in support of the higher standard of care that you purport to promote, you threaten Nurses, even though the actions are in the best interest of patients.

Des pointed out to Mr. O'Donoghue that we now have the extraordinary situation where:

- Nurses as citizens of this state have a constitutional right to withdraw their labour.
- Government and its agencies have determined that if the Nurses work to rule their full pay will be withdrawn.
- If they strike and provide emergency cover their employer will seek emergency cover often in excess of what they regularly provide as a norm. Those providing emergency cover will not be paid, nor will those on picket duty.
- If nurses engage in any action you will examine same on behalf of the Minister, the HSE and Management and determine if such action is such that you can take disciplinary procedures against them.
- You will use Nurses monies to take out adverts threatening nurses.

Yet, you see no role for yourself in supporting the Nurse in ethical and moral distress because of the impact of Managements decisions and the resulting negative impact to patient care.
He stated that following the ad in the press to Mr. O'Donoghue's letter that PNA Head Office was inundated with calls from Nurses asking:

"Why does our nursing board see itself as part of the Ministers stormtroopers"?

"Why does An Bord not see any role for itself in protecting patients by supporting Nurses"

"Why does it only see its role in the negative context of threatening Nurses?"

"Why have An Bord Altranais become the lapdog for HSE/Dept of Health in attempting to stop Nurses advocating on behalf of patients in support of appropriate services and standards of care?"

In other parts of the world threats by Regulatory Boards resulted in mass resignations by Nurses (or the threat of same) as a result of which the claims of the Nurses were conceded. Perhaps the same will have to happen here!

Special Schemes Announced by the Minister for Finance in Supplementary Budget

These Circulars are currently on hold since management have "withdrawn" them in a fit of pique to try to force the Unions to withdraw our directive.

The following schemes

- **Incentivised Scheme for Early Retirement (I.S.E.R.)**
- **Special Incentive Career Break Scheme 2009**
- **Shorter Working Year Scheme**

as per HSE HR Ciculars 16,17 and 18 previously announced in April 2009 are currently on hold. The "Agreed Directive" supported by the majority of health service unions contains an instruction to resist redeployment at this current time.

Main Provisions at a glance (full Circulars on schemes on www.pna.ie/ IR/ Cost Containment Measures)

1. Incentivised Scheme for Early Retirement

- The Scheme does not apply to Nurses registered under section 65 of the 1945, Mental Treatment Act because this provision allows for " faster accrual rates of service for pension purposes" as it allows staff to retire "with full pension after less than 40 years actual service"

- It will apply to :
  New entrants to Psychiatric Services i.e. those who joined the service after April 2004.
  Those Psychiatric Nurses who work in areas not covered by section 65 e.g. St. John of Gods, those directly employed by St. Vincent's Fairview.
  All I.D. Nurses
  All General Nurses

- Subject to:
  Employees being over 50 years of age by 18th September 09
  Staff not being replaced except in the most exceptional of circumstances and provided that the grades/staff groups concerned co-operate with the requirements in relation to re-deployment, mobility, skill mix and flexibility outlined in the employment control framework.

- Operation of the Incentivised Scheme for Early Retirement
  Nothing in the circular confers an absolute right or entitlement on staff to avail of the I.S.E.R. but in general employers will be expected to facilitate the early release of staff with priority being given to employees with the longest service.
  If the retirement will give rise to difficulties of a substantial nature in the management of the organisation employers may:

(a) Postpone the date of retirement for a period of up to one year.

(b) In exceptional cases refuse the application.

- Applications must be made no later than 18th September 2009.
- A decision will be given no later than 6 weeks after the application is made.
- If decision to refuse, appeal must be lodged within 2 weeks.
- An application must contain a preferred date for leaving no later than 30th November 2009.
- Once an application has been approved with a signed form B2 received by the employer the application cannot subsequently be withdrawn.

Note:

- While the Cost Neutral Early Retirement Scheme (Circular 05/2005) will continue, all other existing early retirement schemes are now closed.
- Pension along with 10% of lump sum will be paid immediately, without any actuarial reduction.
- The remaining balance of the lump sum 90% will be paid on reaching normal preserved pension age (usually age 60)
  Full terms and conditions of the scheme with application form on www.pna.ie

2. Special Incentive Career Break Scheme 2009.

- Successful applicants for a career break under this scheme who work full time will be paid an incentive payment of a third of gross pay to a max of €12,500 per year payable quarterly in arrears, for 3 years.
- Application must be made to HR on prescribed form no later than 1st July 2009.
- While employers are requested to facilitate applications the "needs of the work may require that some applications will have to be refused to ensure that in particular "essential service provision is not undermined".
- A career break under this scheme may start no later than 1st September 2009. There are some exceptions e.g. those on maternity leave at 1st September.
- An extension may be applied for at end of 3 years but the incentive payment will cease after 3 years.
- The same provisions regarding redeployment, flexibility etc as apply to the ISER also apply here.
  N.B Return to Work
- If an employee fails to contact the employer before the expiry of the career Break s/he will be deemed to have resigned from the organisation.
- Those returning will be:
  -Assigned to the next appropriate vacancy.

-With a guarantee of re-employment i.e. a fillable vacancy in the officers grade and department in the location in which s/he was serving prior to commencing the career break, not necessarily in

his or her existing department within 12 Months of the expiry of the career break.
-Location is defined as “within local catchment area or within a reasonable distance with the Dublin area being treated as one such location”.
Full terms & Conditions together with application form on www.pna.ie

3. Shorter Working Year Scheme

- This scheme now supersedes the Term Time Circular.
- Special Leave is available as a period of 2, 4, 6, 8, 10, or 13 consecutive weeks. The leave may be taken as one continuous period or as a maximum of 3 separate periods.
- The period of leave shall be "unpaid special leave."
- Annual leave allocation may be reduced as a consequence.
- Participants may not avail of sick leave during the period of special leave.
- Participants in the scheme may apply for special administrative arrangements for the payment of part of basic salary during the period of leave – conditions apply.
- Persons availing of the leave must re apply each year.

Pregnancy and Undergraduate Nursing Internship HSE circulars issued recently.

1. Pregnancy related sick leave (HSE HR Circular 25/2008)

The HSE has changed its policy with regard to female employees who are medically certified as unfit to work due to a pregnancy related illness by circular of the 11th November ’08. Moving forward, salary will not drop below half pay prior to going on maternity leave. (A HSE employee who is pregnant and suffering a pregnancy related illness could at present find themselves cut off pay altogether depending on exhausting their sick leave entitlement over the previous one year or over a four year period)

The circular also changes the criteria for sick leave entitlement post pregnancy when following maternity leave, where an employee is unfit for work due to ill health her entitlement to sick pay at half pay will be extended by the period of absence due to pregnancy related illness which occurred prior to her maternity leave provided she has not benefitted from pregnancy related sick leave during pregnancy.

The changes introduced by this circular relate only to pregnancy related sick leave and the circular stresses that not all illness during pregnancy is necessarily pregnancy related.

2. Undergraduate Nursing Internship (HSE HR Circular 28/2008)

This circular covers the Salary, PRSI, superannuation, leave entitlement, sick leave, maternity leave and replacement ratios. This document has been forwarded to all branches and should be copied and given to all students in your service and similarly circulated to all wards.

Uniform Tax Allowance

Tax Allowance for PNA members.	
Where obliged to supply and launder their own uniforms	€733
Where obliged to supply their own uniforms but are laundered free	€638
Where obliged to launder uniforms that are supplied	€353
Where uniforms are supplied and laundered by the employer	€258
Tax Relief on Union Subscriptions	€350

Senior Staff Nurse Grade – Revised Criteria.

The HSE have revised the complicated service criteria for filling senior staff nurse posts. The only criteria moving forward will be 20 years post qualification experience.

Background
As part of the settlement terms of the nine day nurses strike in 1999 the post of senior staff nurse (SSN) was created. Hundreds of PNA members have benefited since its introduction, as well as having their experience and knowledge recognised. Recently the qualifying criteria was made more straight forward.

Current Filling of Posts

- In order to be eligible for a SSN/Midwife post, the following criteria must be satisfied on 5th November (each Year).
- Following the issuing of a circular on the 17th November this year "the revised eligibility for application to the grade of Senior Staff Nurse will be **20 years post qualification genuine nursing experience."** All the previous requirements to have Irish Service during the 20 year period have been put aside.
- The Job Profile as contained in LCR 16330 will apply.
- The reference date for the determination of service and payment will be the 5th November each year and application must be made on the prescribed application form. Payment in respect of SSN/Midwife appointments will not be retrospective i.e. the 5th November is the effective appointed date end the payment date each year.

Temporary Nurses who meet the eligibility criteria are also entitled to apply and to be appointed to for S.S.N Posts (Temp).

Recently a number of queries have been received in Head Office relating to some local managements insistence that eligibility is confined to those who have worked 20 'full' years. In this regard we can refer to correspondence to Mr Des Kavanagh from Mr Brendan Mulligan HSEA (01.06.2000) which notes the following methodology with regard to calculating service.

Service
As with the Incremental Credit Agreement for Nurses service constitutes all genuine nursing experience in Ireland and abroad.

Career Breaks
Genuine nursing experience obtained during the course of a career break is reckonable for purpose of calculating service.

Job Sharers
Nurses who are currently job sharing or who did so in the past will have their period(s) of job sharing treated as full time attendance e.g. a nurse who is job sharing for 5 years will be returned as having 5 years reckonable service.

Part – Time Attendance
A nurse who had worked in a part-time capacity in the past will have that period of service calculated on the following basis-

Each week in which 8 hours or more was worked will constitute as 1 reckonable week. Therefore 52 reckonable weeks is equivalent to 1 year's service.

Having regard to the foregoing it is clear that nurses do ***not*** require 20 ***full*** years service to qualify, rather that they work a shift pattern of 8 hours or more each week.

Sponsorship of Nursing/Midwifery Third Level Education Initiatives

The following circulars are superseded by this circular.

- **Circular 095/2000** - Revised Arrangements for Student Midwives
- **Circular 098/2000** - Payment of Fees for Part-Time Nursing Degree Courses
- **Circular 149/2000** - Revised Arrangements for Student Paediatric Nurses
- **Circular 150/2000** - Specialist Nursing Courses
- **Circular 047/2001** - Specialist Nursing Courses
- **Circular 011/2005** - Payment of Fees for Part-Time Nursing Degree Courses

This circular applies to the following nursing/midwifery education initiatives and the conditions under which they will be sponsored by the HSE.

Post Registration Student Midwives
Recognised midwifery education Hospitals/NMPDU's are authorised to pay course fees for all students studying for the post-registration Higher Diploma in Midwifery.
Student Midwives are to be paid at their existing salary and are entitled to receive incremental credit. This initiative is subject to the conditions set out below.

Post Registration Student Children's Nurses
Recognised children's nursing education Hospitals/NMPDU's are authorised to pay fees for all students studying for the post-

registration Higher Diploma in Children's Nursing. Student children's nurses are to be paid at their existing salary and are entitled to receive incremental credit. This initiative is subject to the conditions set out below.

Part-Time Nursing/Midwifery Degree/Access Courses

Under this initiative a registered nurse or midwife who has commenced a part-time undergraduate nursing/midwifery degree/access course prior to 1 January 2009 and who does not already hold a recognised third level degree will be entitled to have their fees paid in full by their employing agency. This funding initiative is discontinued for all new entrants with effect from 1 January 2009.

Specialist Nursing Courses

Under this initiative a registered nurse or midwife undertaking an An Bord Altranais Category II approved (as at November 2007)* Post Graduate/Higher Diploma courses in specialist areas of clinical nursing/midwifery practice and who have not been already been funded for a specialist course within the last thirty six months (or less if specifically required by service need) be entitled to have their fees paid in full provided the conditions of this initiative are fulfilled.

* Appendix 1

This initiative is subject to the conditions set out below.
Conditions

1. Eligibility

Candidates must be registered with An Bord Altranais and employed in the public health service on a permanent or temporary basis (provided the term of their contract allows them fulfil their service commitment see section 4 below), whether working full-time or part-time to be eligible to receive funding.

Courses undertaken must be relevant to the nurse's/midwife's area of practice and meet patient and service needs with due regard to cost and the educational needs of the employing organisation as a whole. Applicants requiring a work visa/authorisation for employment in the State must provide evidence that their work visa /authorisation allows them to fulfil their commitment required under the circular. These funding initiatives do not apply to agency staff or nurses/midwifes employed in private hospitals and private nursing homes or GP practices.

2. Funding

Course funding will only be provided for courses run in the State and at the fee applicable to an EU/EEA citizen. Any amount in excess of the fee applicable to an EU/EEA citizen will not be funded under the terms of this circular.
No funding will be provided for repeat module(s), units of study or examination fees. Such fees must be borne by the nurse or midwife concerned.

3. Satisfactory Employment Record

In order to qualify for sponsorship, the Director of the Nursing/Midwifery must be satisfied that the applicant has a satisfactory service record.

4. Service Commitment

Successful applicants for sponsorship will be required to give a written undertaking to their sponsoring public health service agency that they will following successful completion of the programme, work for their sponsoring agency for a minimum period of twelve months or for the length of the academic course undertaken, whichever is longer (see paragraph 7 below in relation to service commitment required of part-time employees). The employing agency has responsibility for enforcing the sponsored employees' compliance with their contractual service commitment contract. Until such time as a sponsored employee has fulfilled their service commitment they will not be approved for further sponsorship under any other nursing/midwifery education initiative.
In exceptional circumstances, all or a portion of the service commitment may, with the prior agreement of the sponsoring public health service agency concerned, be given in the employment of an alternative Irish public health service agency.

A sponsored employee who fails to honour their contractual undertaking to work as a nurse/midwife for their sponsoring agency (or agreed Irish alternative public health service agency) for the period of the service commitment immediately following successful completion of the programme shall be required to repay to that sponsoring agency their fees and in the case of fulltime courses the value of the salary received by them during the theory element of the programme. Any repayment due will be adjusted on a pro rata basis for any period of service commitment honoured.

5. Additional Costs

All other and additional costs, charges and expenses, including travel, text books and library charges incurred by the student undertaking the programme will be discharged by the student at their own expense.

6. Retention of Salary

A public health service employee who is sponsored in accordance with the terms of this circular will remain on the payroll of their public health service agency. They will retain their existing basic salary plus specialist allowances (where applicable) throughout the period of the programme, and will continue to be entitled to normal incremental progression up to the maximum of that scale.

7. Part-time Employees

Part-time employees who are awarded sponsorship for a full time course leading to an additional registration with An Bord Altranais will be required to become full-time employees for the duration of the programme. Following successful completion of the programme, they may, with the prior agreement of their Director of Nursing/Midwifery, revert to working part-time (provided the part-time work is not less than half-time)

8. Annual Leave

In the case of fulltime courses sponsored employees shall retain their annual leave entitlements throughout the period of the programme. However, annual leave may only be taken outside of academic semesters and in accordance with service need.

9. Student Obligations
The student will attend in full the programme with proper diligence and will undergo such examination and tests as may be prescribed in or required by the programme curriculum with a view to successfully completing the programme.

10. Governance
The student will be required to provide their sponsoring agency with a copy of their examination results at the end each academic term...

11. Exceptions
A student absenting themselves, and/or failing to complete the programme due to unforeseen or exceptional circumstances, may be facilitated at the discretion of the sponsoring agency and higher education institute to complete the course and examinations in such manner as may be specified.

12. Repayment of Fees and salary
Part-time programmes
Where an employee is required to repeat elements of a part-time programme they must remain in the employment of their sponsoring agency during the repeat period.
If they cease employment or do not complete the programme they will have their sponsorship terminated and will be required to both course registration and tuition fees.

Fulltime programmes
When an employee is required to repeat elements of the programme they must remain in the employment of their sponsoring agency during the repeat period.
If they cease employment or do not complete the programme they will be required to repay both course registration and tuition fees and the portion of the salary received by them during the theory element of the programme.

In exceptional circumstances all the above repayments may be waived or deferred at the discretion of the Sponsoring Health Service Agency. Such repayments shall be made to the public health service sponsoring agency where they were employed.

13. Review of Initiatives
These initiatives will be kept under annual review.

14. Definition:
A Sponsoring Health Service Agency is a statutory or voluntary agency in the public health service in which the student is working when they commence the sponsorship. This includes any of the following:

- **an acute/non-acute hospital**
- **a community care area**
- **a long-term care facility**
- **a mental health service,**
- **an intellectual disability service**

Nursing & Midwifery Advisory Committee (Implementation of the HSE Report of Nursing & Midwifery Post – registration Education Review)

The Office of the Nursing Services Director has established the above group to oversee the implementation of the HSE report **Nursing & Midwifery Post – registration Education Review.**

The PNA made a significant contribution to this report as part of a wide ranging consultation process and submission **www.pna.ie publications.**

The committee is chaired by Dr Siobhan O Halloran, Director of Nursing Services, the PNA representative on the Advisory Committee is Ms Aisling Culhane Research & Development Advisor. The committee in the first instance will support the implementation of the recommendations of the report and will:

- Be representative of relevant stakeholders in post registration & midwifery education.
- Inform & advise on the implementation of the recommendations of the report of Nursing & Midwifery Post Registration Education Review Group.
- Ensure a partnership approach is taken at a national level which will influence and inform the approach taken locally
- Ensure the communication of key developments to stakeholders
- Produce & distribute an annual report charting the progress of the implementation process

The Method of Work is divided between four committee subgroups as follows:

Education Commissioning & Quality Review Sub group

Finance Sub group

Information management Sub Group

Professional & Regulatory Sub- Group

The Report can be downloaded @
http://www.hse.ie/eng/About_the_HSE/Nursing_Services/Post-registration_Nursing_and_Midwifery_Education_Review_.pdf

Disclaimer Form

A Number of requests have been received in head office regarding "Indemnity" forms that Nurses could complete and submit to Management. Head Office has issued an updated version of the form that we previously circulated.

Seamus Murphy Deputy General Secretary states “that the minimum that should be done in any circumstances where wards are left short is that this form should be submitted”.

It may not resolve the situation but it will protect you in the event that you are accused at some stage of being aware of a situation that placed patients/clients in jeopardy or militated against safe standards of practice and did nothing about it.

Seamus Murphy asked members to be aware that the very existence of this form creates an added responsibility on a nurse to submit it in the event that you have a concern about any aspect of your practice and that he was aware of an inquiry where a Nurse brought short staffing issues to the attention of her Management on several occasions, orally, but this was denied by Management at the inquiry. She was asked to account for, if this was so, why she did not complete her own Unions' (not the PNA) standard "Indemnity" form.

It may also be necessary to complete a clinical incident/close call form. This will have the benefit of alerting the insurance companies of the unsafe or potentially unsafe situation in your ward/unit. These forms should be available on the Ward/Unit.
Nurses on a Unit left short staffed should also demand a "Risk Assessment" required under Section 19 of the Health Safety and Welfare Act 2005.

In addition to this Nurses in charge of a Ward/Unit and up to and including a Hospital/Service need to be mindful of Section 80 & 81 of this Act.

Section 80 : "Liability of Managers"
Outlines that where an offence is committed 'by an undertaking and the doing of the acts that constituted the offence has been authorised, or consented to by, or is attributed to connivance or neglect on the part of, a person, being a director, manager, or other similar officer…….. or a person who purports to act in any such capacity, that person as well as the undertaking shall be guilty of an offence….."

Section 81: "Onus of Proof."
"In any proceedings for an offence under any of the relevant statutory provisions consisting of a failure to comply with a duty or requirement to do something so far as is practicable or so far as is reasonably practicable, or to use the best practicable means to do something, it shall be for the accused to prove that it was not practicable or not reasonably practicable to do more than was in fact done to satisfy the duty or requirement, or that there was no better practicable means than was in fact used to satisfy the duty or requirement.

Definition of "Reasonably Practicable."
The extent of an obligation which is said to require an employer to take reasonably practicable measures has been explored by the Courts, particularly in the context of occupational health and safety law.

For example, in Boyle - v - Marathon Petroleum (Ireland) Ltd. (1992) 2 IR 460, the Supreme Court held that reasonable practicability creates a duty that "is more extensive than the common law duty that devolves on employers to exercise reasonable care in various respects as regards their employees. It is an obligation to take all practicable steps. That seems to me to involve more than that they should respond that they, as employers, did all that was reasonably to be expected of them in a particular situation" (Mr Justice O'Flaherty) (Trust in Care 2005)

Seamus Murphy gives an example of the smart alec response that he got from a Senior Nurse whom he had contacted about a unit left dangerously short, commented " what do you expect me to do, knit a nurse for you?" This Nurse Manager would not meet in his view the requirement that he did all that could reasonably be expected of him and had something happened in that Unit that individual could have been prosecuted and held personally liable. Our advice to any nurse from the Staff Nurse acting up for a day to Directors of Nursing is not to accept responsibility for deficits arising out of the Embargo/Moratorium that is affecting patient care.

Pass it on to your Line Manager by using the form attached.
In addition members need to have regard to the Directive circulated to members of all the Trade Unions in the Health Service and of the necessity to comply with these Directives.

Conference 2009 has also made it clear that branches who wish to challenge these cutbacks by way of Industrial Action up to and including strike action will receive the full support of the PNA in ensuring that the action is successful.

STATEMENT

To: Name:

Grade:

CNM1, CNM2, CNM3, Assistant Director of Nursing, Director of Nursing, Local Health Manager

I, Title,

Am currently in charge of/on duty in
Ward/Unit/Service and the number of staff on duty is, in my opinion, insufficient to provide safe standards of patient care due to:

An Bord Altranais's Code for Nurses states "The Nurse shares the responsibility of care with colleagues and must have regard to the workload of, and the pressures on, Professional Colleagues and subordinates and take appropriate action if these are seen to be such as to constitute abuse of the individual Practitioner and/or jeopardise safe standards of practice" and further "any circumstances which could place patients/clients in jeopardy or which militate against safe standards of practice, shall be made known to appropriate persons or authorities".

I have sought your advice and guidance on this matter at Time Date
and your advice was: **

** If no response, please state that fact.
which does not in my opinion, resolve the situation.

Signed: Status:

Time: Date:

Guidelines to the Nurse:
Inform your immediate Line Manager of the situation, requesting immediate advice and guidance on the matter. Complete the above and send to appropriate Manager, holding a copy for yourself and a copy for your Branch Secretary.

Attention Those Nurses Considering Retirement

Scope to Fund for Extra Tax Free Lump Sum

Scope to fund for extra lump sum.
The superannuation Scheme works on the basis of 'pensionable' Salary whereas the Revenue allows you to draw down benefits based on 'final' salary (a definition that is also used by the AVC Scheme) which at a minimum matches, and is often higher, than the 'pensionable' salary definition used by the Superannuation Scheme.

This means that PNA members can use overtime payments paid to them over the last number of years to fund for an additional tax free lump sum. This is one of the core reasons why many PNA members have to date taken out an AVC.

To calculate your scope to make AVC contributions you must look at the "gap" between what you will receive under the Superannuation Scheme and the maximum benefits the Revenue allows you overall in terms of your retirement benefits.

Your benefits at retirement are based on your salary at the time you retire. This means that the definition of exactly what constitutes "salary" is important in determining your benefits in retirement.

Revenue Definition
Final salary is calculated on all earnings paid to you by your employer whether you paid superannuation contributions on them or not and is made up of:

- Your annual basic salary at the time you retire
- Annual average of any other earnings on which you paid Superannuation contributions in the best 3 consecutive years over the 10 years prior to retirement.
- The annual average of any fluctuating earnings in the best three consecutive years over the 10 years prior to retirement.

Superannuation Definition
"Pensionable" salary is calculated only on earnings on which you paid superannuation contributions and is made up of:

- Your annual basic salary at the time you retire
- Annual average of any other earnings on which you paid Superannuation contributions in the best 3 consecutive years over the 10 years prior to retirement.

Example:

- Senior Staff Nurse (S.S.N) Salary €49194
- Other payments e.g. Premiums/allowances which are superannuable over a three years period amounting to €32418 for an average of €10806
- Overtime payments over three years of €24000 for an average of €8000.

Under superannuation rules overtime does not qualify so Pension and Lump Sum based on Pensionable Pay of €60,000 (ie salary plus average of other superannuable payments)

Pension €60000 x 40/80 = €30000
Lump Sum €60000 x 120/80 = €90000

Revenue Rules will allow you to reckon average overtime earnings in determining the amount of Lump Sum.
So Pensionable Pay for revenue purposes is €68000 i.e.

Salary + average of other pensionable allowances + average of overtime payments.

This means that a nurse could fund an AVC in this case for €12,000 i.e. 1 1/2 times the excess of €8000 that was not allowable under the superannuation rules. If the member has less than 40 years pensionable service the potential to benefit may be even greater. This means that the nurse could put in €12,000 into an AVC and get tax relief at 41% therefore the net payment would be €7080. When you retire you would have €12,000 in your AVC fund which you can take tax free.
The cost of setting up the AVC is as follows:

Cost: 4% of amount invested subject to a minimum payment of €450. This is also tax relievable and after tax relief at 41% the net fee in this instance is approx €283. In addition to this there is a management charge of 1% of the fund on a per annum basis. This can fluctuate depending on the type of investment that one chooses.

Based on these figures the cost for an investment of €12,000 will amount to approx €350. In this case the benefit to the nurse of taking out an AVC to cover the overtime earnings would be approx €4570 after tax relief.

The amount that one can invest tax free depends on age.
Age % of salary
Less than 30 15%
30-39 20%
40-49 25%
50-54 30%
55-59 35%
60 and over 40%

* The maximum% salary contributable is dictated by the age you turn in that year i.e. if you turn 40 in April 2009, you can contribute 25% with affect from January 2009.
This overall contribution limit is calculated as a % of annual salary and takes in account contributions to all pension related schemes you may be contributing to including the Superannuation

Scheme, Spouses and Children's Scheme, Purchase of Notional Service Scheme, contributions in respect of the purchase of Superannuation Credit for temporary and training years, other contributions you may be making to buy back any other service or contributions to the AVC Scheme.

NOTE 1:
The example quoted is for illustration purposes only since each individual case will differ and if one decides to take out an AVC a consultant from Cornmarket will meet each individual personally and provide the exact detail of what the benefits may be.

NOTE 2:
The usual warning applies, funds that are invested may rise or fall, however, funds invested for somebody near retirement are invested in cash unless the person requests otherwise and as such the potential for losses are minimised.

PNA Cavan / Monaghan Highlights Dismantling Of Community Mental Health Services!

On June 15th of this year, members of PNA Monaghan and Cavan branches took the unprecedented decision to invite the media to the Hillgrove Hotel, Monaghan for a press conference to highlight not only outstanding grievances concerning non-replacement of key front-line nursing vacancies and a virtual halving of all Community Nursing activity, but also the lack of proper engagement by local management on both issues. All local print and broadcast media attended as did a camera and report crew from RTE. Three local public representatives including the Cathaoirleach of Monaghan Town Council were also present.

General Secretary, Des Kavanagh gave a brief overview of the members' concerns before handing over to seven speakers, representative of the clinical activities most affected by the issues involved. There was a discernable hush in the earlier bustling room as speaker after speaker outlined their particular delivery of Mental Health services both before proposed HSE non-replacement of retiring colleagues and existing mileage caps and the likely impact on services of further proposed policies, especially another 25% cap on journeys allowed to visit clients in the community.

The speakers outlined the situation in Cavan – Monaghan, which they stressed, was quite particular to their service and marked an attempt by local managers to achieve budget savings at the exclusive expense of Service-users in Mental Health. In May 2008, all clinical mileage was capped at 15% below claims approved for 2007. This was applied in monthly quotas and with no provision for carry-overs tolerated, the actual cut for 2008 was closer to 20% - internal HSE memos set the "saving" at 18%. Speakers exposed examples of deliberate misleading of the Labour Relations Commission (LRC) Officials at two Conciliation Conferences held in Monaghan some months previous to the Press Conference to address Branch grievances in this regard. Managers were on the one hand saying to the public that normal delivery of service was being maintained at the levels assured to all stake-holders, while expecting PNA members to face users and families when the opposite became apparent. Of particular concern to speakers were their obligations under An Bord Altranais (ABA) regulations, especially regarding the Code of Professional Conduct. Letters outlining concerns from care teams were firstly ignored and when finally replied to, placed clinical responsibility solely at the doors of the nurses concerned.

A number of outcomes emanated from the exercise. Sean Conlon, Monaghan Town Council Cathaoirleach, proposed at that night's meeting, the first for the newly elected Authority, that a delegation from the PNA be invited to their July meeting to reiterate what he heard that morning. A supplementary proposal was seconded and carried that Oireachtas Members be invited to listen also. That meeting occurred on July 20th and was again introduced by Des Kavanagh. The Branches received cross-party support for their efforts in highlighting the issues raised. Correspondence will be sent to all Local Authorities in both counties with a view to requesting a meeting with the Minister of State responsible for Mental Health. Many Councillors expressed a view that cuts in community activity would disproportionately affect clients in the more rural catchment areas in both counties.

This meeting along with the Press Conference itself was covered extensively in the local print and broadcast media. Speakers to the media on the day were invited to debate the issues live on air on Shannonside Northern Sound Radio with HSE management. The HSE subsequently failed to appear, issuing instead a statement that they would not discuss their activity publicly and that the PNA had refused to utilise the Industrial Relations (IR) machinery provided. However, in what's seen locally as a sinister development, both Branches received letters from the Human Resources Manager identifying by name, the members involved in the publicity exercises and requesting by return in what capacity they were acting. Des Kavanagh penned a reply and circulated all Councillors, TD's and reporters present at the Town Council meeting with copies of both letters. He reminded the HR Manager that a senior member of the Management Team in Cavan – Monaghan gave several media briefings [over the course of two election campaigns} in which he was sharply critical of then HSE policies. Furthermore, he invited the HR Manager to furnish the PNA with evidence that similar intimidatory correspondence was

issued to the person involved. Northern Sound Radio covered this development extensively the following day, including an interview with Mr. Kavanagh.

The Branches welcome that in the immediate aftermath of the Press Conference, the proposed further cap on clinical mileage was not implemented. HR has indicated some movement on the recruitment issue but at time of writing, this is at best, ambiguous. Less ambiguous, however, was the visit by the HR Manager, The Hospital Administrator and the Director of Nursing to the St. Davnets' Community Support Centre on July 21st, during which the six nurses providing a vital 7-day-week service to several discharged clients were informed that they are being redeployed as and from the 1st of September. Following this meeting, the HR Manager phoned local Branch Secretary, Joe Campbell, informing him that there was a HSE policy regarding staff speaking to the media.

That's what now passes for engagement by the HSE on IR issues in the Cavan – Monaghan Mental Health Services. Monaghan Branch Officials have responded to the latest threats from HR by further briefing the local Media. Public sentiment towards all things HSE is at an all time low in both counties following their eventual closure of Monaghan General Hospital in recent days and is pretty ill disposed right now to tolerate the attempted silencing of front line staff highlighting further diminution of health services in the region!

PNA Deliver a Compensation Scheme for Nurses Injured By Assault following Successful Industrial Action

Settlement Terms arrived at under the auspices of the Labour Relations Commission have at last seen the introduction of a compensation Scheme for nurses injured by assault. You will recall that members were forced to take action as a result of years of broken promises by government and more recently the refusal by management to implement the Labour Court Recommendation 18864, which recommended that a scheme for physical and psychological injury be put in place.

The settlement terms of 14th May 2008 were contingent on Government acceptance of the proposals relating to psychological trauma.

A Cabinet meeting at the end of June 08 approved a Compensation Scheme for Psychiatric Nurses to include cover for psychological trauma fully in accordance with the terms of the settlement of the dispute at the LRC on 14th May.

Subsequently a draft scheme issued from the HSE-EA and an examination of the proposals highlighted a number of anomalies over that of the LRC agreement. These were formally raised with the HSE-EA by letter of 3rd July 08 but it is fair to say that most of the anomalies were not major and related to wording and issues of clarification.

On Sept 11th 2008, a revised draft scheme was received that reflected the agreement reached at the LRC. That was put to ballot and accepted. The formal Circulars issued on 26/11/08. The scheme is in two parts:

- The first element of the scheme is an insurance based scheme which will provide for compensation for physical injury and provides for personal injury cover for nurses employed in the Mental Health Services who are assaulted in the course of their duties. The schedule of benefits cover 46 categories of injury ranging from €5,000 to €100,000 and will operate from 16th May 2008.
- The second element of the scheme is an insurance based mechanism to address significant trauma that will provide for a fixed quantum of compensation in respect of PTSD arising from trauma in line with that outlined in the scheme. This scheme can only be utilised following an assault by a patient where no physical injury occurs, or, where a physical injury occurs which has not led or will not lead to a claim under the Physical Injury Scheme and which results in a recognised medically certified psychiatric condition/s (WHO ICD listings). In summary this scheme provides for an award of €15,000 in particular instances which are outlined in the Circular. The scheme will operate from 15th July 08.
- Operational dates for both schemes as set out above relate to the date of issue of the insurance policies. However there is a retrospective element to these schemes and the LRC agreement of 14th May states.

  "To clarify that the scheme and mechanism shall be implemented on the date of issue of the insurance policy. However, the effect of the Court's intention in setting an implementation date of 29th March 2007 shall be preserved by implementation of the Court's intention in regard to the then lodged 40 (approx) cases and also to deal with cases which have been recorded in the system (incident report form) since."

- It must also be recorded that proposals to deal with the nurses stabbed in Artane in 1993 have been accepted by the nurses and their legal representatives.

Please also note:

- The 5/6ths Scheme will continue to operate as normal.
- There is agreement that both Management and Unions are committed to implementation of the recommendations and findings of the National Joint Working Group on managing violence and aggression in the workplace, chaired by Mr Pat Harvey. This report which has just issued can be accessed on www.PNA.ie.
- This agreement does not limit in any way the legal entitlement of any individual to pursue claims in any external (to HSE) forum.
- There is a requirement to report incidents within 48 hours.
- The claim procedure is set out in the circulars.

The circulars which issued from Mr Sean McGrath National Director of Human Resources HSE, are reproduced in part on the following pages. However there is significant detail attached to the insurance based mechanism to address significant trauma and it is not possible to produce in full in this article but it can be downloaded from the PNA website as can both circulars on **www.pna.ie.**

(A) Insurance Based Scheme for Nurses Employed in Mental Health Services

Following acceptance by the HSE, PNA and SIPTU of Labour Relations Commission proposals, concerning a Personal Injury Insurance Scheme for nurses in Mental Health Services, the provisions of HSE Circular 04/2008 on the above matter have now been amended to read as follows:

"I refer to the introduction of a scheme of personal injury cover for nurses employed in Mental Health Services who are assaulted during the course of their duties. As you may be aware, the introduction of such a scheme has been the subject of protracted

engagement with staff representatives, particularly, though not exclusively, in relation to the matter of psychological trauma. The revised Insurance Based Scheme provides a set of payments associated with the agreed range of physical injuries; those payments to incorporate compensation in respect of psychological trauma normally expected in cases of assault leading to physical injury. The event insured against is assault arising as a direct consequence of the insured person's employment, which shall, independently of any other cause, be the sole cause of any of the assaults. Cover will operate on a 24 hours basis, in the relevant hospital, home centre, patients' home, travelling as part of the nurse's employment to and from patients / clients. The Insurance Based Scheme came into operation on 16 May 2008".

Benefits

The schedule of benefits payable under the scheme, are as follows:

	Benefit	Amount
1	Death	€25,000
2	Loss of two or more limbs or both eyes or one of each	€100,000
3	Loss of sight in one eye	€30,000
4	Permanent and total loss of speech	€100,000
5	Permanent and total loss of hearing in both ears	€100,000
6	Permanent and total loss of hearing in one ear	€30,000
7	Permanent and total loss of use of one limb	€75,000
8	Permanent and total loss of use of one big toe	€12,500
9	Permanent and total loss of use of any other toe	€10,000
10	Permanent and total loss of use of one thumb	€20,000
11	Permanent and total loss of use of one forefinger	€12,500
12	Permanent and total loss of use of any other finger	€10,000
13	Permanent and total loss of use of one hand	€30,000
14	Permanent and total loss of use of shoulder or elbow or wrist	€20,000
15	Permanent and total loss of use of hip or knee or ankle	€20,000
16	Total loss of use of back or spin (excluding cervical) without cord involvement	€30,000
17	Total loss of use of neck or cervical spine without cord involvement	€30,000
18	Removal by surgical operation of a kidney	€20,000
19	Quadriplegia	€100,000
20	Paraplegia	€100,000
21	Fracture to leg or arm	€12,500
22	Fracture to hand	€10,000
23	Fracture to skull	€12,500
24	Fracture to cheek or nose or jaw	€10,000
25	Fracture to vertebra	€12,500
26	Fracture to rib or sternum	€7,500
27	Fracture / dislocation to hip or pelvis	€12,500
28	Bodily injury resulting in treatment requiring sutures	€5,000
29	Dislocation of shoulder or arm or elbow or wrist	€10,000
30	Dislocation of thumb or finger	€5,000
31	Dislocation of knee or ankle	€12,500
32	Dislocation of foot	€7,500
33	Dislocation of big toe or toe	€5,000
34	Burns or scalds to any area apart from the face requiring hospitalisation	€6,000
35	Bite injuries resulting in medical treatment	€7,500

Reporting of Incidents

All incidents are required to be reported through the appropriate channels within 48 hours of their occurrence.

Claims Procedure

The claims procedure for the scheme is consistent with that already in place for other types of insurance claims under HSE insurance policies.

The various stages of procedure in such eventuality are:

1	Claim notified by employee to HSE
2	HSE notify the Irish Public Bodies Mutual Insurances Ltd (IPB)
3	IPB issue claim form to HSE
4	Claim form completed by injured employee

5	Medical Certificate section of claim form completed by employee's doctor
6	Completed claim form returned to HSE
7	HSE forward claim form to IPB
8	IPB validate claim and issue cheque

(B) Insurance Based Mechanism to address Significant Trauma Reads as Follows:

"The Government has conveyed approval to the HSE for the establishment of an Insurance Based Mechanism to address significant trauma for exceptional cases where a serious assault occurred on a nurse working in the mental health services and resulted in Post Traumatic Stress Disorder (PTSD). The Insurance Based Mechanism is attached.

The establishment of the Insurance Based Mechanism was included in proposals from the Labour Relations Commission on 14 May 2008 following discussions with the PNA / SIPTU involving the HSE and officials from the Department of Health and Children and Department of Finance. The Mechanism will provide a fixed quantum of compensation in respect of Post Traumatic Stress Disorder arising from trauma in exceptional cases and in line with conditions laid down".

In summary, the Insurance Based Mechanism provides for an award of €15,000 in particular instances where a psychiatric nurse is:

- Threatened with
- o Death
- o Serious injury
- o A viable weapon (including a syringe used as a weapon)
- o Sexual assault

Held hostage, attempted or completed kidnap, false imprisonment or prevented egress from a closed space of more than two hours duration.

- Persistent and intrusive stalking over a prolonged period, verifiable threatening behaviour while off duty by a patient or former patient.
- Strangulation
- PTSD (as defined in the WHO International

Classification of Diseases Version 10 (see Mechanism for details A claim under the Insurance Based Mechanism will only be considered once the full terms of the Mechanism have been satisfied. The Insurance Based Mechanism is only to be used following an assault by a patient where no physical injury occurs, or where a physical injury occurs which has not led and will not lead to a claim under the Insurance Based Scheme, and which results in a recognised psychiatric condition (WHO ICD listings) which can be medically verified.

The Mechanism will deal with exceptional cases which are not covered by the Insurance Based Scheme as outlined in HSE HR Circular 04(A)/2008.

The Insurance Based Mechanism came into operation on 15 July 2008.

Reporting of Incidents
All incidents are required to be reported through the appropriate channels within 48 hours of their occurrence.

Claims Procedure for Both Schemes
The claims procedure for the scheme is consistent with that already in place for other types of insurance claims under HSE insurance policies.

A claim should be lodged by or on behalf of the claimant within six calendar months of the assault. The various stages of procedure in such eventuality are as follows:

1	Claim notified by employer to HSE
2	HSE notify Irish Public Bodies Mutual Insurance Ltd (IPB)
3	IPB issue claim form to HSE
4	Claim form completed by injured employee
5	Medical certification section of claim form completed by employee's doctor
6	Completed claim form returned to HSE
7	HSE forward claim form to IPB
8	IPB validate claim and issue cheque

Arbitration Mechanism
A joint arbitration Mechanism will be put in place to deal with situations where disallowance of a claim is not accepted for both schemes.

Review
The operation of the Insurance Based Mechanism will be reviewed twelve months from date of commencement. At a meeting of the parallel process on the 15th May 2009 a number of aspects relating to the scheme were raised by the P.N.A.

(1) The protocol for making a claim
- Standardization of application form.
- Necessity to have a named HSE official with responsibility for processing claims.

H.S.E-EA will discuss this with the relevant section of the H.S.E and the intention is that both of these issues will be dealt with.

(2) Process for Dealing with Claims prior to the introduction of the Insurance Scheme
- Those who were informed after date of the Labour Court recommendation of 27/03/07 to the date of introduction of both schemes 16th May 08 and 15th July 08.

- The 40 (approx) cases that were lodged in the system at the time of the Labour Court Recommendation. The H.S.E-EA is in discussions with the State Claims Agency regarding these issues.

(3) Appeals Process
• Agreement that a 3 person arbitration committee will be set up to comprise of an independent chair and a nominee from the unions and from management. The unions to submit nominations.

"Linking Service and Safety: Together Creating Safer Places of Service"

Working Group established to develop a strategy for managing work related aggression and violence within the Health Service publishes its report.

The report of the working group on work related aggression and violence within the Health Service has published its report.

Prof Drumm in a letter accompanying the publication of the report on the 9th April stated:

"I am pleased to endorse its recommendations. A formal 'position paper' with regard to our collective response and the need to focus very deliberately on successfully meeting the various targets and deliverables set out in the report is attached"

"While mindful of the current climate and the associated demands on all of us I am keen to see the report's recommendations implemented"

Professor Drumm spoke of the Partnership philosophy being at the heart of the work to date and that the successful completion of the Report is significant testament to the value and effectiveness of this approach. He also acknowledged the financial support by the Health Service National Partnership forum as being very welcome as it "gives increased impetus to implementation of the action plan"

Professor Drumm went on to say this "Report and our future actions will not only serve our staff very well in terms of their health and safety but will most likely place us to the fore internationally as an example of very best practice"

He concluded by stating that it is his "hope that this letter and more importantly this mandate to move toward implementation will find favour with you all"

The position paper referred to by Prof Drumm follows in its entirety.

Position paper on the Management of Work related Aggression and Violence

Background

Work-related aggression and violence is a serious problem within healthcare which diminishes the quality of working life for staff, compromises organizational effectiveness and impacts negatively on the provision of services. The Health Service Executive has developed a comprehensive suite of corporate responses to the issue of conflicts within the workplace. Interpersonal conflict among staff is addressed in the Dignity at Work policy and conflict between staff and service users is addressed in the Trust in Care policy. The Linking Service and Safety report now completes this suite by addressing aggression toward staff by service users, and as this work proceeds this statement should guide efforts in managing aggression and violence.

Position Statement

It is the position of the Health Service Executive that aggression and violence towards its staff is unacceptable. It is important that all staff appreciate that such behaviours should not be considered as inherent, inevitable or acceptable. Ensuring the safety of personnel and patients is a priority concern for the HSE which is committed to creating safe environments in which to work or to be treated. This complex task requires an integrated organizational response which adequately and equitably addresses the obligations owed to all concerned.

Scope

This policy applies to all personnel, including permanent, temporary and agency staff, contractors, volunteers, students and those on work experience. It should support and be congruent with local and service specific guidance for managing work related aggression and violence.

Definition of Violence and Aggression Definitions

The Health Service Executive has adopted the EU definition of work related aggression and violence as:

'any incident in which a member of staff or person working in Health Service Executive is verbally abused, threatened or physically assaulted by a patient or member of the public in circumstances relating to his or her employment'.

Work related aggression and violence within the healthcare context is a complex phenomena which has neither quick fix or simple solutions. Consequently occurrences need to be understood as being embedded within the broader context of service provision and involve a broad range of contributory factors and influences. These factors can functionally be considered as involving a process of complex interactions between:

- Service users and others
- Service providers (personnel)
- The interaction taking place
- The physical and service environment in which the interaction takes place

Policy Aims

The purpose of this statement is to guide ongoing efforts in the context of the continuing work which will formulate a comprehensive corporate policy on the management of work related aggression and violence. This interim policy is intended to:

- Increase staff awareness of work related aggression and violence;
- Ensure that risks associated with work related aggression and violence are methodically assessed in systematic and continuous way
- Ensure that safe systems and practices of work are in place to minimize associated risks as far as is reasonably practicable;
- Ensure that staff are provided with appropriate training which provides practical advice on how to prevent, recognize, and manage work related aggression and violence
- Ensure that appropriate supports are available to staff who encounter occurrences of work related aggression and violence
- Ensure that recording and reporting mechanisms are understood and that the importance of reporting occurrences of work related violence and aggression is appreciated.

Responsibilities

The Chief Executive Officer has overall responsibility for:

- Ensuring that arrangements exist for identifying, evaluating and managing risks associated with work related aggression and violence.
- Providing resources necessary for implementing policy
- Ensuring that governance arrangements are in place in order that organizational, professional, and legislative obligations in relation to the management of work related aggression and violence are being addressed.

Senior and Line Managers are responsible for:

- Ensuring that all staff are aware of the policy;
- Ensuring that regularly reviewed risk assessments are conducted and reflected in safety statements;
- Putting procedures and safe systems of work into practice which minimise associated risks as far as is reasonably practicable;
- Making sure that personnel identified as being at risk are give appropriate education, instruction and practical advice on how to prevent, recognize, and manage work related aggression and violence
- Ensuring that appropriate supports are available to staff who may encounter occurrences of work related aggression and violence
- Ensure that recording and reporting mechanisms are understood and that the importance of reporting occurrences of work related violence and aggression is appreciated.
- Monitoring the effectiveness of preventative measures and ensuring that remedial measures identified through occurrence review are implemented.

All staff are responsible for:

- Taking due care of their own safety, health and welfare and that of others
- Adhering to procedures designed for safe working
- Utilising preventive measures and strategies provided to minimise factors which might compromise their safety e.g. mobile phones, alarms
- Undertaking relevant education and training provided
- Reporting dangers or concerns identified and occurrences of work related aggression and violence;

Assessing Risk

Risks associated with work related aggression and violence must be methodically assessed in all settings in which there is a potential for such occurrences. Assessments will be conducted by competent individuals and should consider potential contributory factors including service users; service providers; interactions occurring; and environmental variables as relevant to the particular setting. It is essential in instances where work related aggression and/or violence are identified as foreseeable, that the safety statement explicitly outlines the control measures required and identifies those responsible for their implementation, communication to personnel, and their ongoing audit/review.

Managing Occurrences

Safety statements based upon risk assessments will provide practical guidance to staff on managing occurrences of work related aggression and/or violence including details of emergency procedures. All staff must be familiar with local procedures for raising the alarm and securing assistance in the event that their safety, or that of others under their care, is compromised.

Staff Training

All personnel must be provided with education and training in the work related aggression and violence, which is appropriate to their professional and organisational responsibilities. The assessment, design and content of training provided should be based upon a service specific risk assessment and should be fully compliant with the organisational, professional and legislative structures within which services are provided. A strong preventive emphasis will underpin all education and training which should focus on providing practical guidance on recognising, assessing and managing occurrences. Training will also reinforce guidance on occurrence recording, post occurrence review; and post occurrence support needs of those involved.

Use of Physical Interventions

The use of physical interventions is a complex issue, which should be considered as a last resort option in all instances. However it is acknowledged that on occasion such interventions are the only or most appropriate option. In such situations it is critical that staff are competent in the employment of safe effective techniques in order to preserve the safety of all concerned. The HSE is committed to the use of such interventions being governed by standards of best practice. Priority is assigned to establishing the safety and fitness for purpose of physical interventions currently in use in the first instance.

Support for Staff

Staff who are exposed to various manifestations of aggression and violence will be provided with sensitive and practical support

to assist them cope with the occurrence. While most staff will require only minimal post-occurrence support, others may require a wider range of support measures. Consequently an integrated multi-layered repertoire of best practice support measures should be readily available to staff together with information as to how services may be accessed. The role of the line managers is pivotal in providing support, and it is important that they are prepared for and supported in this role.

Organisational Security Responses

Responding to perpetrators of aggression and violence within the healthcare context is complex as occurrences often take place within a professional service relationship. Decisions taken in the aftermath of such occurrences must balance the obligations to provide services with the duty of care owed to staff. Notwithstanding this debate there is a need to protect the welfare of staff and others and the property of the organization. Subsequently in circumstances in which a risk is posed to the safety of staff or others the organization is obligated to institute measures which ensures the safety of all concerned. The HSE is committed to developing a structure to guide and support decision making in such circumstances. Priority is assigned to providing services with a structured system of legal advice in the first instance.

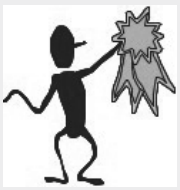
Implementation

The proposed framework comprising of the Project Joint Governance Committee, reflecting the partnership ethos, along with the Central Project Office, and the Multi Agency Advisory Forum will be established forthwith. These structures will be charged with the responsibility to ensure that the recommendations of the report are implemented in the shortest possible timeframe consistent with the expectations set out in the report.

Review

This position will be reviewed within twelve months of issue to reflect developments accomplished in line with the recommendations of the Linking Service and Safety strategy.

Please go to www.pna.ie/health and safety/workplace violence and aggression for more Details



The Martha McMenamin Memorial Scholarship 2009 For Nurses & Midwives

Martha McMenamin was the Chief Nurse in the Western Health & Social Services Area and Divisional Chair of Business & Professional Women who bequeathed a fund for members of the Nursing and Midwifery professions working in Ireland to undertake a study in the fields of nursing or midwifery.

In this rapidly changing Health & Social Care climate there is a great need to improve the quality of care and make a real difference to the patient/client experience. This scholarship could provide you with an opportunity to influence the modernisation of Health & Social Care Services, through one of the following categories. Each Scholarship is worth up to a maximum of £5,000 which the Panel will allocate as deemed appropriate.

- **A project demonstrating improvements in care or the patient's experience.**
- **A small scale research, audit project and/or reflective practice.**
- **Undertake a research or development project, which may be part of a research degree, where no other source of financial support would be available.**
- **Leadership Development – Personal Development or Team Development For a proposal/ application form please write to:**

Management & Organisation
Development Unit
Western Health & Social Care Trust
Lime Villa
12c Gransha Park
Clooney Road
LONDONDERRY
BT47 6WJ

Tele: 028 7186 5112 (N.I.)
048 7186 5112 (RoI)

E:mail pat.hannaway@westerntrust.hscni.net

Closing Date: Friday 9 October 2009, no later than 12:00 noon

- Previous successful applicants may not apply within a 4 year period of receiving an award.

Pension and Income Levy

Colm Nolan, Taxation Advisor, has kindly agreed to respond to members queries.

2009 is likely to be remembered for many reasons not least of which being the number of "levies" introduced and subsequently modified by the Minister for Finance.

In this article we'll look at the most common questions members have raised concerning the Pension and Income Levies, and provide some insight into some of the issues/problems likely to be encountered.

The "pension-related deduction" or Pensions Levy was introduced with effect from 1 March 2009. These measures were subsequently amended following the Emergency Budget in April 2009 with the introduction of revised rates and bands effective from1 May 2009.

What is the Pensions Levy?
This was introduced with effect from 1/3/2009 and applies to all remuneration payable to a member of the public sector including Nurses.

Following the Emergency Budget in April 2009, the Minster introduced a new series of rates. One reason behind this change was to reduce the impact of the deduction on lower paid public sector employees. The new rates are effective, from 1st May 2009 are:

First €15,000 of annual earnings	exempt
Between €15,000 and €20,000 p.a.	5%
Between €20,000 and €60,000 p.a.	10%
Above €60,000 p.a.	10.5%.

How are the original and revised rates applied?
The legislation provides that, with effect from 1st May 2009, the original and revised bands are "pro-rated" on a weekly basis.
This may mean that if you receive a larger than usual remuneration due to arrears, premium pay, overtime etc then you should review the amount of the Pensions Levy deducted from you as you may be pushed from one bracket into another for that one payday.

To check the amount of the levy applicable to you, the Department of Finance has made a pensions levy calculator available on their website www.finance.gov.ie

I already have a public service pension and I'm working for a public service body on a contract which says nothing about a pension - am I still liable?

If you are employed under a contract of service (i.e. the normal employment arrangements) you are liable in respect of your remuneration as a public servant but not in respect of the pension you receive.

I work on a part-time basis for a couple of different public sector employers - what is my liability?
Your liability is based on your total remuneration as a member of the public sector from whatever source.
It is charged at the same rates as if you had one employer. It is important at the end of the year to have the total sum paid checked to ensure you have mot paid an excessive amount. Any income you receive from outside the public sector won't attract the levy.

I have a full medical card, am I exempt from the Pensions Levy?
No. As the pensions levy is not related to the tax system or the income levy the holding of a medical card is not relevant.

Are any members of the public sector exempt?
Yes. Because of their constitutional position, the President and members of the Judiciary are not liable for this levy.

I am on a short-term employment contract for a public service body, am I included?
The length of a contract is not relevant as to whether or not a deduction is to be made. In general most contract staff in the public service are now eligible for pension scheme membership. In addition, a person who is on a contract and, for example, is in receipt of a payment in lieu of membership of a pension scheme, would be liable for the deduction from 1st March 2009 or the start of the employment if later.

If I leave before completing the minimum period for accruing a pension benefit do I receive a refund?
If the person to whom the deduction has applied leaves
(a) Without a benefit or preserved benefit, or
(b) Without a payment in lieu or preserved payment in lieu, and
(c) Without transferring the service, then a refund is provided.

What about if I later rejoin a public service body?
If you later are employed in a public service body, the refund previously received, plus interest, would have to be paid back to the earlier public service body before that service
Could be transferred and reckoned for public service superannuation purposes.

Do Class D and Class A PRSI contributors pay the same rate?
Yes. The social insurance class of the public servant has no bearing on the rate of charge.

If I receive travel and subsistence payments will they be affected?
No, the deduction is being applied to taxable remuneration and not to travelling and subsistence allowances.

Do I get income tax & PRSI relief on the deduction?
Yes. The deduction will be treated as if it were a pension contribution. It will be calculated on you gross income after deducting any other pension contributions but before the income levy.

Does the deduction affect the overall threshold levels for tax relief on pension contributions?
No. The deduction does not count towards a person's annual % limit to receive tax relief on pension contributions. For example, a person aged between 40 and 49 can contribute up to 25% of their gross income towards pension and receive tax relief on those contributions. The pension levy will not count towards that 25%.

Will I receive any additional pension benefits as a result of this deduction?
No. Additional pension benefits are not available because of this deduction.

Are the normal pension contributions affected?
No. The existing rate of pension contributions will continue to apply in addition to this new deduction. They will not be affected in any way by the new.

Income Levy - What is the income levy?
The income levy, which came into effect on 1st January 2009, is a levy payable on gross income, before any relief pension contributions or other tax reliefs.

Who is liable for the income levy?
All individuals are liable to pay the income levy if their gross income exceeds the threshold of €15,028 p.a., (€289 per week) or if they exceed the income exemption limit of €20,000 p.a. for an individual aged 65 or over.

Could I be exempt?
Yes. Where an individual's total income for a year does not exceed €15,028 p.a. or holds a full medical card they may be exempt. Similarly the levy does not apply to individuals aged 65 or over whose annual income does not exceed €20,000

Are the first €15,028 p.a. earnings exempt?
No – once your income is greater than the minimum threshold above, you pay the levy on the full amount of your income according to the above income threshold.

What income is exempt from the income levy?
All social welfare payments including social welfare payments including any received from abroad are specifically excluded. Income subjected to DIRT – deposit interest, credit union dividends are also exempt.

The current rates of contribution are:

Income Thresholds Per Year	Rate of Income Levy
Up to €75,036	2%
Between €75,037 and €174,980	4%
In excess of €174,980	6%

Is the higher % being charged on all earnings or just on the earnings over the relevant threshold?
The 4% levy is charged only on payments between €75,037 p.a. and €174,980 p.a. and the 6% is charged only on all payments in excess of €174,980 p.a.

I am separated from my spouse and paying maintenance payments. How are these payments treated for income levy purposes?
How maintenance payments are treated for income levy purposes will depend on whether they are due under a voluntary or legally enforceable arrangement.
Voluntary maintenance payments (payments paid under an informal arrangement)
The spouse making the payments does not receive an exemption from the income levy on the portion of their income which they pay as maintenance.

The spouse who receives the payments is not subject to the income levy on the maintenance payments they receive.

Legally enforceable maintenance payments (payable under legal obligation)

The spouse making the payments is entitled to receive an exemption from the income levy on the portion of their income which they pay as maintenance (either directly or indirectly to their spouse). There is no income levy exemption due in respect of any portion of the maintenance payments paid towards the maintenance of children.

Are Pensions subject to the income levy?
Occupational Pensions are subject to the income levy but any social welfare pensions are not.

What if I have overpaid the income levy? Can I claim a refund?
The income levy is calculated on a pay period by pay period basis. Where the income levy has been applied for particular pay period(s) throughout the year but you are ultimately liable at either a lower rate or are exempt because you have not exceeded the thresholds at the end of the year, you will have overpaid the income levy.

The Revenue Commissioners will deal with any refund of income levy due at the end of the year.

PRSI and Health Levy

In addition to the Pension & Income Levies the Minister for Finance also made several changes to the Level of PRSI and Health Levy payable. The main changes effective from 1st May 09 can be summarised as follows:

- The annual earnings on which you pay PRSI was previously capped at €52,000 per annum. This has now been increased to €75,036 per annum.
- The rate of Health Levy has increased from 2% to 4% and from 2.5% to 5%.
- The threshold for payment of the lower rate of the Health Levy remains at €500.00 per week.
- The threshold for payment of the higher rate of the Health Levy had been lowered from €100,000 to €75,036 per annum.

Health Levy

The Health Levy has been doubled.

- The old levy was 2% on earnings up to €100,000 P.A with 2.5% payable on earnings above that.
- The new levy has doubled and the threshold for payment of the higher rate has reduced from €100,000 to €75,036 p/a therefore 4% is now payable on earnings up to €75,036 P.A and 5% is payable on earnings above that.
- The threshold for payment of the levy remains at €500 P.W per week i.e. if you earn less than €500 per week you pay no levy. However, if you earn above €500 per week you pay on all earnings including the first €500 per week.
  P.R.S.I.
- From the 1st May 09 the cap for payment of PRSI has been raised from €52,000 to €75,036 per annum.

Class D 1

Earning more than €500 per week.

How much of weekly pay did I pay before 1st May 2009?

First €26	2%
€26 – €1000 (€52,000 p.a.)	2.9%
€1,000 - €1925 (€100,000 p.a.	2.0%
Balance	2.5%

After 1st May

First €26	4%
€26,000 - €1443 (€75,036 p.a.)	4.9%
Balance	5.0%

Included in the above figures are the Health Levy, therefore actual PRSI payable is 0.9% on earnings above €26 per week and up to €1443 per week. The change in P.R.S.I is that the ceiling has increased from €52,000 p.a. to €75,036 p.a. and you pay the 0.9% up to these earnings. Beyond that you don't pay PRSI but you pay the higher Health Levy.

PRSI Class A 1

Earning more than €500 per week.

How much of weekly pay did I pay before 1st May 2009

First €127	2%
€127 - €1000 (52,000 p.a.)	6%
€1000 -€1925 (€100,100 p.a.)	2%
Balance	2.5%

After 1st May

First €127 – 4%

€127 - €1449 (€75,036 p.a.) – 8%

Balance – 5%

These figures also include the Health Levy and actual PRSI payable is 4% on salary over €127 per week and up to the new ceiling of €1443 per week up from €1000.00 per week.

Note

It is not possible to outline all the detail of PRSI code here since they are many and varied e.g. even if one does not earn above €75,036 per annum but because of premium, etc may earn above €1443, say in 1 week out of 52, the balance above €1443 will be levied at 5.90% Class D1 and 9% Class A1 for that week.

Different rates apply to medical card holders and some recipients of social welfare benefits/pension etc under both Class A and Class D PRSI being mostly that they are exempt from the Health Levy.

Review of Car Insurance Scheme Administered by Cornmarket

Cornmarket have contacted us to state that the current insurers Zurich were seeking substantial premium increases to continue underwriting the Nurses Scheme. Having regard to this Cornmarket sought alternative quotations from the market following which they have recommended the transfer of the scheme to RSA Insurance Ireland Ltd (RSA) for the following reasons:

- RSA will provide cover at similar competitive rates as currently enjoyed
- RSA have included a significant number of enhancements to the policy cover which make the contract the most attractive from a cover and benefits perspective including Comprehensive driving of other cars for comprehensive policyholders
- Enhanced NCB protection on claims up to €10,000, without affecting your premium at renewal
- Reduced policy excess and enhanced car hire cover
- Personal effects cover
- Uninsured driving protection

- RSA have agreed to relax the Scheme's entry criteria, including:
  - Allowing named drivers from the age of 17
  - Allowing policyholders from the age of 20
  - Providing wider for work related travel cover

Cornmarket state that:

Taking all of the above into account, they have made arrangements to transfer the scheme from its current insurer to RSA Ireland Ltd, with effect from 1st July 2009 for new business and 1st September 2009 for renewals.

As part of the transfer arrangement they will be communicating with all members to update them on the new policy benefits and improvements.

Cornmarket went on to say that:

The Nurses Motor Insurance Scheme is not just about offering competitive premiums – it is also about offering comprehensive benefits to each member. There are in total some 20+ main benefits under the Scheme including Accident & Breakdown Cover, Legal expenses, protected no claims bonus, malicious damage cover etc. A benefits comparison is comparing the new and old arrangements set out hereunder

	Old Nurses Scheme	**New RSA Nurses Scheme**
Partial NCB protection	One claim within 2 years no more than €5,000. Malicious damage claims, no effect on NCB	Two claims within 3 years no more than €10,000. Malicious damage, fire, theft claims, no effect on NCB
Step back NCB	Two years for accidental damage and third party over the protection limit. One year	Fire and theft claims - no loss of NCB, AD/TP claims over protection limit, 2 year step back. If claim occurs whilst travelling on union business, then no effect on NCB
Driving of other cars	Third party cover for policyholder driving other private motor cars	Comp DOC for comp policyholders. Third party cover for TPF&T policyholders

Windscreen cover	Unlimited COMP & TPF&T if approved repairer is used, otherwise max claim is €225	Unlimited COMP & TPF&T, approved repairer direct billing
Car hire	Theft claims €130.	7 days car hire (similar vehicle) for fire and malicious damage claims. 14 days car hire for theft claims.
Green card	Up to 60 days	No time limit
Car theft Bonus protection	No loss on bonus where vehicle has a professionally fitted alarm in operation at time of theft	Theft and fire claims do not affect NCB - no car theft protection requirements
Indemnity to Health Boards	Class 1 up to 8,000 business miles. Indemnity to HSE/employer available at no extra charge	Unlimited business use excluding commercial travelling while using the car on insured's employer's business. Indemnity to HSE/employer included automatically
Excess	€250 own damage, €550 drivers aged 21 to 24, no excess for third party, fire, theft of windscreen claims, €50 for malicious damage claims	No excess for fire, theft, theft of keys, fire brigade charges, rugs, clothing effects, personal accident or medical benefits. Otherwise €450 excess for drivers aged 17 to 21, €250 if 25+. Reduced excess if approved repairer used 21 to 24 €250, 25+ 0 excess. €30 excess for malicious damage claims.
Malicious damage	Designated parking space at work, reduced excess €50, no loss of bonus, Comp policies only.	Designated parking space at work, reduced excess €30, no loss of bonus, Comp policies only.
New car concession	If destroyed/lost within 12 months as new, vehicle will be replaced.	In first year, if damaged beyond economic repair

Personal accident cover	€2,600 in the event of death, - insured and spouse.	Cover up to €30,000, insured and spouse
Accident and breakdown cover	Included	Included
Legal expenses cover	Included	Included
Uninsured driver protection	Not available	No loss of NCB if policyholder not at fault with a known uninsured TP
Keys/locks cover	None	€ 1,000
Fire brigade charges	None	Unlimited cover
Rugs, clothing and personal effects	None	Cover up to €500 (includes work equipment)
Medical expenses	None	€130 per occupant per day spent as an inpatient in hospital up to a maximum of 20 days
Audio equipment/car phones/sat nav	Limited cover	€1,000 where permanently fitted to car
Trailer cover	Third party attached cover	Third party whilst attached. Third party detached up to 1/2 tonne unleaded weight single axle
Spouse's/Partner's car insurance	Class 1 occupations	Class 1 or 2 occupations
Provisional License holders	Comp or TPF&T cover	Comp or TPF&T cover

REVIEW OF THE PNA SALARY PROTECTION SCHEME - THE OUTCOME -

Dear Member,

I'm pleased to report that the recent review of the PNA Salary Protection Scheme has proven to be extremely positive for members.

Schemes of this kind are reviewed every couple of years to ensure 'fit for purpose' and 'value for money' for members. This gives the PNA through Cornmarket (the administrators of the Scheme) an opportunity to canvass the insurance market to make sure that members are still getting the best deal available. Following consideration of the different proposals from a number of underwriters, it was agreed that Irish Life should continue to underwrite the Scheme.

This Review has resulted in, the contribution rate for the 'Disability element' of the Scheme being reduced from 1.60% to 1.34% (including the new government levy of 1%) of salary. This new lower rate has been guaranteed for the next 5 years (until December 2013). The PNA Executive Board has decided to use this saving to introduce a number of new significant benefits and enhancements. These benefits include:

- A benefit of an additional one times annual salary under the 'Death Benefit' element of the Scheme being introduced. This means that members will now enjoy a Death Benefit equivalent to three times annual pensionable salary (previously this was twice annual salary).
- A valuable additional element of protection for members' families in the form of a 'Specified Illness Benefit'. This pays out an additional once off cash lump sum of 25% of annual pensionable salary if a member suffers a specified serious illness.
- Details of all the new benefits are outlined in this bulletin.

Despite the introduction of these new benefits, the overall contribution rate has not been increased. However, members will see a marginal increase in their after tax contribution as tax relief is only available on the 'Disability Benefit' element of the Scheme.

These new benefits became effective from December 1st 2008. This means that from this date, all existing members of the Scheme will automatically enjoy these new benefits.

If you have not already joined or are currently a member of the old Income Continuance Plan (pre 2001). I would urge you to consider doing this. You may also be able to take advantage of the special once-off preferential terms of entry we have negotiated — see attached application form at the back of this article. Please don't risk your future financial security.

Seamus Murphy
Deputy General Secretary

The role of Cornmarket

Cornmarket has been administering the Salary Protection Scheme for PNA Members since its launch in 2000. The Scheme helps to guarantee a realistic level of income in the event of loss of salary through illness. Cornmarket also administers the original PNA Income Continuance and Life Assurance Plans.

Cornmarket's role includes:

- Negotiating with insurers to obtain the most competitive rates and to secure the best possible benefits
- Promoting the Scheme to PNA members
- Assisting members who want to make a claim from the Scheme by guiding them through every stage of the claims process and acting as the members' advocate in all dealings with the insurer.

For contact details, please see the back page.

The Scheme in action

Cornmarket has helped protect the financial security of more members of public sector unions than any other company in Ireland through its various Salary Protection Schemes. Here is what one PNA member who has benefited from the Scheme has to say...

"The reality is if you have no money, you are then dependent on the state and I think everybody in this country knows what it is like to depend on the state. It's very difficult.

I knew I was facing a life threatening situation. I was able to park my worries around that whole area and know that I was looked after. That was very important because with a young family, in terms of the Salary Protection Scheme, I knew I would have my salary. In terms of my life assurance, it would get my children through school and college. It sounds very cold but I can guarantee you the first thing I thought of was my children...

Its going to cost you very little and the benefits far outweigh the cost you have to pay out of your salary and I genuinely mean that.

At the end of the day we all need money to survive."

Mary McMahon
PNA Scheme Beneficiary,
Co. Kildare

REVIEW OF THE PNA SALARY PROTECTION SCHEME
- PROTECTING YOUR LIVELIHOOD -

Although many members feel that they will never need the protection the Scheme provides, sadly our experience has been that even the healthiest person can suffer unexpected illness or indeed, have a serious accident. This is why membership of the PNA Scheme is so vital for every member.

What happens when your sick pay runs out

There is a maximum period for which your employer will pay you full, half pay or pension rate of pay if you are ill. Typically if you fall ill for more than 12 months or if you are ill on aggregate for 12 months in any period of 4 years you are taken off the payroll leaving you dependent on social welfare (if you qualify) and/or pension rate of pay. What's more, if within this period you are ill for more than 6 months in any one year your pay is cut by half.

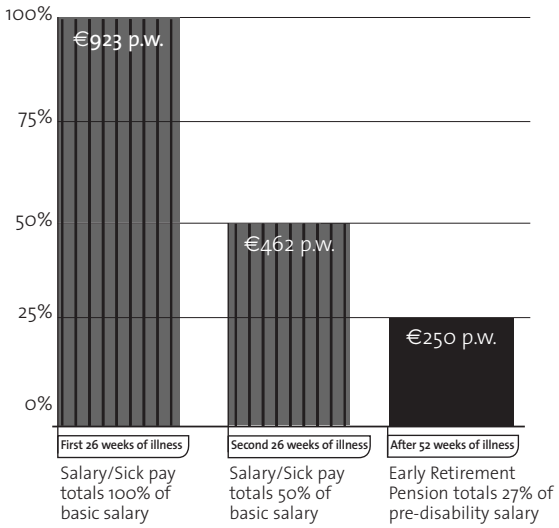
If, at this point, you are forced to retire on the grounds of ill health you may be entitled to an Early Retirement Pension (ERP) or pension rate of pay. Even if you have many years of service, your Ill Health ERP will only be a fraction of your pre-disability salary (see example). If you do not retire at this point you will receive no income from your job. Only those members who are paying PRSI at the higher 'A1' rate, will be entitled to any State Illness Benefit. At a little over €10,660 a year (2009), the State Illness Benefit provides only a subsistence income. The reality is that long-term illness inevitably means a severe drop in living standards. The need for some kind of additional income is vital.

How the Scheme works

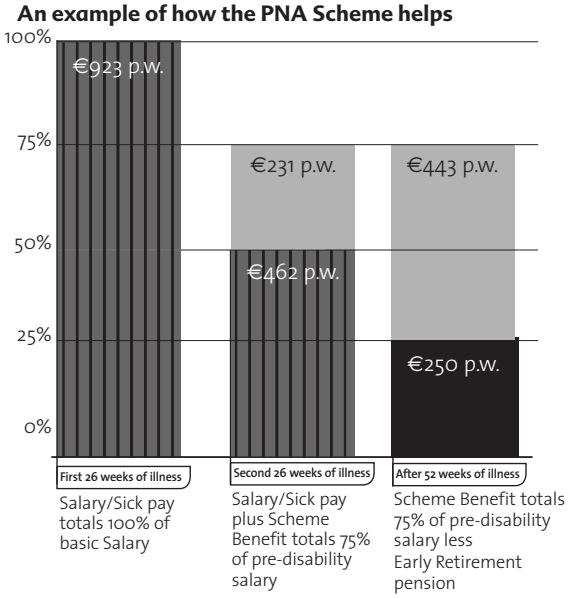
In return for a modest contribution from salary, this Scheme helps guarantee you an income of up to 75% of your pre-disability salary in the event that you fall ill. It does this by topping up your sick pay or Early Retirement Pension (ERP)/pension rate of pay to 75% of your pre-disability salary, and goes on paying you until you recover, go back to work, reach the age of 60 if you are permanently disabled, or die. Claims under the Scheme will be paid if Irish Life, the Scheme's insurer, is satisfied that because of injury or illness you are unable to carry out your normal job and you are not involved in any other remunerative occupation.

Example* of how the PNA Scheme works

An example of what happens when sick pay runs out



An example of how the PNA Scheme helps



Example based on benefits for a permanent, full-time psychiatric nurse who is a member of the Superannuation Scheme with 15 years' service, earning €48,000 p.a. (€923 p.w.) paying PRSI at the lower 'D1' rate, who is now unable to work due to long term illness or disability.

REVIEW OF THE PNA SALARY PROTECTION SCHEME - MAIN ENHANCEMENTS -

Contribution rate

1 CURRENT CONTRIBUTION RATE BREAKDOWN

The contribution rate of 2.00% will remain unchanged despite the fact that a number of new benefits have been introduced. However, due to the 1% government levy recently introduced by the government on all life insurance premiums, the disability benefit element of the Scheme has been increased to 1.34%. This now brings the contribution rate to 2.01%. Members will see a marginal increase in their after tax contribution as tax relief is only available on the 'Disability Benefit' element of the Scheme.

	PREVIOUS contribution % salary	NEW contribution % salary
Disability Benefit	1.60%	1.34*%
Death Benefit	0.35%**	0.35%***
Specified Illness Benefit	N/A	0.12%
Death Benefit for spouse of married member **OR** Members Specified Illness Benefit for member if single	N/A	0.15%
Medical Immunity Benefit	0.05%	0.05%
TOTAL NEW CONTRIBUTION RATE	**2.00%**	**2.00%**

*1.33% plus 1% government levy ** 2 x annual salary *** 3 x annual salary

Additional protection for you

2 NEW 'SPECIFIED ILLNESS BENEFIT'

The PNA and Cornmarket have successfully negotiated a valuable new benefit for members in the form of a 'Specified Illness Benefit'.

If a member suffers any of the specified serious illnesses listed below (e.g. cancer, stroke or heart attack) the Scheme now pays out an additional once-off cash lump sum of 25% of the member's annual pensionable salary. Should you suffer one of the specified illnesses, this benefit can be vital as extra cash is often needed to meet medical expenses, childcare etc., and may compensate for loss of premiums, allowances, overtime etc.

All existing members of the Scheme are now automatically covered for this benefit. Please note however that if a member has already suffered from one of the Specified Illnesses prior to December 1st 2008, he/she will never be covered for that particular specified illness under this new benefit. (For full terms & conditions please refer to the PNA Scheme booklet.)

Specified Illnesses covered

- Alzheimer's disease
- Angioplasty (two or more arteries)
- Aorta graft surgery
- Benign brain tumour
- Cancer
- Coma
- Coronary artery surgery
- Creutzfeld-Jakob Disease (CJD)
- Emphysema
- Heart attack
- Heart valve & structural surgery
- HIV / AIDS from blood transfusion
- HIV/AIDS from needlestick injury
- HIV / AIDS as a result of physical assault
- Kidney failure
- Loss of hearing
- Loss of sight
- Loss of speech
- Major organ transplant
- Motor neurone disease
- Multiple sclerosis
- Paralysis of two or more limbs
- Parkinson's disease
- Severance of two or more limbs
- Severe burns
- Stroke

3 A. SPOUSE'S DEATH BENEFIT (only payable if you are **married** at the date the event occurs)

The Scheme now includes a valuable new benefit for married members in the form of a 'Spouse's Death Benefit'. In the event of a spouse's death, 100% of the member's annual pensionable salary will be paid to the member.

This provides valuable additional funds for you should your spouse die which will go some way towards easing the financial burden in this tragic situation.

3 B. SINGLE MEMBER'S SPECIFIED ILLNESS BENEFIT (only payable if you are **single** at the date the event occurs)

The Scheme now includes a valuable new benefit for single members in the form of a 'Single Member's Specified Illness Benefit'. In other words, a further once off cash lump sum of 25% of annual pensionable salary is payable if a single member suffers any of the specified illness listed. This is in addition to the 25% of annual pensionable salary already payable under the 'Specified Illness Benefit' which is provided to all members (whether married or single).

IMPORTANT

Members can only ever benefit from either option 3A or 3B i.e. if a member avails of option 3A they will never be eligible for option 3B.

4 Additional Death Benefit

A. EXTRA ONE TIMES ANNUAL SALARY

Following on from the Review, an **extra** one times annual salary Death Benefit has been introduced. This means that members are now covered for a Death Benefit equivalent to three times annual pensionable salary in total.

Early Payment of Death Benefit

Irish Life has agreed to advance part payment of the benefits (equal to 25% of annual pensionable salary) in cases where a member is diagnosed with a terminal illness (with death expected within 12 months) and is under age 63.

B. ACCIDENTAL DEATH BENEFIT

If a member is killed as a result of an accident, a further additional Death Benefit of €15,000 will be paid to their estate. This is payable in addition to the normal Death Benefit of three times annual salary.

C. CHILDREN'S DEATH BENEFIT

If a member's child (under age 21) dies, a Death Benefit of €4,000 will be paid.

REVIEW OF THE PNA SALARY PROTECTION SCHEME - MAIN ENHANCEMENTS -

OTHER ENHANCEMENTS

5 FULL COVER OPTION FOR JOB-SHARERS

If you take up a job sharing post your salary will of course reduce and so too will your contributions to the PNA Scheme. Naturally your level of cover under the PNA Scheme will from that point on also be based on your job sharing salary. Members who intend to remain job sharing for a prolonged period or even permanently may be happy with this.

However members who intend to job share for a limited period and then return to their full time post may wish to retain cover in line with their full time salary — even while they are working in their job sharing post. Given the growing number of PNA members who are taking up job sharing posts a new option has been introduced to cater for this category of members.

Members who intend to job share for a relatively short period (and who therefore wish to maintain their cover under the PNA Scheme in line with their full time salary) may now apply to do so in advance of taking up their job sharing post. Such members must apply in advance to Cornmarket and pay the additional appropriate contribution. Cover on a full time basis can be arranged for a maximum of three consecutive years only.

6 COVER EXTENDED TO AGE 60

Members will now enjoy cover under the Disability Benefit element of the Scheme up until age 60 (this was previously age 58 for the majority of members). This enhancement will apply to all existing and future beneficiaries.

7 NO RESTRICTIONS ON BACK INJURIES/MENTAL ILLNESSES

In an ongoing effort to increase the cover for members, the PNA/Cornmarket has secured the agreement of Irish Life to remove the current restrictions in relation to back trouble and mental illnesses for all existing and future claims. Until now, because insurers have been concerned about the high risk of such claims from the nursing profession, benefit for claims arising from back trouble and mental illnesses were paid for a maximum of 8 years only. This enhancement will apply to all **existing** and future beneficiaries.

8 ENHANCEMENTS TO THE RETIRED MEMBERS' LIFE COVER PLAN

Thanks to the fact that members are paying a 'Medical Immunity' premium of 0.05%, members can opt to join the Retired Members' Life Cover Plan within 4 months of retirement without any medical underwriting. Over the coming years we hope to be able to introduce an arrangement which will allow for cover under the Retired Members' Life Cover Plan to begin automatically at retirement for all members of the PNA Scheme unless the member opts out. This will also allow for contributions to the Retired Members' Life Cover Plan to be collected from pension during retirement (in the same way that contributions to the Salary Protection Scheme are collected through salary while members are still working). However, until such an arrangement is available, members should remember that they must apply for membership of the Retired Members' Life Cover Plan within four months of retirement. Full details are contained in the policy booklet.

As a special concession, an arrangement has been negotiated whereby retired nurses who are under age 65 but did not opt to join the Retired Members' Life Cover Plan will be given an opportunity to join again on a shortened application form. This option is only open for a limited period (please call Cornmarket for details). The contribution rate in retirement is now set at 1% of pension collected by direct debit from the member's bank account.

9 BENEFITS AND CONTRIBUTION RATE GUARANTEED UNTIL 1st DECEMBER 2013

Cornmarket has secured this new contribution rate for the next 5 years. This provides members with greater security as it guarantees that there will be no change to the contribution rate until the next review (regardless of the level of claims which the Scheme may experience).

10 EXCLUSIONS RELAXED

Cornmarket has secured Irish Life's agreement to drop the exclusion related to war and riots. This means the only conditions excluded from cover are those arising from wilfully self-inflicted injury or illness.

FOR FURTHER INFORMATION ON THE PLAN — PLEASE CALL CORNMARKET ON 01 408 4174

REVIEW OF THE PNA SALARY PROTECTION SCHEME - MAIN ENHANCEMENTS -

11 MEMBERS CLAIMING AS A RESULT OF AN ASSAULT AT WORK

Psychiatric nurses who are injured as a result of an assault at work may be entitled to a payment equivalent of up to 5/6ths (or 83%) of their salary while they are disabled. As the benefit under the PNA Scheme (including social welfare, disability pension and other income) cannot exceed 75%, this has meant that until now members in such cases have received no benefit under the PNA Scheme. Following this review, in some cases members in this situation may now receive an amount of benefit from the Scheme. The Scheme benefit will be calculated without taking into account the 'notional income' arising from the gratuity (lumpsum) at the time of their retirement on ill health grounds as a result of an assault in work that is factored into the calculation under the 5/6th Scheme.

ENHANCEMENTS FOR BENEFICIARIES

12 DEATH, SPECIFIED ILLNESS, SPOUSES DEATH BENEFIT/SINGLE MEMBERS SPECIFIED ILLNESS AND MEDICAL IMMUNITY BENEFITS NOW PROVIDED FREE FOR SCHEME BENEFICIARIES

Beneficiaries will enjoy free cover for the Death Benefit, Specified Illness etc. while they are receiving Disability Benefit under the Scheme, i.e. they will remain covered for Death, Specified Illness Cover etc. until age 65 at no extra cost. Thereafter, beneficiaries have the right to apply for membership of the Retired Members' Life Cover Plan without a medical within 4 months of reaching age 65 (thanks to the fact that contributions to the Medical Immunity Benefit will have been paid on their behalf).

13 IMPROVED BENEFITS FOR THOSE NOT CLAIMING EARLY RETIREMENT PENSION (ERP)

If a member making a claim decides not to apply for an ERP and is not entitled to pension rate of pay (perhaps because he/she intends to return to work) Irish Life has agreed to pay a benefit of 75% of salary for a maximum of 2 years. This means that over this 2 year period no deduction will be made from the benefit paid under the Scheme for an amount equivalent to an ERP or pension rate of pay as no ERP or pension rate of pay is being claimed. If the member retires within this 2 year period and an ERP or pension rate of pay is back dated, the additional amount paid under the PNA Scheme must naturally be refunded.

14 'NOTIFICATION PERIOD' IF CLAIM IS ENDED

In the case of longer term claims (where a claim has been in continuous payment for at least one year) if medical evidence indicates that the member is fit to go back to work, Irish Life has agreed to give three months notice before ending the payment of benefit under the Scheme (previously one month's notice was given) assuming the member has not returned to work.

15 NO FURTHER MEDICAL EVIDENCE REQUIRED FOR CLAIMS IN PAYMENT FOR MORE THAN 10 YEARS

Claims which have been in payment for at least 10 years will no longer be subject to periodical medical reviews and therefore are guaranteed to be paid, subject to financial review only (e.g. to confirm that the member is not receiving an income from some other source), until age 60 or death if earlier.

16 RIGHT OF CLAIMANTS TO LIVE ABROAD

In the event that a claimant decides to reside abroad (anywhere in the world), Irish Life has agreed to pay a claim for a maximum of 12 months (previously this was 6 months). After 12 months the claimant must be residing in Ireland or the UK in order to continue receiving benefit.

17 SPECIAL ARRANGEMENTS FOR NON-IRISH NATIONAL MEMBERS

In recognition of the fact that there are now substantial numbers of non-Irish nationals who are members of the PNA Scheme, we are delighted to announce in cases where a non-Irish national member who, in the opinion of Irish Life, is permanently disabled, wishes to move home on a permanent basis, Irish Life will consider paying the member a benefit of up to and no more than five years benefit in one lump sum as a settlement of the member's claim, provided the member has been in receipt of benefit for at least 12 months. The amount of benefit paid will be calculated by Irish Life. Any such payment will be in final settlement of the member's claim, and will be treated as normal income i.e. is liable for income tax, PRSI, and the government levy.

TO SPEAK TO CORNMARKET'S CLAIMS DEPARTMENT - PLEASE CALL 01 408 4166

ATTENTION ALL PNA MEMBERS UNDER THE AGE OF 45

If you are not already a member of the PNA Salary Protection Scheme and you are under age 45, you can now take advantage of a preferential application form to join. The deadline for entry to the PNA Scheme using this preferential application form is October 31st 2009.

This preferential application form is much shorter than the standard application form, with far less medical details required. After this date, entry to the PNA Scheme is likely to involve a considerably more rigorous screening procedure.

This means that many PNA members who might otherwise be able to join now may find that, after October 31st 2009, the benefits of the PNA Scheme are effectively denied to them.

If you are over age 45 and want to join the PNA Scheme, please call (01) 408 4174 and a standard application form will be sent out to you along with an information pack.

DON'T PUT IT ON THE LONG FINGER...

PROTECT YOUR SALARY NOW!

Simply fill out the application form opposite and return the form it to:

Cornmarket Group Financial Services Ltd.,

Christchurch Square,

FREEPOST F3976,

Dublin 8.

(NO STAMP NECESSARY)

or contact us at (01) 408 4174

Contact Details

1. Joining the Scheme: (01) 408 4174

2. Scheme queries (01) 408 4174

3. Advice on making a claim (01) 408 4166

4. Other Cornmarket services (01) 408 4000

2834 PNA SPS insert 11/08

pna

Ref: MMA

cornmarket group financial services ltd

Salary Protection Scheme for PNA members preferential application form

Valid from February 1st 2009 to October 31st 2009 for use only by members under age 45

Please cut along this line

1 personal details

Title: First Name: Surname: Date of Birth: / / 19

Home Address:

Tel: Home: Mobile: Work:

Email: Country of Birth: Gender: Male: Female:

Marital Status: Single Married Separated Divorced Partnered* Widowed *Residing with a partner for over 6 months

2 employment details

Employer: Unit/Area:

Work Address:

Current Annual Salary*: € Pay Group Number: Employee Number:

Grade: Social Welfare Class: A1: D1: Superannuation Scheme member: Yes: No:

I confirm that I am a PNA member

OR

I confirm that I am currently in the process of joining PNA and understand that it is a condition of the Scheme that I must be a PNA member (your application to join the Scheme will not be processed until you confirm in writing to Cornmarket that you have been accepted as a member of PNA)

Is your employment: Permanent: Temporary: Agency Nurse:

If temporary, are you employed on a contract of at least 12 months duration? Yes: No:

Are you working as a job sharer? Yes: No:

Are you working 8 hours or more per week? Yes: No:

If an agency nurse – are you working 2 or more years as an agency nurse? Yes: No:

* For agency nurses salary is based on the average of the previous 2 years earnings.

OFFICE USE ONLY

client no

consultant code: MMA

larc code

3 salary deduction mandate – must be signed

To: The Finance Officer: Employer:

Please deduct until further notice from my pay the appropriate amount of my salary in respect of my contribution under the Salary Protection Scheme for PNA nurses and remit this amount to Cornmarket Group Financial Services Ltd. I recognise that these deductions are being made solely as a measure of convenience to me and that they may be terminated at any time. I also recognise that the ultimate responsibility for ensuring that the correct deductions have been made, and that deductions are cancelled when appropriate, rests with me and that beyond making remittances on foot of sums deducted as stated, my employer accepts no responsibility of any kind in this matter.

Applicant's Signature: Date / /

Name (BLOCK CAPITALS): **DATE OF BIRTH:** / /

Workplace Name & Address:

Employee Number: Pay Group Number: (if available)

4 direct debit mandate Originators Ref: 993020

DD plus

To: The Manager: I/We authorise you until further notice in writing to charge my/our account on or immediately after the 6th of every month unspecified amounts at the instance of Cornmarket Group Financial Services Ltd. by direct debit.

Name of bank Bank Ltd

Address (BLOCK CAPITALS):

Name of Account to be Debited (BLOCK CAPITALS):

Bank Account No: Bank Sort Code:

Account holders Signature: Date: / /

Second Signature*: Date: / /

* Required when bank account is held in two names.

Date of first payment within one calendar month

OFFICE USE ONLY

Client Number:

Please cut along this line

5 declaration - you must read this carefully before signing

WARNING Please read the declaration below carefully and ensure that you fully understand it before completing it.

In the event that any part of the declaration is untrue or incomplete in any respect, your cover may be rendered void and any claim you make may not be paid. If you cannot complete this declaration for medical reasons, please contact your local Cornmarket Consultant for further information.

I wish to join the Salary Protection Scheme for PNA members. I declare that I am actively at work today, or capable of being actively at work today, and that I have not been absent from work due to any illness or injury or any other medical condition for more than 10 continuous working days in the 12 months prior to the date of signing this declaration and I am currently not taking any daily medication for a known long term medical condition. I have never been refused, postponed or accepted on special terms for Salary Protection (Disability Benefit) or Life Cover (Death Benefit) or Specified Illness Cover.

I agree that this declaration and any other declaration made in connection with this application form shall be the basis of the contract of insurance between me, Irish Life and the PNA.

I understand that failure to disclose a material fact may constitute grounds for rejection of a claim. I consent to Irish Life seeking information from any insurance office to which a proposal has been made for insurance on my life and I authorise the giving of such information.

I understand that Irish Life must be notified of any changes in my health and/or circumstances prior to the assumption of risk (i.e. the date Irish Life accepts you into the Scheme). I understand that cover will not begin until this application has been accepted by Irish Life. I also understand that if my proposal for insurance is declined or accepted on special terms then that fact will be noted on a registry administered by the Irish Insurance Federation and may be shared with other companies as a protection against non-disclosure of material facts.

I confirm that I am a member of the PNA and that I understand that it is a condition of membership that I accept that PNA may amend the terms of the PNA Scheme or terminate the PNA Scheme altogether and that decisions of PNA in such matters are binding on all members.

I confirm that I have received an explanatory booklet about the Scheme and have received and understand the contents of the Cornmarket Terms of Business document.

Applicant's Signature: X _____ Date X / /

6 data protection declaration

I hereby consent to the use and recording of my personal details (contained herein or provided subsequently) by Cornmarket and Irish Life. I understand that the details I have provided will be held on computer, and/or in printed form or otherwise by Cornmarket and Irish Life. I agree that this information may be used in the future to contact me (by mail/email/telephone) about Cornmarket services which may be of interest to me. I understand that the information provided by me will not be passed on to third parties for the purposes of direct marketing. I also understand that I may at any stage, at no cost, instruct Cornmarket in writing to no longer hold my data for the purpose of sending me such information and that I have a right of access to and the right to rectify the data concerning me held by Cornmarket.

If you do not wish to receive information about preferential Cornmarket deals available to Union members, please tick here. ☐

Applicant's Signature: X _____ Date X / /

eligibility

To be eligible to apply for membership of the Salary Protection Scheme for PNA members you must be:

- A member of the Psychiatric Nurses Association
- Under age 45 *and*
- Working for 8 hours or more per week
- Employed on:
  - A permanent full-time basis **OR**
  - A contract of definite duration (if you are in a temporary position, you must have over 2 years service and your contract must be of least 12 months' duration **OR**
  - Working continuously for the past 12 months (if you are in a temporary position, you must be actively working now) **OR**
  - Working as an agency nurse for two or more years.

Job/work sharers – Job/work sharing members of PNA who satisfy the eligibility conditions above may also apply to join the PNA Salary Protection Scheme. The level of contribution and benefits which apply for them may differ from those relevant for the full time members (See Scheme booklet for details).

confirmation of Scheme membership

Your cover will commence from the date Irish Life accepts your application. You will receive a formal acceptance letter confirming that you have been included as a member of the PNA Scheme. Irish Life will assess the potential risk of insuring you before membership of the Scheme can be confirmed. This may involve attending for a medical examination. In a small percentage of cases membership of the PNA Scheme may be refused. In such cases applicants will receive a letter confirming that they have not been accepted into the Scheme. In other cases membership may be offered subject to the condition that certain Specified Illnesses are excluded from cover or subject to the payment of an additional contribution. In these circumstances applicants may seek additional clarification from their own doctor who can contact Irish Life to request reasons for their decision.

cornmarket group financial services ltd

Christchurch Square
Dublin 8.
Tel: (01) 408 4000
Fax: (01) 408 4011

Cornmarket House,
6 Kings Terrace, Lower
Glanmire Road, Cork.
Tel: (021) 455 3335
Fax: (021) 450 2014

Galway.
Tel: (091) 562 727

E-mail:
info@cornmarket.ie
Website:
www.cornmarket.ie

A member of the Irish Life & Permanent Group

Treatment Group Programmes for Dual Diagnosis

(Category 1 Recognition with An Bord Altranais)

Starting Date: 7th October 2009

This training programme is aimed at introducing you to the concept of dual diagnosis and the various treatment programmes that you may utilise in your own service while dealing with dual diagnosis service users.

Learning Outcomes

At the end of this training you should be able to:

- Demonstrate reasonable knowledge of dual diagnosis and treatment group programmes.
- Carry out an assessment and make appropriate referrals for clients with dual diagnosis in your service.
- Develop a programme of your own to suit your clients' needs.

Who may attend this training?

Nurses, social workers, gardai, drug counsellors, community out reach workers, probation officers, primary health care workers, medical professionals, along with clinicians working in addiction centres and any other centre that provide a service for drug and alcohol problems who are deemed to benefit from this training programme.

Training Structure

This 35 hours training programme is an introduction to dual diagnosis and the treatment group programmes. It is an intensive five-day programme that includes theoretical information on dual diagnosis, mental illness in general and also practical sessions on "how to conduct the group treatment programmes for dual diagnosis". Included in this programme is Documentation and interagency working.

Teaching Methods

- Lectures
- Videos
- Group works/discussions
- Role play with video recording
- Vignettes
- Skills demonstration
- Guest Speakers
- Reflective experiential accounts by service users

Assessment

Participants are expected to write two 500 word essays and participate in skills demonstration.

A variety of vignettes will be provided through out the training programme. Library and reading list will be made available for further information.

A minimum of 85% attendance is required in order to receive the certificate.

For further information contact Hanora Byrne, CNS in Addictions, Central Mental Hospital, Dundrum Email: hanora.byrne@hse.ie/01-2157556

National Forensic Mental Health Service, Central Mental Hospital, Dublin-14

Treatment Group Programmes for Dual Diagnosis

(Category 1 Recognition with An Bord Altranais)

APPLICATION FORM

Name:.....

Address:.....

.....

Telephone: **Work**..... **Mobile**.....

Email (If Available):.....

Current Employment:.....

Reasons for attending this course:.....

.....

.....

.....

Experience of Dual Diagnosis: .....

.....

.....

Course Fee: 700 Euro
(Cheques made payable to Trinity No. 1 account Ref: 410/F03)

Starting Date: 7th October 2009
Please return completed form and cheques by
Friday 18th September to Hanora Byrne, CNS in Addictions, Central Mental Hospital, Dundrum, Dublin-14.

for abstract * call for abstract * call for abstract * call for abstract * call for abstract * call for abstract * call for abs

Psychiatric section of Czech National Nurses Association
HORATIO: European Psychiatric Nurses

II. European Psychiatric Nursing Congress: Building Bridges

Congress Theme:

We have chosen a subheading Building Bridges for II. European Psychiatric Nursing Congress. A bridge allows people to cross an obstacle, connects or reduces distance. We would like to offer participants an opportunity for building their own bridges by sharing knowledge and experience.

The Scientific Committee of the Horatio invites abstract submissions from all psychiatric nurses and related health disciplines.

15th - 17th April 2010
Hotel Pyramida / Prague, Czech Republic

CALL FOR ABSTRACTS

Abstracts:

Submission may be in the form of a:

Plenary session: 25 mins in lenght with an additional 5 mins for questions

Workshop: 1,5 hr in lenght (based on everyday nursing practice; e.g. suicidal, aggressive, self neglecting, acute psychotic patient etc.)

Poster: on topical developments, research or local issues of wider interest

Abstract submission should be made by email to
praguecongress@gmail.com including the following:

Title/Name/Surname/Qualification/Job title/Work place/Mailing address/ Telephone number

As well as

Presentation title and aim/Three intended learning outcomes/Three reading references/Type of presentation (plenery session, workshop or poster)/ Abstract of no more than 400 words

Closing date for abstracts: 30. 10. 2009

Participants chosen to present will need to be registered for the congress. Delegates will be able to register for the congress from May 2009.
Official language: English, Czech, Russian

for abstract * call for abstract * call for abstract * call for abstract * call for abstract * call for abstract * call for abs

A Word from Des Kavanagh, President of Horatio European Psychiatric Nurses

In November 2008 at the Horatio Festival, Age of Dialogue, in Malta a wide variety of experience and learning in practice development and research was exchanged among 435 colleagues from 35 countries. During the course of the Festival the relevance of European consensus papers within the profession were highlighted several times. The Horatio network enables joint projects to evaluate and improve education of psychiatric nurses across Europe. In practice we also need consensus papers on issues which affect the work of psychiatric nurses in Europe. In 2009 the EU focus is aimed towards the implications for practice of the consensus papers on? Depression and Suicide? and ?Youth and Education?.

From several perspectives practice, research and education in different European countries seems to present both specific and general challenges. Horatio represents the largest workforce in mental health care in Europe and Horatio has now become an important and participative stakeholder in the process towards the development of the EU Mental Health Pact. In this process Horatio also represents the EFN and ESNO interests. Horatio has contributed in the preparatory phase. Apart from the EU Mental Health Pact process other challenges will face psychiatric nurses in the near future , especially in relation to nurse education where major changes will be expected as a result of the implications of the Bachelor / Master Bologna Education Pact. This may have consequences for the curriculum of nursing schools at various levels. From this perspective educational and research institutes will be stimulated to do more collaborative work on lifelong learning arrangement and international exchange of students and lectures.

Members of Horatio are also actively invited to provide input for discussions in the EU Mental Health Pact process. Finally you will find the call for abstracts on the preceding page for the second European Psychiatric Nursing Congress: Building Bridges 15th-17th April 2010, Prague Refer to http://www.horatio-web.eu/building-bridges.html for further info.

1. Michael A Kelly Ballinasloe Having a Relaxing Moment in Malta
2. Here Come The Girls!
3. PNA Delegation Return From Horatio Malta Festival
4. Just a Minute!
5. Martin Ward Horatio European Expert Panel of Psychiatric Nursing; Professor Shirley Smoyak, Professor of Health Care Policy, Rutgers University USA, Des Kavanagh President Horatio ,
6. Martin Fitzpatrick & Paul Brophy Irish Delegates, Officer Board PNA
7. Chrissey Greene Irish Delegate St Vincent's Elm Park, Professor Shirley Smoyak, Professor of Health Care Policy, Rutgers University USA, Des Kavanagh President Horatio, Aisling Culhane Irish Delegate, Research & Development Advisor PNA, Martin Ward Chair, Horatio European Expert Panel of Psychiatric Nursing
8. Des Kavanagh & Seamus Murphy enjoy the local Maltese Culinary Delights
9. Des Kavanagh President of Horatio & Martin Ward Chair, Horatio European Expert Panel of Psychiatric Nursing

Contributions from our Colleagues in the Southern Hemisphere

Partnership in Coping (PinC) - A System Of Recovery

The Partnership in Coping system of Recovery has been developed by r Eamon Shanley and Maureen Jubb-Shanley

Q - In a sentence, what is PinC about?

A Eamon - In a sentence, it's a way of organising our practice. Patients/clients are helped to use their existing strategies to cope with their immediate mental health concerns and, where appropriate, develop new coping skills.

I know that many of us have been doing this for years. However this is the first time it has been clearly identified as central to our work in a system developed for psychiatric nurses!
The trick in developing the system was to 'keep it simple"

Q - What benefit is the PinC system of Recovery to psychiatric nurses?

A Eamon - Well, for practicing psychiatric/mental health nurses it gives a structure to what many experienced psychiatric nurses do already without using any specific system. It raises our professional status and help get rid of the 'jack of all trades' tag for once and for all. And for managers it more clearly helps psychiatric nurse use the recovery approach without incurring the costs of buying in a system. It can be freely downloaded from the website www.pinc-recovery.com or simply Google 'Partnership in Coping'.

Q - Is there much training involved?

A Eamon - No, experienced and competent staff would require little training. However junior and new staff will require some training in its use.

Q - Where can we get a copy of it and see for ourselves?

A Eamon - All the information and documentation is free on www.pinc-recovery.com. This includes the user's manual, client process records, illustrations of the use of PinC and background information. Any of your readers are very welcome to contact us through thewebsite blog is they want more information or make comments.

WISDOM

An Information System for the Mental Health Services – Article for the Vision for Change Magazine

The HRB is working in collaboration with the HSE and stakeholders to develop an information system to expand the data currently collected from in-patient and community settings. The name of this mental health information system is WISDOM. In June 2008, the Centre for Management Organisation Development (CMOD) sanctioned the resources necessary to run WISDOM as a Proof of Concept (POC) in the Donegal Local Health Area.

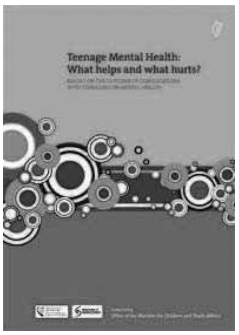
A number of organisational groups oversee the project at both a local and national level. Membership at each level includes representatives from professional disciplines, management, patient advocacy groups and specialists in various areas such as data protection. Working groups have been in place for this project since 2006.

The WISDOM mental health information system will facilitate the accurate collection and reporting of all patient contacts with mental health services. This includes the full spectrum of mental health contacts from children and adolescent to psychiatry for old age and includes psychiatry of intellectual disability and other specialist services. It will allow for better information sharing between professionals, facilitate better record keeping, allow for immediate access to information in emergency situations together with additional benefits in terms of allowing auditing and research. This single data depository of electronic information will aid in providing a high quality mental health service at every level and aid in good governance.

To date, the software has been designed and developed. Testing on the major modules of the software has been completed. Training on data protection and consent has been delivered to over 200 staff in Donegal with planning for the remaining staff underway. Various policies such as a privacy and confidentiality, consent and security policies have been drawn up. The majority of the planning processes have been completed and it is expected that the first team will go live in 2009.

[Queries in relation to developments at a Donegal Mental Health service level can be directed to the local Project Manager, Ms. Virginia Reid on (087) 6605170.]

Useful Publications!



Teenage Mental Health: What helps and what hurts?

Report on the Outcome of the Consultations with Teenagers on Mental Health. The report outlines the views of 277 teenagers, aged 12-18, who took part in the consultations organised by the Office of the Minister for Children and Youth Affairs in six locations around the country during autumn 2008 Six teenagers, who took part in the consultations at different locations around the country, outlined the outcomes from the consultations described in the report.

Maggie Gethings from Dublin said, 'at the consultations, we discovered that, unlike adults, we teenagers don't only see mental health in a negative way, but also in a positive light'. Teenagers identified eight key areas that hurt their mental health, self-image, school pressure and exams, family problems, bullying, death, peer-pressure, relationships with boyfriends and girlfriends and isolation. The teenagers also identified many things that could help with problems in the areas of exams, facilities and supports, relationships, family and self-image. 'Adults need to realise that teenagers can hurt as badly as adults, especially on issues such as death and relationships. Teenagers' feelings need to be taken seriously' concluded Maggie.

Danny Costello, also from Dublin, said that among the top issues that hurt mental health were self-image and bullying. 'Self-image is a big part of a typical teenager's life. It can be unbearable for any young teenager to see the attractive people on TV or in magazines, and see the way that they are not like those people. Girls especially are more influenced by the media in a negative rather than a positive way'. Danny went on to say, 'bullying came up at every consultation venue. Bullying goes on 24/7 in all different ways.

School was found to the place where the most bullying takes place. Bullying by people your own age is very hurtful. The impact from bullying can lead to a lot of different things, including self-harm and suicide. The teenagers at the consultations said that bullying can lead to depression, which makes young people feel that there is no way out and no one there for them'.

Martin Clancy from County Leitrim spoke about how school or exam pressures and family issues emerged as key hurts for teenagers' mental health.

'Participants said that there is too much focus on doing well in one set of exams, which potentially dictate what you do with your life. They feel that there is too much pressure to decide what you want to do for the rest of your life at just 16' said Martin. Teachers were found to play a role in creating this stress and pressure, with some teachers ignoring non-academic talents and skills and favouring students who are high academic achievers. 'A negative family environment emerged as one of the greatest stresses for young people. Any kind of abuse such as alcohol or drug abuse, sexual abuse or living with somebody with an eating disorder makes things worse. Fighting within the family can put huge pressure and stress on teenagers' concluded Martin. Claire O'Shea from Limerick spoke about how the school system could help teenager's mental health. 'Students at the consultations felt that there should be at least one class per week on mental health, with the issues chosen by young people and taught by teachers who understand and care,' said Claire.

Young people also favoured a move away from sole reliance on exams to continuous assessment. They want the curriculum to be more holistic and integrate sport, art and drama to cater for different abilities and skill sets, with an option in every school to sit the Leaving Cert Applied. Students proposed a confidential mentor, advisor or guidance councillor in every school. 'In my school, we have peer mentoring, where the first-year students are mentored by the fifth-year students, which creates friendship networks and builds a sense of community in the school' concluded Claire.

Julie O'Shea from Bantry, County Cork highlighted how leisure facilities and other supports for young people can help mental health. 'Young people noted the lack of facilities for teenagers and stressed the importance of setting up youth cafes or clubs, which have free teen health and counselling services.

Another point made at the consultations, was that well organised discos, with proper supervision are hugely important, especially in rural areas. We also consider recreational activities hobbies and sports to be very important in maintaining positive mental health as they help you to let off steam. All these facilities need to be affordable and accessible, particularly transport,' said Julie.

David Matthews from Ballymahon, County Longford said, 'We teenagers chose all the topics discussed at the consultations and the report is an account of exactly what we said. We discussed the signs of poor mental health and agreed that a change in someone's personality can be a tell tale sign - where somebody's behaviour, character or attitude to life changes dramatically. We agreed that it can be very difficult to tell if someone has a problem because "it's normal to be moody as a teenager".

The participants felt that suicide rates in Ireland would be a lot lower if the signs were picked up on. Young people need to be informed about the signs and symptoms of poor mental health and what to do if they are in that position. It was welcoming to see that this report has already had some impact, especially in the National Office for Suicide Prevention advertising campaign, which will be launched in the next few months. It is hoped that this report and awareness campaign will persuade politicians and decision makers to improve mental health services and supports for young people'.

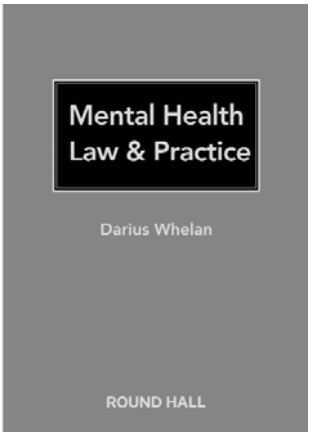
Drug Use, Sex Work and the Risk Environment in Dublin

National Advisory Committee on Drugs NACD 2009.
The first Irish qualitative research on female and male drug using sex workers.

The overall aim of research was to explore, and gain an understanding of, the local risk environment within which problem drug – using sex workers in Dublin live and work, and their responses to these risks.

Findings from the Drug Use, Sex Work and the Risk Environment in Dublin study highlight that drug-using sex workers are exposed to multiple risks and harms in their daily living and working lives. The physical, economic and social environments within which drug-using sex workers find themselves impacts on their construction of 'risk' and 'harm'.

While the men and women interviewed implemented a range of innovative strategies to reduce the risk of harm, there is an acceptability associated with certain risk behaviours in certain circumstances. Drug-using sex workers are a vulnerable client group who have multiple, interlocking needs that span health, social, economic and legal issues. Therefore addressing their wider social and situation needs such as poverty, housing, health, education needs and employment prospects are as fundamental to reducing their risk of harm as addressing their drug use.



Mental Health Law & Practice

This book is a comprehensive examination of civil and criminal aspects of mental health law. Both aspects have been the subject of major legal changes in recent years, with the coming into force of the Mental Health Act 2001 and the Criminal Law (Insanity) Act 2006. Emerging practices of the recently established Mental Health Tribunals and the Mental Health (Criminal Law) Review Board are reviewed.

Contents: Constitutional and human rights in mental health law; Institutions of mental health law; Legal criteria for civil commitment; Procedure for civil commitment; Mental health tribunals; Wards of court; The insanity defence; Diminished responsibility; Mental health in sentencing; Fitness to plead; Patient transfers; Patients rights; Confidentiality; Consent to treatment; Negligence actions.

Dr Darius Whelan is a lecturer at the Faculty of Law, University College Cork.

Amnesty International Ireland Mental Health Campaign

On 15 June 2009 Amnesty International Ireland launched the next phase of its mental health campaign at the Abbey Theatre in Dublin. Seeking to put the right to mental health centre stage in Irish society, the groundbreaking mental health campaign has been devised in partnership with people who have had mental health difficulties, which marks an international first for the organisation.

This campaign will use human rights to demand action from the Government on policy and legislation relating to mental health, and will also seek to challenge individuals and society to put an end to discrimination against people with mental health difficulties.
Under international law, everyone in Ireland has the right to the highest attainable standard of mental health. But the Government's mental health policy, A Vision for Change, which promised much, has failed to deliver.

It is clear the Government needs to implement a radically different approach to mental health, focused on each individual's human rights and dignity and promoting conditions where people can live a full life in the community.
To find out more visit www.amnesty.ie/mentalhealth

A Peaceful Mind

Bernie Kirwan[Sherwin] is a 49 yr old woman living in Gorey Co Wexford .In June 2000 she was diagnosed with breast cancer and following a mastectomy and chemotherapy she remains healthy and well. A nurse who trained in Waterford Regional Hospital she has nothing only praise for the staff there that looked after her so well at that time. She is originally from outside Mullingar in county Westmeath.

Her story of hope and inspiration is told in her book **A PEACEFUL MIND** that was recently very successfully launched in Gorey. It is available online from originalwriting.ie and kennysbooksgalway and now from Eason's nationwide. Indeed any good book shop will order it in.

The best thing about reading **A Peaceful Mind** is that it's just like having a conversation with the author. Bernie Kirwan's honesty and humour effortlessly engage the reader in her harrowing journey through breast cancer, from diagnosis to treatment to recovery.

At no time does Bernie avoid sharing the pain and hardship of her experience. Yet her determination to explore every possible way of becoming well in the most holistic sense makes this an inspiring and uplifting read. Bernie's journey back to health is one of reclaiming and celebrating the importance of self honesty and the willingness to experience and appreciate beauty in all things, from the changing of the seasons to the value of human relationships. This book is gentle, compassionate and above all practical. It is a powerful and essential read for anybody facing a cancer diagnosis and invaluable for anyone close to them. In it she shares not only her story but also the many tools and techniques she learned to help her on her path to wellness. Bernie still attends Doctor Paula Calvert for her six monthly checks, indeed Dr Calvert has kindly written the foreword for the book. She currently works at THE HOPE CANCER SUPPORT CENTRE IN ENNISCORTHY CO WEXFORD which provides therapies such as massage reflexology counselling etc for cancer patients and their families. She is married to Michael and lives in Gorey with her three children.

Praise for A Peaceful Mind

"An honest, courageous and inspiring book, A Peaceful Mind will be an invaluable 'Lonely Planet guidebook' offering direction and skills to anyone navigating the cancer journey." **Dr. Paula Calvert** Consultant Medical Oncologist Waterford Regional Hospital

"This book is gentle, compassionate and above all practical. It is a powerful and essential read for anybody facing a cancer diagnosis and invaluable for anyone close to them." **Rex Dunlop** Kinesiologist

"I have read a lot of books on cancer and cancer treatment and its effects on each of us individually but Bernie's book is a first in that it gives a realistic account of the journey from diagnosis to her life today." **Catherine O'Riordan Breast cancer survivor**

A Peaceful Mind is available online from www.originalwriting.ie or
www.kennys.ie or on order from any good book shop. ISBN: 1906018383

First Impressions

There have been long-standing concerns over the way parents are informed about their child's learning disability. A number of women are told on their own, with no offers of support. For some parents, the situation is handled so badly that it influences the way they feel about any support which is offered then or later. First Impressions is developed as a guide to professionals supporting families with very young who have been identified as having learning disabilities.

First Impressions was commissioned by the Foundation for People with Learning Disabilities in the UK in early 2004, in order to look at the emotional and practical needs of families who have a small child – aged up to five – with a learning disability. It found that while some families do get a great deal of support and information, from a sensitive diagnosis onwards, others have to fight for a diagnosis in the first place and are then left to cope very much on their own.

To download this Report click on the following link:
http://www.library.nhs.uk/LEARNINGDISABILITIES/ViewResource.aspx?resID=260437

Or
http://www.iimhl.com/iimhlupdates/20090630b.pdf

Research Study Information

Research Study to Develop Measures for early Detection of Alzheimer's Disease at AMNCH

A major research study on cognitive impairment and Alzheimer's disease is currently being undertaken in the Adelaide and Meath Hospital, Tallaght; St Patrick's Hospital; and other centres including St James's Hospital in Dublin. The study is headed by Prof Harald Hampel, Chair of Psychiatry (AMNCH), Trinity College Dublin.

The aim of this study is to gain a better understanding of the molecular and systemic mechanisms that underlie the pathophysiology of Alzheimer's disease. It is to help identify and characterize problems of memory, language and other mental abilities in persons aged from 55 to 90 years.

The study will examine brain scans and blood tests in order to find biological factors that may relate to changes in mental abilities. The researchers expect that this study will be of great benefit to help us better understand memory problems and eventually help in developing ways to treat and prevent these problems.

With an ageing world population the economic burden of Alzheimer's disease, a major devastating brain disease, will increase significantly and this will increasingly impact on our society. Much research interest to date has focused on making an early and accurate diagnosis of the disease, which is particularly important in view of the potential treatment advances and ongoing therapeutic trials. A number of research studies are currently looking into the earliest cognitive deficits and measures of early detection such as structural and functional brain changes detected on non- invasive neuroimaging and other novel biomarkers of the disease.

The questions of the current study are:

1. Can we improve diagnosis and assess the risk of Alzheimer's disease by protein measures of blood circulation.
2. What specific structural and functional brain changes predict or correlate with cognitive impairment and early Alzheimer's disease.

These important questions will hopefully contribute meaningfully to the recognition of Alzheimer's disease early in the course of the disease.

The study involves recruiting suitable participants from the different hospitals, provided they meet the inclusion criteria and have also consented to enter the study. The target age group will be people over 55 years with or without memory problems. Patients with heart failure, diabetes, acute psychiatric illness or recent ECT that can explain changes in cognition are excluded.

This study will involve the use of non-invasive Magnetic resonance imaging (MRI) of the brain to produce a representation of the structures and function of the brain. The participants will also undergo a neuropsychological assessment and blood will be drawn to measure microvascular indices.

This research study has been approved by the research ethics committees of the involved hospitals.

For further information, please contact:

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1 896 3706

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We look forward to your valued support and cooperation.

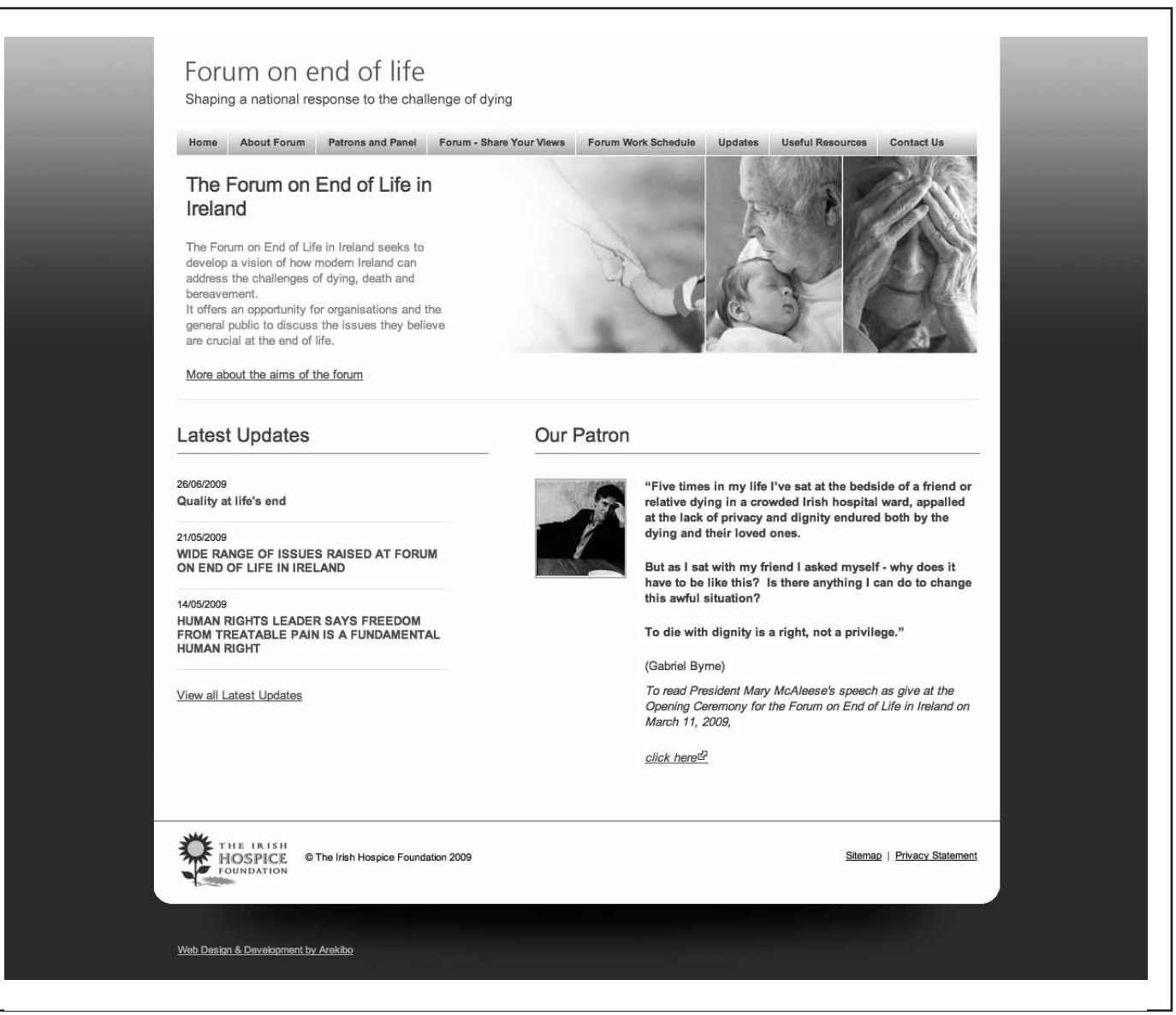
With best regards,
Professor Harald Hampel, M.D., M.Sc.

The Forum on End of Life in Ireland

A national forum on end-of-life care in Ireland was launched by the President, Mary McAleese, on in March 11, 2009, at the Royal Hospital Kilmainham. The Forum on End of Life in Ireland aims to develop a vision of how modern Ireland can address the challenges of dying, death and bereavement. End of life refers to all deaths - sudden, traumatic and expected - and the aftermath. It also refers to matters that emerge during the extended period of one to two years during which time a person, their family or healthcare professionals become aware of the life-limiting nature of their illness.

The Forum will examine a range of issues around end of life in Ireland such as the models of care which are available to older people, the trend towards hospitalisation at the expense of home and community-based services; the situation of carers; regulation of the funeral industry; the trauma of prenatal or sudden infant death; the need for the public to engage in advance care planning and registering their care preferences and the needs of families affected by suicide or homicide.

As a Specialist Nursing Union we (PNA) were approached to present our views of what matters most at end of life in Ireland for those service users in mental health & Intellectual Disability services, the issues for us as a profession delivering care, the circumstances we deliver that care and/or indeed the impact of exposure for nurses today involved with end-of-life care. We gave this presentation to the forum on June 3rd 2009. Our thanks to those who responded to our call for both verbal / written submissions in preparation for the presentation. The webpage is provided for those of you who may yet wish to submit your views @ http://www.endoflife.ie/.



Alcohol Liaison Project Cavan General Hospital

Two members of the Cavan/Monaghan branch of the PNA have introduced an award winning Alcohol Liaison Project. John Mohan and Martin Sheridan, two specialist nurses in addiction who are part of the Cavan/Monaghan Mental Health Service have initiated this project aimed at reducing the frequency of repeat admissions to Cavan General Hospital and enhancing awareness of alcohol as a legitimate health issue amongst all grades of staff.

Alcohol related admissions constitute a large percentage of all presentations to general hospitals. Consequently, there is increasing onus on all departments to provide a coherent response to the difficulties associated with problem drinking.

There is extensive evidence in the literature that hospital admissions may present the nurse with the opportunity to assist patients in addressing their use of alcohol. In particular, opportunistic brief interventions can be utilised as a useful health promotion strategy. Nurses are ideally positioned due to their extensive contact with patients to intervene in helping patients evaluate their alcohol intake. It has been demonstrated that patients who receive information and advice from health care professionals are significantly more likely to address their use of alcohol.

This initiative was piloted in 2006, has since extended and is now offered to all units and departments. Part of the process involved introducing a reliable and validated alcohol screening tool which would identify problem and hazardous drinkers that otherwise would be missed. The modified AUDIT-PC is utilised in Cavan General Hospital. The nursing staff administered the questionnaire as an integral component of their assessment procedure. Over 2400 patients have been screened for alcohol to date and 600 have had direct contact with the alcohol liaison nurses.

This involved conducting a comprehensive assessment in conjunction with brief opportunistic intervention with a view to helping them establish a connection between their hospital presentation and pattern of alcohol consumption. Patients were then offered a menu of options and given a specific leaflet outlining these options.

These included brief intervention, referral to community-based addiction services or possibly to residential rehabilitation services as required. Routinely, with patient consent a discharge letter is sent to the G/P informing them of proposed follow up. Returns are also made to the National Drug Treatment Reporting System and a database kept locally.

The focus on alcohol as a health issue has been afforded greater priority since this service was introduced. The liaison nurses have also been involved in providing education and training to nursing and medical staff. They also facilitate medical students on their placement in psychiatry and those from The Diploma in Addiction Studies, Trinity College, Dublin.

Both nurses have recently successfully completed the Certificate in Nursing (Nurse/Midwife Prescribing) postgraduate education programme approved by An Bord Altranais and delivered through the Royal College of Surgeons in Ireland (RCSI). This enables them as graduates to now apply for registration as 'Registered Nurse Prescribers" with An Bord Altranais.

They have also attained Master of Science Degrees in the specialist area of addiction nursing and in 2008 won the prestigious 'Elaine McCluskey Award' for nursing innovation and practice in the Cavan/Monaghan Hospital Group.

HSE Dublin Mid-Leinster Laois Offaly Longford Westmeath Mental Health Services launch a Portfolio of Mental Health Assessment Tools

Introduction:
A Portfolio of Mental Health Assessment Tools was formally launched in February 2009 designed to facilitate nurses to provide effective skills of assessment when caring within the mental health setting. This was the work of the Mental Health Services with generous education sponsorship from Janssen Cilag Pharmaceutical company.

Explaining the Portfolio:
The assessment portfolio is a book of 22 scales and questionnaires which enables screening for symptoms of mental illness / mental health difficulties of various types such as depression, anxiety, schizophrenia symptoms, suicidal ideas, social problems etc… .

They are evidence based giving a more accurate health/illness picture for the patient and nurse and support therapeutic engagement . They also assist in tracking the progress of patients/clients as they journey through their recovery.

Each tool/scale in the publication is accompanied by explanatory information and all are referenced.

The Portfolio is divided into six sections that out-lines the various components of care. **These are:**

- Mental Health Symptom Screening Tools
- Self-Evaluation Screening Tools
- Medication Effect Screening Tools
- Alcohol/Drug Screening Tool
- Living Skills Screening Tools
- Making sense of the assessment data

The final section on making sense of the data includes a stress vulnerability framework from a psycho social model with strong emphasis on a recovery ethos that can assist in guiding users on how to incorporate information into meaningful practice.

The Mental Health Commission (2005) has highlighted the importance of individualised care planning as one of the key aspects of holistic service delivery, and inclusion of more formal assessments/scales to contribute to informing care. These tools add to the assessment dimension and describes the levels of support and treatment required in line with patient needs. Care Planning includes broad based history taking assessment and observing current picture of presentation etc.. With this portfolio and training available it increases skill base of nurses to include more formal assessment and thus it represents a broadening of nursing practice. An assessment tool is reliant on the therapeutic relationship which is part of the overall assessment of the patient. Assessment tools measure and record data to assess potential and actual mental health problems in an objective systematic way.

The Portfolio was developed by a locally identified service need found in a regional nursing documentation audit. A working group was set up and an extensive literature review was conducted, which included the review of over 50 assessment tools.

The group consulted widely with nurses/health professionals regionally and nationally and internationally for best practice tools/scales being used in mental health.

Members of the working group:

- Louise Johnston
- Catherine McManus
- Claire O Connor
- Mary Kerrigan
- Rosalia Kavanagh
- Mick Hyland
- Mick O Hehir
- Margaret Daly
  (see inserted photograph of the committee with Liam O'Callaghan LHM, Laois Offaly)

Benefits of evidenced based assessment for patients

- A more accurate health/illness picture of the patient.
- Formal assessments more widely available , as nurses up-skill in this area
- Evidenced based tools increase objectivity of assessment
- Increases the therapeutic engagement between the patient and health professional.
- Many of the scales/tools are self reporting so patients can fill in for themselves and thus this increases autonomy

Education Package:

In addition to the portfolio, an education package was devised locally. 60 nurses attended training in 2008 and a further 47 completed the course in 2009. The education was supported in 2009 by the National Council for Nursing and Midwifery Development. Implementation of the tools to practice is critical and audit of the successes and challenges of using the tools is ongoing.Primarily the portfolio was directed towards nurses and promotes continued professional development but it is hoped that any professional (Doctors, Occupational Therapists, Psychologists, Social Workers) with appropriate knowledge and training in the mental health services can utilise relevant/applicable tools/scales from this portfolio.

The portfolio is available through the HSE intranet and library services to facilitate disciplines accessing these tools/scales. This is a resource that can used by all disciplines and thus become a more standard component of care which means improvement.

Annual reviews and updates are planned if newer tools become available and if service needs demand alternative tools/scales that better meet the patient's needs.

For further information please contact:

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Nurse Practice Development Co-ordinator Mental Health Services
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Crossing The Line

An Evaluation of a Music in Healthcare programme in Mental Health settings, Waterford City

Abstract

Kevin O' Shanahan was Musician-in-Residence with a hospital-based arts programme in Ireland for a six month period in 2007 during which time he facilitated a programme of participatory music workshops with users of Mental Health Services in the area. An evaluation of this residency explores the transformative impact of music making in terms of social interaction among clients, increased self expression, communication, motivation and mood and indicates the contribution that musical activity, with an emphasis on participation and inclusion, has to offer in the provision of quality holistic Mental Health care. The evaluation is based on questionnaires completed by staff members, clients and facilitating musicians, and on the observations of the Musician-in-Residence.

Introduction

In health care settings, patients often have limited access to the arts and the quality of the aesthetic environment can be poor. (Caspari et al 2006). This is unfortunate due to the fact that arts projects have been shown to make a unique contribution to enhancing well being and self esteem, (Cohen 2005). In France, the Ministry of Culture and Communication, have introduced legislation which obliges every hospital to partner with an arts organisation in its region, thus enabling the strategic delivery of arts and culture in hospitals. While in some ways the alliance of the arts and healthcare may seem an unlikely one, research indicates the arts may have much to offer in the provision of holistic healthcare (Smith 2002). The term "arts and health" broadly refers to the emerging area where the arts sector and the health sector intersect and is as an area of increasing activity in Ireland (The Arts Council 2003). The practice of "music in healthcare" refers to one type of arts in health intervention which focuses on encouraging creativity, participation and self expression through the medium of music. The facilitators are professional musicians with experience of working in healthcare settings. This differs to music therapy, where the emphasis is on the use of music to clinically change the state of a client, and the facilitators are registered music therapists. (Oireachtais Report 2006). Music in healthcare has been shown to have emotional, psychological, cognitive, physical and social benefits for participants. (HSE/Music Network 2005) This paper describes the impact of a music residency in two mental health settings in Waterford. The aims of this study were to assess the perceived benefits of the programme from the viewpoint of patients, nursing staff and the musicians involved and to identify if there was a change of clients social interaction, behaviour and mood from before and after the sessions, based on nursing staffs clinical observation.

Methods

Between March and August 2007, Kevin O Shanahan was Musician in Residence with the Waterford Healing Arts Trust . During this time, Kevin facilitated a series of music making workshops with the clients of the Department of Psychiatry in Waterford Regional Hospital and Ard na nDeise Hostel , a residential high support hostel for people with mental health problems.

These workshops aimed to:

- Engage mental health clients in participatory music experiences in a group setting
- Facilitate social interaction between mental health clients through participatory group music workshops.

During this residency, Kevin collaborated with a range of musicians in the facilitation of the music workshops. This resulted in the introduction of clients to various music styles and instruments. Kevin also used a number of simple percussion instruments such as drums, shakers, maracas, cow bells and chime bells which gave the participants the opportunity to engage in active music-making. Kevin facilitated nine music workshops in Ard na nDeise and on average nine clients and two staff members participated in each workshop. He facilitated fourteen workshops in the Department of Psychiatry in the Day Ward as part of a structured programme of weekly activities. On average ten clients and one staff member attended each session.

Results

The evaluation of the residency is based on questionnaires completed by staff members, clients and musicians at the end of each session and on the observations of Kevin O'Shanahan. The data gathered from these questionnaires and observations has been summarized, analyzed and contextualized within the experience of Kevin O'Shanahan, a musician with over ten years experience of facilitating music workshops within community and healthcare settings, and a trained and practicing psychiatric nurse. The evaluation outcomes have been categorized and presented here in a number of key themes and short case studies. 81 questionnaires were given to patients, staff and musicians who participated in the music workshops. This provided both quantitative and qualitative data. Of the 81 questionnaires, 13 were completed by staff, 42 by patients and 26 by musicians.

Social Interaction

Given that increasing social interaction between clients was an aim of the residency, it is significant that sixty-seven percent of clients in Ard na nDeise said that they felt "part of a group" during the music session. Staff members expressed increased social interaction between clients in a number of ways:

- "Group behaviour toward one another [was] more friendly and at ease".
- "[They were] more forward in their social interaction".
- "Interaction improved, swapping instruments discussing various songs and experiences. Clients were more inclined to initiate conversation".

One musician observed that "the group showed encouragement for those who made individual contributions during the session" and also that they "gelled as a group when using the instruments".

60% of staff members in Ard na nDeise said that clients were more talkative after the music session and 75% of staff members in the Department of Psychiatry observed continued interaction after the session.

The increased interaction between clients continued after the session. One staff member observed that clients in Ard na nDeise "continued to talk about [the session] way into the afternoon". Similarly, a staff member in the Department of Psychiatry said "[the clients] spoke about the songs, instruments, the voices etc., well into the evening". In the same unit, another staff member said "after the group session, many of the patients appeared more comfortable with each other and interacted well together, discussing the session." Another said "After the music session, behaviour of clients changed, more smiling and relaxed posture in general. Social interaction improved through small talk. "That was a good session wasn't it?" Clients reported that they really enjoyed the session and would "return again".

This increased level of social interaction is personified by one particular client in Ard na nDeise who sat outside the group, with his back to the group in the first music session. As the weeks progressed, Kevin observed that Frank* began to sit with the group, and to the staff's surprise, after two weeks, took a percussion instrument when offered it. Kevin observed that particularly at times when Irish folk songs were being sung, Frank responded to the music through increased eye contact, smiling and tapping his feet. Later, Frank began to mouth the words of certain songs. This progressed to singing. This transformation of Frank from a silent, solitary client, who usually sat in the corner and never spoke to staff or other clients, to a participating member of the group was in evidence when he voluntarily spoke to one of the musicians at the closing music session. It can be argued that this shift in behaviour creates the potential for Frank* to enter into a therapeutic relationship with the healthcare staff.

The benefit of increased inter-personal communication is recognised as important in preventing social isolation and its associated mental health difficulties. The factors that determine mental health have been shown to fall into three broad areas, personal, social and community. (Lahtinen et al 1999). As the definition of health widens, to take into account social factors, creative activities such as music which encourage participation and community are increasingly being recognized for their therapeutic benefits, in that they are an activity which involve and empower participants, as well as offering effective strategies that promote self expression and enhance self esteem.

Self-expression and communication

Whereas the responses given by staff, clients and musicians suggested greater social interaction, an increased level of self expression and communication on an individual basis was also observed by staff members:

- "Music became the focus of discussion".
- "[Clients] talked about the music listing other songs they would like to sing".
- "Some [clients] suggested new songs for [the] next session"

It became clear that self expression was manifest in a number of ways, not just verbally. Staff noticed that "faces became animated" and clients were "tapping [their] feet and clapping [their] hands". Another staff member observed a change in "mood and body language from uninterested to interested".

The communication between staff, clients and musicians was primarily a musical one. Kevin observed a musical transformation in the course of the sessions whereby sounds produced by a range of individual musical contributions came together without external instruction or direction, into a cohesive group sound leading to sense of group celebration and emotional release.

The musicians observed greater self expression and self determination manifested through individual clients choosing instruments they wish to play, songs they wish to sing, and suggesting songs in the session and songs for the next session. Kevin observed that the participants in Ard na nDeise took more ownership of the music sessions by requesting specific songs for the final music session which took the form of a get-together and party.

Kevin observed that John*, a resident of Ard na nDeise, when asked to sing a song at the final session, approached this in a more animated and performative way than before. Previously, John would have been difficult to motivate and reticent in his participation in the group. However, at the final session, when asked to sing a song, he sat forward in the chair, made eye contact with other members in the group, winked to the group and delivered the song in a more confident way than before. The group responded positively through applause. Kevin observed that John* had become more and more willing to perform with less and less prompting needed as the weeks progressed. He performed his button accordion at the end of each session. His increased confidence may be as a result of the positive feedback from his fellow residents. It can be argued that this willingness to perform was a reflection of John's increased self esteem and creative expression and that John was finding his own voice in the course of the programme.

Staff members observed that clients were "very definite about how they felt" when completing the questionnaires after each session. They also observed a residual impact at the sessions which were expressed in a number of ways. For example one staff member said that "some [clients] were still humming melodies" after the session.

Motivation

Another interesting finding to emerge from the research is the positive influence music appears to play in motivating participants. This is very relevant in mental health settings, where motivating individuals to become involved in social activities can be difficult. Staff in both settings commented that music is one of the activities they find it is easier to motivate clients to attend. This

is indicated by the regular weekly average of ten participants at each of the settings. Another revealing statistic is that between 80-90% of participants, when asked responded they would like to participate in the music sessions again.

Staff observed that as the residency progressed, participant's interest and motivation to remain involved appeared to deepen. One staff member observed one individual with prior musical experience began to practice the accordion and tin whistle in advance of the sessions. In a climate where motivation among clients can be low, increased motivation as a result of the music session was expressed by clients who "were looking up books for music for next session" and "wondering when was the next session".

Kevin observed shortly into residency that as participants became more familiar, both with himself and the way in which the groups were facilitated (with an emphasis on participation, more than passive listening) that individuals appeared to invest more of their energy into the group. This was indicated by individuals communicating verbally in a more obvious way by asking questions about the instruments or types of music, as well as offering suggestions for future sessions. Numerous other participating musicians noted that at the end of the one hour sessions participants appeared to be very motivated to continue with the music making activities. One visiting musician commented "The group were eager to attend the session and were interested in what type of music we were going to play. After the session it was evident that their mood was happy and elated. Kevin and I were aware that the session could have extended longer in the Department of Psychiatry and we had their attention and participation."

Shift in mood and behaviour

The transformative potential of music is reflected in the fact that a 100% of staff and musicians involved in the programme stated that they noticed a difference in clients mood, behaviour and level of social interaction both during and after the music session.

When asked how music sessions made them feel, 79% of clients in Ard na nDeise said that they felt happy, 67% felt that they felt part of a group, 58% were interested, 39% were energetic, 36% were excited and 33% were calm. 64% were relaxed. In the Department of Psychiatry, 67% of clients said they felt energetic, 55% felt happy, and 44% felt confident, excited and interested.

This shift in mood and energy level was observed by Kevin on an individual and group level. Kevin observed a high level of self consciousness and nervousness among participants at the beginning of each session. This was more the case at the beginning of the programme. However, as participants engaged with the music-making, the mood shifted from apprehension to engagement in the process and concluding at the end of each session with a sense of elation and group celebration.

The radical change in behaviour of one particular client in the Department of Psychiatry during the music session was noted by two different staff members and Kevin. One staff member said of this client "one patient, whose behaviour can at times be bizarre, behaved appropriately during these sessions". Another staff member noted that the same client had acted inappropriately before the session but as the session progressed, his behaviour improved and [he] participated throughout the session". However, "the client I mentioned earlier reverted back to his previous state [after the session]". Kevin noted that this client was at times highly elated at the beginning of sessions to the point that his behaviour was challenging to Kevin and the group. However, the music had a calming influence on him and his behaviour became more coherent as a result.

Although participation in the session was demonstrated through music-making, singing, foot-tapping, clapping and at times even dancing, it is worth noting that for some participation was more passive in nature. One client in the Department of Psychiatry, who did not seem to be participating in the sessions, later told Kevin that he was a musician who played the trombone and had really enjoyed listening to the music. Active listening is also a valid form of participation.

Percussion instruments in particular allow a high level of participation. A high level of musical skill is not required and therefore participation can take place with relatively low personal risk. Kevin observed a point in each music workshop whereby participants "crossed" a line", that is they were more willing to take a risk in participating in the music sessions which they may not have done at the beginning of the session.

Relationship building

The involvement of the staff in creating atmosphere and making a safe space conducive to music was essential to this process. The staff member's involvement in the programme gave clients a positive signal and enabled clients to build a relationship of trust with Kevin and the other musicians. This relationship was expressed by clients who said that they were "looking forward to seeing Kevin again" " ..couldn't wait to see them [the musicians] again" and " …found Kevin to be very friendly". One staff member in the Department of Psychiatry noted that "Kevin's gentle manner included all clients in the group without them feeling pressurised". The relationship, however, was a dialogical one which impacted on the musicians as well as the clients and staff. A number of musicians commented at the end of each session how moved and touched they were by the experience. All of the musicians involved have expressed an interest in working more in health care settings. Three of these musicians (Una McSweeney, Liam Merriman, Una McSweeney) along with Kevin O'Shanahan are collaborating on the second stage of this project which began in October 2007. This stage also includes provision for staff training in St. Otterans Hospital to become more involved in the delivery of music in healthcare projects and has been greeted with much interest and date, as many of these staff have experienced first hand the benefits of music in health care in practice.

Discussion

In conclusion, the responses by staff, clients and musicians to the music sessions point to the transformative impact of music in terms of mood, social interaction, communication and motivation. This transformation is particularly evident in clients who prior to the music session were unmotivated or unwilling to communicate. By

engaging in the music-making, they took a risk and in Kevin's words "crossed the line". This is a line between non-engagement and engagement. However, it can be argued that the line between client and healthcare professional dissolved in this process, and the collective experience of making music in a group setting had a leveling impact on the hierarchy that can exist within mental health care settings. This is relevant in that "A Vision for Change" (Government Publications 2006) recommends that a "recovery" approach which empowers service users to work with health professionals in a more collaborative way should inform every level of future service provision. Music in Healthcare may be one method of facilitating this collaborative approach and its potential to contribute to the recovery approach in mental health is a question that warrants further research. The recovery approach has been described as "a social process of recovering a fulfilling life" that includes the need for hope and empowerment as some of its core principles. (Kruger 2000). Music in healthcare has been shown to contribute to this need for hope and empowerment, as well as impacting positively on the therapeutic environment and quality of life of both patients and staff in mental health settings (Moloney 2005). It has been shown that some of the outcomes for nursing staff involved in music in healthcare programmes have included an increased awareness of client individuality and potential, a greater appreciation of the creative challenge activities such as participative music making provide, a greater appreciation of the potential of complementary approaches to health care and a greater confidence in their own individual creativity. It is also recognised that management support as well as the participation of key nursing staff in the delivery of music in health care programmes, are vital if such initiatives are to succeed (HSE/Music Network 2005)

Another recommendation in the strategy document for the future development of the Irish Mental Health services "A Vision for Change" (2006) is the provision of "a comprehensive range of medical, psychological and social therapies, relevant to the needs of service users and their families." This evaluation appears to indicate musical activities, with an emphasis on participation and inclusion, have much to offer as a social therapy, in the provision of quality holistic mental health care. Further research, with adequate resources is needed to answer this question in more detail. While this study may include biases that the staff and researchers may be unaware of, and ideally would have the resources to investigate these issues in a more in depth manner, its findings do appear to be consistent with independent evaluations of music in healthcare programmes which demonstrate the social, emotional, therapeutic and educational benefits for patients involved in such activities (Preti and Welch 2004) The National, Economic and Social Forum report into Mental Health and Social Inclusion (2007) highlights the strong link between positive mental health and social supports in the community. This study suggests that music in healthcare could be an innovative way in providing such a social support effectively in that service users appear to be motivated to participate in musical activities, which foster self expression, empowerment and social interaction and so contribute to positive mental health.

Acknowledgements

The authors would like to thank Pat Byrne and the staff at the Department of Psychiatry, Noleen Hayes and the staff at Ard na nDeise and Joe Mooney, Administrator, Bill Fruen, Director of Nursing and Dr. Darina Sloane, Consultant Psychiatrist in St. Otterans Hospital, Waterford for their support. We also extend our thanks to the musicians and service users who participated in the study.

* The names of clients have been changed for the purpose of this article.

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An Examination of How Community Mental Health Nurses Experience and Assess the Level of Risk of Violence Posed by Clients During Home Visits

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Introduction

Having a comprehensive community based mental health service has been a political aspiration since the early 1980's, as outlined in various government policy documents and guidelines, such as "Planning for the Future" (Department of Health and Children (DoHC), 1984), "A Vision for Change" (DoHC, 2006) and "Quality Framework for Mental Health Services" (MHC, 2007), and documented in local health board initiatives, such as the "Focussing Minds" (Southern Health Board (SHB), 2001) document.

Community mental health nurses (CMHNs), defined by McCardle and McKenna (2007) as psychiatric nurses working in the community and carrying out a significant proportion of their care in the client's home, form the largest group of community mental health care professionals. According to the National Council for Nursing & Midwifery (NCNM) in 2006 there were 198 CMHNs (this figure represents CNS grade and does not include the grade still referred to as Community Psychiatric Nurse) in Ireland, although no formal statistical data are maintained on the number of CMHNs employed in Ireland (McCardle & McKenna, 2007). It has been reported that during home visits, CMHNs may occasionally find themselves at risk from either verbal abuse, threats or physical assault by the client (Fry, O'Riordan, Turner & Mills, 2002).

This article/paper presents the findings of a study which examined how CMHNs experienced and assessed the risk posed by clients during home visits. Relevant literature around violence, risk assessment and community mental health nursing will briefly be reviewed, followed by an outline of the methodology and an overview of the findings.

The incidence of violence in health care

International studies attempting to quantify the extent of the problem estimate that between 35% and 80% (Rippon, 2000) of healthcare staff have experienced some form of violence at work, with evidence that the problem is increasing (Doyle & Dolan, 2002; H.S.A., 2001b; Jackson et al, 2002; Rippon, 2000). The incidence amongst Irish healthcare workers is estimated at 21% (Ryan and Maguire, 2006).

Nurses have been identified as a high risk group (Doyle, 1996; Carter, 2000; Fry et al, 2002; Ryan & Maguire, 2006), with psychiatric nurses at even higher risk (Housen, 1996; H.S.E., 1997; Nolan et al, 1999; Doyle et al, 2002). A comparative audit conducted by the PNA found that psychiatric nurses' reports of having been assaulted increased from 7.2% in 2001 to 10.65% in 2005 (Psychiatric Nurses Association (PNA), 2005). A study by Ryan and Maguire (2007) reported that in a one-month period, 80% of mental health nurses in one HSE area reported non-threatening verbal aggression, 54% reported threatening aggression, 38% reporting mild physical violence and 1% reported severe physical violence. No specific reference was made to CMHNs in either the PNA (2005) or Ryan and Maguire's (2007) study. However, studies undertaken in the United Kingdom (UK) and Australia found that between 10% (Eastwood & Pugh, 1998) and 96% (Fry et al, 2002) of CMHNs reported having experienced some form of violence. This large variance in figures in some of the studies referred to above may be attributed to the lack of a clear and universally accepted definition of violence.

Violence, risk assessment and community mental health nursing

Very few studies have examined violence and risk within the context of community mental health nursing. Risk assessment is seen as an important role of the CMHN (Doyle, 1996; Crowe & Carlyle, 2003; Trenoweth, 2003), although Doyle (1996) suggests there is little evidence as to how this is carried out. Rippon (2000) and Kettles (2004) observe that although violence risk assessment tools have been developed for in-patient and forensic settings, none have been specifically developed for community mental health settings. This lack of appropriate assessment tools may explain the large variations in risk assessment practices reported in recent UK studies (Lemmer, 2000; Doyle & Dolan, 2002), although Doyle (1996) argues that inadequate training and preparation for the risk assessment role may explain the different approaches adopted by CMHNs. His qualitative study of CMHNs (n=12) found that they assessed risk in a fairly arbitrary manner, and were largely unaware of risk assessment tools. Although they drew on actuarial and clinical risk factors, intuition played an important role in assessing the risk of violence.

A more recent qualitative study by Murphy (2004) found that all CMHNs (n=16) cited risk assessment as a function central to their role, focusing on factors such as a reduction in the client's self-care, the presence of levels of agitation or physical signs of anger/agitation such as sweating, pacing, anxiety, dilated pupils and tremors. A concept analysis of forensic risk identified increased/glaring eye contact, invasion of personal space, verbal abuse/threats, threatening gestures and anger as key risk factors prior to a violent episode (Kettles, 2004). Murphy's (2004) study also highlighted the role of intuition, which appeared to have some objective factors arbitrarily attached to environmental changes and client presentation. Godin's (2004) qualitative study of 20 CMHNs found that while all were aware of and utilised formal risk assessment tools, some CMHNs found them to be too mechanical, behaviourally reductive and dehumanising, and expressed a preference for integrating them with professional intuition. Finally, Alaszewski et al (1998) concluded that pre- and post-registration nursing students were not adequately prepared to assess and manage risk.

It can be concluded that the incidence of violence towards CMHN remains patchy. There is some evidence from studies undertaken in the UK that CMHN assess risk of violence, drawing on a range of sources to assess such risk, however no Irish studies were located. The study presented here focuses specifically on how CMNHs experienced and assessed the risk to themselves, based on the assessment of the potential for violence posed by clients during home visits.

Methodology

The aim of the study was to gain an understanding of how CMHNs in one Irish Health Service Executive (HSE) area experience and assess the level of risk of violence posed by clients during home visits. The following operational definition of violence was adopted for this study: 'displaying aggressive behaviour, including spitting, scratching, deploying physical force, or using an object as a weapon, either to threaten or physically assault' (Nolan et al, 1999: p936).

Within the context of the overall aim of the study, a phenomenological qualitative design was adopted. Phenomenology focuses on how people make sense of their experiences and transform those experiences into consciousness (Patton, 2002). In this case, the experiences of CMHNs in relation to the assessment of risk posed by clients during home visits. Ethical approval was granted by the local research ethics committee. Permission was sought from the relevant Directors of Nursing to allow access to this sample group. Written invitations to participate in the study were sent to all 25 CMHNs in four local catchments areas of the HSE South. Nine CMHN responded and consented to participate. The participants met the inclusion criteria, having had a minimum of two year's experience at CMHN level, and carrying a generic client caseload. Data was collected through audio-taped in-depth interviewing by the first author (JS), assisted by an interview guide, adapted from a study by Gijbels (2003). Interview transcripts were analysed drawing on methods described by Colaizzi (1978), Osborne (1990), and Polkinghorne (1989). Seven CMHNs were interviewed, as analysis of the seventh interview indicated that no new issues were emerging and that saturation had been reached.

Findings

Six themes emerged: articulating the meaning of risk; experiencing risk in home visits; the emotional impact of experiencing risk; risk assessment strategies; judging the level of risk; actions following risk assessment. Credibility of the findings was enhanced by independent reading of the transcript by the research supervisor, who arrived at similar themes. Interview transcripts were shared with the participants to verify the accurate description of their experiences. The themes were presented to the participants for validation, inviting confirmation that their experiences had been portrayed accurately.

Transferability was achieved as the findings were acknowledged as a true representation of the experiences of the entire sample group across the different catchment areas. A reflexive stance was adopted by JS as a means of ensuring overall rigour throughout the research process (Hammersley and Atkinson, 1995). This on-going reflection on the various aspects of the research process and activities enabled the researcher to engage with the participants and the subsequent interview data in a collaborative and insightful manner.

Although none of the participants had received specific training for their role, they all described completing some form of post registration training, ranging from courses in acute and enduring mental health nursing, counselling, community and preventative medicine, social studies, behaviour therapy, cognitive and behavioural psychotherapy, addiction counselling and management. These courses were either at certificate, diploma, degree and higher diploma level.

The participants' caseload size varied from twenty to one hundred and twenty, with clients described as 'mostly acute', or as presenting with a broad range of mental illnesses, or as presenting with 'pure mental illness' (as opposed to drug and/or alcohol addiction).
Referrals came mainly from consultant psychiatrists, other members of the multidisciplinary team, and occasional referrals from local General Practitioners.

Theme 1 - Articulating the meaning of risk

Participants differed in their perception of the notion of risk, with risk being described as uncertainty, the presence of weapons, risk of physical harm, and risk of verbal abuse. The tolerance of some degree of risk was described as acceptable by some of the participants, in order to diffuse a situation, or sometimes they made allowances, depending on the mental state of the client.

Theme 2 - Experiencing risk in home visits

Experience of risk ranged from intimidation and threats, verbal abuse, assaults on the participants and damage to their cars. The nature of threats ranged from threatening phone calls up to face-to-face threats, and the content of the threats ranged from physical assault up

to death threats. The demeanour or body language of the client was described as intimidating by some participants, whilst another participant described the atmosphere in a client's house as intimidating.

Verbal abuse towards the participants was described and experienced by most, ranging from mild abuse to extreme verbal abuse, with obscene language at times being a feature of this abuse. This was accepted by some as part and parcel of the job, while others saw this as something more serious.

One participant described the experience of having been physically assaulted fifteen years ago, explaining that it happened before modern medications were widely used, and in a time when clients presented with more acute psychosis.
Two participants described how their cars were damaged by clients during a home visit in an outburst of violence.
In the majority of experiences of episodes of violence described by the participants, the client would be a young man with a history of aggression, and who, at the time of the incident, would be displaying 'active psychotic' or 'paranoid' symptoms.

Theme 3 - Emotional impact of experiencing risk

The participants described a range of emotions, from feeling really frightened, feeling threatened, unhappy going into situations on their own, not comfortable, feeling insecure, feeling vulnerable, feeling isolated and cut off, feeling anxious, not feeling safe, and feeling trapped. Some described the uncertainty in situations, or potential for harm to occur, as feeding their anxiety and increasing their feeling of vulnerability. Two participants described how the extent of their psychological reaction to a situation (fear and anxiety) resulted in manifestation of physical symptoms.

Theme 4 - Assessing risk

Although there was no evidence of any formal structured approaches to assessing the risk of violence, there were similarities in how the participants arrived at the judgement that risk was present, with each participant indicating that past experience, and a good knowledge of the client and their history prepared them for assessing risk.

All participants emphasised the importance of knowing the history of the client, with a past history of aggressive and/or violent behaviour viewed as an indicator of the potential to display such behaviour in the present.

Changes in the client's presentation or usual baseline behaviour (displaying hostility/agitation) was described by all participants as a means of determining the presence of the risk of violence. Some cited the level of engagement with the client as an indicator, with those failing to engage or engaging poorly to be deemed a greater risk. Others described the client's paraverbal communication (rate, rhythm and tone of voice, as well as vocabulary used) as an indicator of rising agitation. Others cited the total lack of communication, or where the client became silent as an indicator.

The attitude of the client (hostile and/or antisocial behaviour, not co-operating) was described by some participants as giving some indication of their psychological and emotional state of mind. Hostile and antisocial behaviour, not co-operating, were seen as warning signs, as were clients who were described by the participants as 'becoming belligerent and demanding'. Impulsiveness of the client was also cited as a factor that would be taken into consideration.

CMHNs described that it was not the presence of specific diagnosis, but more the associated symptoms as being associated with an increased risk. Clients displaying paranoia were deemed to present with the greatest risk, in particular those who were acutely unwell at the time of the visit. In addition, those clients presenting with alcohol and/or drug abuse were seen as presenting a greater degree risk.

CMHNs also described how they attached significance to the demeanour or body language (leaning forward, invading personal space) displayed by clients. Some participants attached significance to whether a house was well maintained as opposed to being in a dishevelled condition, reasoning that people who did not value or respect their property, would more than likely not value or respect other people.

Theme 5 - Judging levels of risk

Although the presence of high and serious risk in various situations was mentioned by participants, none referred to specific levels of risk. Judging the nature and level of risk was an unquantified, unscientific and subjective measure, informed by the participants' exposure to aggressive/violent incidents in their personal and/or professional life. Intuition, gut feeling, or instinct played an important role in the assessment of risk, and was seen as a valid method in assessing risk. Although its presence and importance was acknowledged, some found it difficult to articulate this intuitive process. One of the participants described it as a combination of experience, training, what has been learned, what has been passed on from colleagues, and common sense. Others also cited a relationship between intuition and experience. Another participant, comparing intuition and formalised risk assessment tools, argued that while intuitive methods, often based on perception, were useful, they were not as reliable as risk assessment tools which used rating scales to measure risk, suggesting that a combination of both might be more effective. This intuitive judgement was carried out in the 'here and now', informed by the client's symptoms, body language and para-verbal communication.

Education was seen as helpful in how the presence of risk to the participants themselves was assessed, with one participant reporting that he had attended a local training course in the prevention and management of violence and aggression, and had learned some useful strategies for assessing risk based on recognising some of the precipitating factors and warning signs of potential aggression and violence.

All the participants were aware of risk assessment tools, with three of the participants mentioning the Sainsbury Risk Assessment Tool. However, only one participant used a formalised risk

assessment tool, not on a regular basis, but when there was a need. Some participants perceived limitations with the use of risk assessment tools, whilst others expressed time constraints as a key reason for not using such tools. Some participants held the belief that risk assessment tools were only as accurate as the nurses who completed them. Knowing the client well, and having a full history, were seen as essential to accurate risk assessment, enhancing the view that new clients could present the greatest risk of violence.

On the whole then, there was no evidence of a formalised or a consistent approach by the participants either across or within any of the four catchment areas. Judging the presence and nature of the risk was undertaken intuitively, informed by a combination of clinical information and some knowledge of actuarial risk factors.

Theme 6 – Actions following risk assessment

Prevention was identified by the participants as the preferred strategy. Knowing the client and having a good background history were seen as factors enabling the participants to anticipate risk situations and reduce the likelihood of these occurring.

Although most of the participants indicated that they would leave the client's house if they perceived themselves to be at risk, this decision depended on their reading of situations. If they perceived the risk to be low, or they felt comfortable with the situation, they would stay and attempt to defuse the situation and calm the client down. Such decisions were influenced by the participants' background and experience, and based on having a good knowledge of the client.

Some participants described how they would park their cars in such a manner that they could get away quickly if the need arose. Others would observe the physical layout of the house and the room they were meeting the client, and note their exits and potential escape routes. Some participants identified the mobile phone as an important safety feature. Its strategic use allowed them to keep in touch with colleagues, and inform them of their whereabouts. Finally, some participants described situations where they would arrange to see clients in a day centre or health centre instead of in the client's own home.

Discussion

All the participants had experienced being at risk of violence by clients they had visited at home. In assessing risk, they drew on their previous nursing knowledge and nursing experience, both as psychiatric nurses and as community mental health nurses, their personal knowledge of the client, and on their intuition, and less on formalised risk assessment tools and strategies. Indeed, the use of intuition was highlighted in assessing risk. Doyle (1996) and Godin (2004) also highlighted the reliance on intuition and experience in their respective studies. Drawing on such intuitive feelings was acknowledged as being unscientific, made unconsciously, and possibly fuelled by negative past experiences. However, Murphy (2004) found that 'gut feelings' appear to have some objectivity attached, with the participants in Murphy's study reporting that they looked for changes in the environment and presentation, linking this to individual perceptions attributed to the client.

This was also described by the participants in the study presented here, with participants referring to noting changes in the client's presentation, as well as environmental changes to inform them of the possibility of risk. As in Godin's (2004) study, they displayed a resistance to dispense with tacit knowledge and their belief in intuitive expertise, and its value in the risk assessment process. This may explain their reluctance to use standardised risk assessment tools, indicating that these were only as good as the nurse completing it, although lack of training and the time required in using structured risk assessments tools were also given as reasons for its limited use. Rippon (2000) and Kettles (2004) found that violence risk assessment tools are generally for use in-patient settings and forensic settings. A risk assessment tool specifically designed for community settings may overcome CMHNs' reluctance in using structured risk assessment tools.

Recommendations

Education

Although all the participants had undertaken post registration courses, they highlighted the need for a specific post registration community mental health nursing programme, to equip them with attitudes, skills and knowledge to function effectively and safely as a CMHN. Such programmes should include areas such as risk, risk assessment, risk management, judgement and decision making strategies, and responding to the potential of violence.

Practice

There was variation in the way the participants assessed risk. They relied on their professional experience, their knowledge of the client and their intuition to assess the risk of violence posed by client. Practice development initiatives may assist is addressing and understanding these variations, and whether such variations have an impact of patient outcomes. Standardised risk assessment tools currently available are primarily designed for use in forensic and in-patient settings. A more standardised approach may be facilitated by the development and introduction of a risk assessment tool, combining actuarial, clinical and intuitive information and experiences. This may also overcome the reluctance of CMHNs in using standardised risk assessment tools in their work.

Research

Further research into the work of CMHNs in relation to risk and risk assessment, involving a larger sample, and including perspectives from service users and carers, may confirm the findings presented here and further broaden our understanding of the way CMHNs, service users and carers deal with the risk of violence. Finally, the impact of post registration programmes undertaken by CMHNs needs to be evaluated in terms of improved patient outcomes, especially

in relation to issues relating to assessing and managing the risk of violence.

John Shannon has lectured in the Catherine McAuley School of Nursing and Midwifery, he is currently a Community Mental Health Nurse (CMHN) in rehabilitation Nth Cork, Mental Health Services.

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The Irish Institute of Mental Health Nursing

The Irish Institute of Mental Health Nursing was formally launched on 17th June 2009 at the School of Nursing & Midwifery, Trinity College Dublin. The PNA welcomes the development of this initiative and indeed congratulates the formation of its Executive recognising the substantial contribution and consistent collaboration of the Interim Executive who championed the initiative/process over the past two years. The Institute is intended to provide a focal point and professional voice for Mental Health Nursing and positively contribute to the professional development of Mental Health nursing in Ireland. The aim of the Institute is to promote excellence in the provision of quality Mental Health Nursing and mental health service delivery, within the context of a multidisciplinary approach, both in Ireland and internationally.

The PNA are represented on the Executive by Ms Aisling Culhane Research & Development Advisor.

Aim and objectives

The aim of the Institute is to promote excellence in the provision of quality Mental Health Nursing and mental health service delivery, within the context of a multidisciplinary approach, both in Ireland and internationally.

The objectives of the Institute are to:

- act as a forum to facilitate and enable discussion and debate on issues relevant to the Mental Health Nursing;
- promote excellence in Mental Health practice and mental health nurse education;
- foster the ongoing development of the profession of Mental Health Nursing;
- contribute to policy development on matters relevant to Mental Health Nursing and mental health service development;
- serve as a critical voice for Mental Health Nursing;
- promote opportunities for networking and professional development among Nurses practising in the Field of Mental Health;
- promote and advocate the use, development and expansion of Mental Health Nursing.

Membership

Ordinary Membership of 'Institute' is open to all Nurses practising in the Field of Mental Health' Associate membership is open to all persons and organisations who are not eligible for ordinary membership.

Benefits

Membership benefits shall include:

- Opportunity for networking and professional development;
- Opportunity to contribute to and influence policy development;
- Opportunity to collaborate in relation to research, practice development and education;
- Opportunities to avail of grants, bursaries, made available by the Institute;
- Access to a quarterly electronic newsletter;
- Access to interactive discussion forums;
- Reduced fees for conferences, workshops, seminars, and master classes organised by the Institute.

Contact Details

Web site: www.iimhn.org

E-mail contact: contact@iimhn.org

E-mail list: If you are interested in contributing to the development of this organisation please consider joining the-mail list group by sending a blank message to elist-subscribe@iimhn.org.

National Quality Standards: Residential Services for People with Disabilities

In May 2009, the Health Information and Quality Authority (HIQA) launched its national quality standards for people with disabilities. These standards have been developed for the purposes of registration and inspection of residential services for people with disabilities. They will assist service providers to assess the quality of the service they provide in advance of inspection. They will also act as a guide to individuals and families as to what they can reasonably expect of a residential service.

The standards were developed following a period of consultation to which the PNA contributed www.pna.ie/publications.

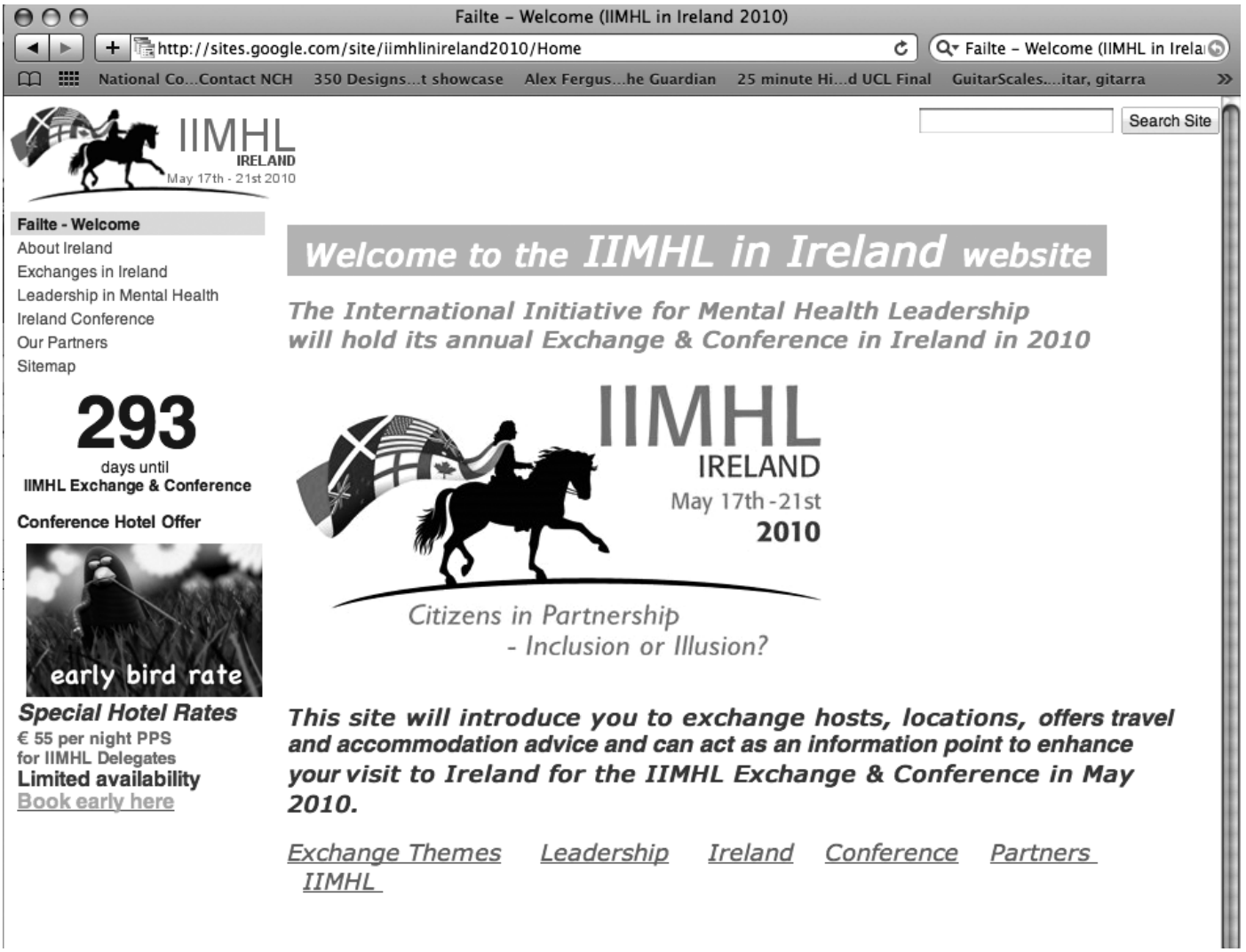
The areas that are addressed by the standards are:

- Quality of life
- Staffing
- Protection
- Development and health
- Rights
- The physical environment
- Governance and management

Copies of the standards document are available for download from www.hiqa.ie

International Initiative for Mental Health Leadership

IIMHL In Ireland



NDA Annual Conference 2009

The National Disability Authority (NDA) is currently engaged in a multi-annual programme of work exploring independent and community living options for people with disabilities. NDA's recent work in this area has focused on policy and practice in promoting independent and community living options for people with intellectual disabilities. Future work will broaden this focus to include those with other disabilities in the course of this multi-annual programme. Its annual conference 2009 entitled:

Promoting independent and community living for people with intellectual disabilities will be hosted at the Croke Park conference centre, Dublin 3 on Tuesday 6 October 2009. A call for papers was issued recently on this theme in the following areas:

1) Using technology to promote independent and community living
2) Sexuality, intimate relationships and parenting
3) Innovation in systems and practices to promote independent and community living

For further information contact Emma Doyle at emdoyle@nda.ie

Introducing Sheila Duffy, National Intellectual Disability Representative

I trained in Scotland as a R N M H qualifying in early 1994, from there I went on to work in community group homes until 1998. When I came to live and work in Ireland, initially I worked in a care of the elderly services until I came back in to the Intellectual Disability (ID) services in 2000.

I have worked in a variety of settings from nursing care to high support units for clients who display behaviours that challenge both in community and residential settings. I am currently working in a respite unit which provides a service to both children and adults.

My role within the PNA is to ensure that ID nurses have a voice in relation to issues within the union and also by setting up working groups to feedback on proposed legislation to give ID nurses a voice in the decision making process. I will be highlighting the issues and looking after the rights of the nurses in the ID sector. The role of the RNID nurse is vital within the ID services and we need to promote our role.

To enable me to fulfil my role I need branches and members to liase with me regarding any issues that are arising, to allow us to address them in the best way possible.

I can be contacted by e mail Sheila.duffy@hotmail.com or 086 1062684

I look forward to hearing from you and hope to get to meet some of you in the near future

Sheila

Publication - Inclusion Ireland Booklet "Who Decides & How?"

Decision making problems often arise for parents/carers of people with intellectual disabilities who are aged over 16 years and require a medical procedure. All persons in Ireland have a right to give consent to medical decisions from the age of 16. Medical and surgical procedures may not be carried out without the informed consent of the patient.

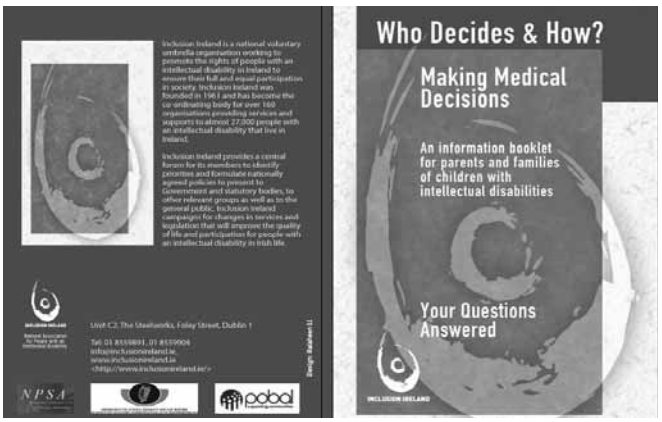
The law however is not clear on what constitutes "informed consent" or on what is to happen if a person is not capable of giving consent. The most recent Medical Council Ethical Guide (2004) states that: "If a person with a disability lacks the capacity to give consent, a wide ranging consultation involving parent/guardian and appropriate carers should occur"

The guidelines do not state what should occur if the family members disagree with the doctors or each other on what is the best form of treatment. At present it is the responsibility of the medical professionals to make a final decision

Inclusion Ireland considers the current situation be totally unsatisfactory.
There are two major gaps
1. There is no formal system for assessing whether or not a person has the capacity to consent to medical treatment (Unless there is an application to have the person made a Ward of Court under the Lunacy regulation (Ireland) Act 1871)

2. There is no legal basis for a person to give consent on behalf of a person with an intellectual disability to such treatment though this is often done informally.
The Government is preparing a new Bill on Mental Capacity and Guardianship which follows on the recommendations of the Law Reform Commission Report on Vulnerable Adults, 2006 It is clear that Ireland requires a form of supported or substitute decision making law.

This means that the present system will have to change and that an adult with an intellectual disability who does not have capacity can have an appointed person to assist him /her make decision Inclusion Ireland, in publishing this booklet wishes to provide parents and families with information on current practise in this difficult and complex area, as Dr John Hillary, a former President of the Medical Council, states in his introduction to the booklet " to be effective advocates people need information".



Jimmy Connolly Chair Galway ID PNA Branch had the privilege of attending the booklet launch by inclusion Ireland which is centered on the difficult area of decision making, medical or otherwise for people with I.D. and their families. Commenting on the booklet he stated "this group has much in common with our own aspirations as I.D. nurses and their vision reflects this. People with an intellectual disability living and participating in the community with equal rights as citizens, to live the life of their choice to their fullest potential".

Inclusion Ireland (formerly N.A.M.H.I.) has been working on behalf of people with I.D. and their families for nearly 50 years. They are passionate and dedicated to the pursuit of their goals. They draw from international sources as well as Irish, to help them achieve equality for people with I.D. He found some of the information particularly interesting as included.

*Article 17 of the convention of rights of persons with a disability states that " every person with a disability has a right to respect, for his or her physical and mental integrity on an equal basis with others"

*Persons with disability have the opportunity to choose their place of residence and where and with whom they live.

*They have access to a range of in-home residential and other community support services including personal assistance necessary to support living and inclusion in the community.

*Community services and facilities for the general population are available on an equal basis to persons with disabilities and are responsive to their needs.

*People with I.D. should enjoy legal capacity on an equal basis in all aspects of life. There is general consensus that greater support and assistance is needed in the area of decision making for people with disabilities, this is being driven by the U.N. convention on the rights of people with disabilities, which our government has signed, but to date has not yet ratified.

The title of the most recent booklet from inclusion Ireland is 'Who Decides& How?'.

For more information on the work of this organization go to info@inclusionireland.ie.

Intellectual Disability Nursing 50 years Celebration

2009 is a very special year in the history of Intellectual Disability Nursing in Ireland as it celebrates its fiftienth anniversary.

Ms Sheila O' Malley Chief Nurse DOH&C, Ms Mary Mc Ardle Chair ID Nurse Managers

The Nurse Managers Association for Intellectual Disability held a **Special Conference Celebrating 50 Years in Intellectual Disability Nursing in Ireland**, taking place on Thursday 28th May 2009 in the Conrad Hotel, Earlsfort Terrace, Dublin 2.

The Nurse Managers Association in Intellectual Disability is committed to promoting quality driven, person centred services.The association will strive to collectively inform regional and national policy while also maximising the nursing contribution within Intellectual Disability Services.

Clockwise: Ms Sheila O'Neill, DON Moore Abbey, Eilish Madden CNM 3 Daughters of Charity, Mary Reynolds ADON Daughters of Charity.
Eddy Denihan Director of Services Stewarts Intellectual Disability Services & Sean Duffy Assistant Director of Services Bawnmore
Kevin Curraghar Service Manager HSE Cavan Monaghan, Beirnie Brennan Day Services Manager HSE Cavan / Monaghan

The core values that underpin the Mission Statement of the Association are:

(a) Person centeredness which is characterised by:
Respect in every action, partnership, participation, advocacy and quality based on person centred outcomes

(b) Promotion of best practice which is charactised by:
pursuit of excellence, innovation in practice, efficient and effective use of resources and having a clear vision

50 years of Intellectual Disability Nursing in Ireland

The history of the care of persons with an intellectual disability in Ireland is one with roots in institutional care and separation from the community. The first Irish service for persons with an intellectual disability was founded by Dr. Henry Hutchinson Stewart at the Spa Hotel, Lucan in 1869.

The service was transferred to its present location at Palmerston, Dublin in 1877, where it continues to provide services for people with an intellectual disability. Aside from this, organised institutional care services were primarily provided within a Christian denominational context under the aegis of bodies such as the Order of St. John of God and the Daughters of Charity.
The first training schools offering a three year course for nurses in mental handicap opened in 1959 at St. Louise's School, Clonsilla run by the Daughters of Charity and at St. Mary's School of Nursing, Drumcar, County Louth, under the auspices of the Brothers of St. John of God.

Care providers and nurses providing care for persons with an intellectual disability moved from a position of having no specific nurse education or training in intellectual disability to now defining a new programme and role and function for this new discipline. Defining roles is a process that intellectual disability nursing has had to engage in regularly throughout its short lifespan, since the first nurses entered onto the Register as a Registered Nurse in Mental Handicap in 1961.

Intellectual disability nursing in Ireland has developed considerably since its inception as the newest branch of nursing, both in terms of the development of the nursing role and the advancement of professional pre and post-registration training.

There has been a considerable increase in the life expectancy of people with intellectual disabilities.

Right to Left: Dr Siobhan O Halloran & Ms Maureen Flynn Office of the Nursing Services Director HSE, Dr John Sweeney Lecturer UCC & Ms Mary McArdle Chair ID Nurse Managers

There has also been an increasing recognition of the general and mental health needs of people with intellectual disabilities. These changes demonstrate an increased need for nurses working in the intellectual disability sector to continue to expand their practice in relation to actively promoting healthier and more active lifestyles, as well as responding to the significant health challenges experienced by this client group.
The challenge of looking to the future, whilst concurrently providing for the present needs of persons with an intellectual disability, provides an opportunity for nurses to further develop the identity and role of the profession in the 21 st Century. One only has to examine the various roles undertaken by intellectual disability nurses today to see the diversity of roles engaged in, roles that would not have been considered at the inception of the discipline 50 years ago.

Aras to Aras Cyclethon

June 6th 2009

After two months of preparations, the day finally arrived. The grounds of Aras Attracta, Swinford came alive shortly after 7am on Saturday morning, June 6th 2009. Cyclists from the Swinford and Castlebar Cycling Club, together with volunteers, who all willingly gave up their personal time to travel with and support the cyclist as they took on the physical challenge of cycling from Aras Attracta, Swinford to Aras an Uachtaran, Dublin. This undertaking by the cyclist was a fundraising event for the Family and Friends Association of Aras Attracta, which is a voluntary organisation.

Everything was in place for this big event apart from the only thing one cannot plan…… The Weather!! So we lived in hope as the Men from Mayo were about to embark on their long journey from Aras Attracta to Aras an Uachtaran.
After the cyclist had signed in, followed by a light breakfast, they got the opportunity to re-collect their thoughts for a while over the long journey ahead of them. It was quickly approaching 8am and time for the cyclist to gather at the starting point, where John O' Mahony TD spoke to the cyclist and all concerned before cutting the ribbon to officially commence the Cyclethon from Aras to Aras.

It was a dry but exceptionally cool Summers morning, with temperatures much lower than previous weeks and they were facing a north east wind, but thankfully this didn't deter any of the cyclists.

As the cyclist followed by a convoy of transport with helpers, made their way through the towns and villages of Co. Mayo and Co. Roscommon, they reached their first official stop for refreshments at Strokestown. It was wonderful to see their enthusiasm as they headed off on the next leg of their journey.
Approximately two miles before entering Longford town, the weather changed for the worst. What started out as a cold morning became an additional challenge for the cyclists as heavy rain, wind and a further drop in temperatures put the Mayo Men to the test!! Natures elements certainly wasn't on their side but nothing was going to deter this wonderful group of cyclists of achieving what they had set out to do.

Their fitness levels, physical training and sheer determination was clearly evident, as they battled the elements. A well earned half hour break at Feericks in Rathowen gave the cyclist an opportunity to take a break from the winterly conditions where food and hot drinks was the order of the day. They had reached the half way mark of their journey and were on schedule for their arrival into Dublin for 6pm.

With counties Mayo, Roscommon and Longford behind them, counties Westmeath, Kildare and Dublin awaited this enthusiastic group of Mayo Cyclists. With no signs of a change in the weather, they cycled with sheer determination through the towns and villages along the way. A quick stop in Maynooth, Co. Kildare and onwards they went to take on the last leg of their journey……. Destination Aras an Uachtaran, where awaiting their arrival was Mary Davis CEO of Special Olympics Europe/Eurasia.

Apart from a very wet and cold group of cyclists, there was a great sense of pride, delight and relief on everyone's face to have reached their destination safely.

Words cannot express our gratitude to such a wonderful team of people who helped make this special event possible.

The Family and Friends Association of Aras Attracta would like to take this opportunity to thank the following people.

Firstly a big "Thank You" to the wonderful cyclists from the Swinford and Castlebar Cycling Club, who willingly offered to give up their personal time, raise money and take on this challenge to help support the Family and Friends Association of Aras Attracta. We'd also like to thank all those who volunteered to give up their time and travel with the cyclists on their journey from Aras to Aras. Those include Tommy Rumbley (Motorcyclist), Brendan Doyle (Transport), Tommy Regan (Transport and Photographer), William Lowry (Transport), the two Civil Defence Personnel who travelled the journey by Ambulance and also provided a bus for the event, staff members of Aras Attracta who assisted the clients that travelled the journey, Seamus Mc Nally (Physio) and members of the Family and Friends committee.

Our thanks to John O' Mahony TD for officially starting the Aras to Aras Cyclethon. A very special word of thanks to the Traffic Division of An Garda Siochana from Co. Longford to Dublin, for escorting the cyclists on their journey. Their expertise and presence throughout the journey gave everyone concerned peace of mind and ensured safety for all, which was a priority.

Thanks to Tony Lynskey Bus Hire, Swinford and Pat Kelly, Autopoint Swinford for providing transport for the event. Also a special word of thanks to Geri Maye (RTE Broadcaster) for contacting the National Radio Stations on the morning of the cycle. Information they received was announced throughout the day, so motorists travelling to and from Dublin were made aware of the Aras to Aras Cyclethon.

We were delighted and are very grateful to the CEO of Special Olympics Europe/Eurasia, Mary Davis for being there to meet the cyclist on the arrival to Aras an Uachtaran.

Finally a very big "Thank You" to all those who have contributed money through sponsorship cards and donation forms. Your support and generosity is very much appreciated. A cheque will be presented to the Chairperson of Family and Friends Association, which will be then published in the main Mayo papers.

On behalf of The Family and Friends Association of Aras Attracta, we like to say "THANK YOU" and let you know that your support will make a difference in promoting the lives and improving the abilities of adults with Intellectual and Physical disabilities who are residing and attending Day Care Services at Aras Attracta, Swinford.

Training Comparative over 50 Years - Brief Account of Past and Present Psychiatric Nurse Training

Psychiatric nursing has been populated by many families in some cases over several generations. Over the coming months, we would like to highlight some of the family trees in the profession. In this edition we are featuring Mary Nolan and her son Kevin. If you wish to contribute to this initiative please forward your photos and thoughts to info@pna.ie

Mary's class picture

St. Luke's in Clomel, county Tipperary was an 850 bed mental hospital where psychiatric nurses trained in the 1960's. It consisted of a class and clinical practice room where one nurse tutor and one doctor on occasion gave lectures. Ward's were overcrowded with 30 to 50 patients, one sister, two staff nurses and three students. Students did both clinical and domestic work with wages of £2. 18 shillings and 7 pence per month. Attendance was important with 4 hours a day of lectures, over a 48 hours working week. Antipsychotic's tranquillisers and anti-depressants were new on the scene then. Chlorpromazine and thioridazine were magic anti-psychotics while parnate, nardil and E.C.T. were used for depression. There were no depots. The mental hospital was self sufficient and patients worked on the farm, ground maintenance, laundry and occupational therapy supervised by nursing staff. Accommodation was deducted from your monthly cheque.

Letterkenny Institute of Technology, County Donegal facilitates the new Bachelor of Science psychiatric nursing degree. The course is full time over four year's with lectures on average 30 hours per week. Experience is gained in various areas during clinical placement. The degree provided an opportunity to apply learning within a practice environment, including: day centres, supervised residential units, acute admission units, community nursing, psychiatry of old age and therapeutic group work. Students are exposed to the old psychiatric hospitals, such as St. Conal's which now only have a few wards' open. Training is very much holistic centered with group work and role play particularly important.
Students have written exam's, assignments and are visited regularly by their clinical practice co-coordinator's while on clinical placements. Depots and new medication have now enhanced the treatment of mentally unwell persons with atypical anti-psychotic's having fewer side effects. The importance of developing a therapeutic relationship between nurses, and patients has always been imperative during past training and the current nursing degree.

Kevin & Mary Letterkenny Graduation

www.headsup.ie

HeadsUp is a project targeted at improving young people's mental well-being with the overall goal being to reduce suicide amongst the 15-24 year age group.

Up to 500 people die from suicide in Ireland annually, a significant proportion of these being young adults. HeadsUp is run by the Rehab group and steered by a group of youth advisors that ensure the content and direction of the project is appropriate to the needs of the target age group. HeadsUp consists of many elements including a website (www.headsup.ie) HeadsUp text service, an automated text referral service, HeadsUp Lifeskills, an 18 hour lifeskills and life coaching course, Raising Boys for Fathers, a parenting course for fathers of sons and Suicide intervention skills training.

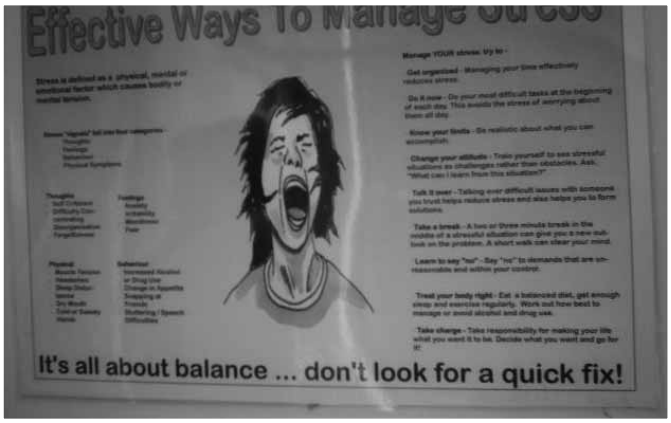
Headsup.ie was launched in November 2008 and is the focal point of information for the HeadsUp project. The website also provides a range of information for young people including tips on mental wellbeing, Art from the Heart a platform for expressing your deepest thought through art, a range of computer games aims at improving cognitive function and fact sheets on mental ill health. The website has an extensive 'Outside Help' section that utilizes Google Map technology to display a list of support organisations and professionals. Another feature of the HeadsUp website is the Cognitive Behavioural Therapy based Online Course.

This course was developed in Scotland and has been extensively evaluated. It consists of ten modules including anxiety control training, noticing and changing unhelpful thinking, assertiveness and practical problem solving.

For more information on the HeadsUp project go to www.headsup.ie or contact Collette Ryan, HeadsUp Project Manager on 01 2057326 / 086 8380218 or email collette.ryan@rehabcare.ie

Contributions from our Students

Healthy Ways of Managing Stress Among the Student Community



Late last year the then second year (currently third year)student nurses of B.Sc. (Hons.) in Psychiatric Nursing at Galway Mayo Institute of Technology, Castlebar, Co Mayo presented a poster on **"Healthy Ways of Managing Stress Among the Student Community".** The students were required to form their own groups to complete the poster. This in itself posed some stress as the students were on placement. However through many phone calls and meetings the groups got together and completed their posters. This project was part of a module "Personal and Professional Development" and during the presentation the students were assessed and the marks awarded were part of the end of year exams.

The poster was aimed at fellow students and how to manage the particular stressors they face during college life in a healthy way. Three groups of students presented their poster including a talk on effective stress management techniques to an audience of visitors, fellow students, Clinical Placement Co-ordinators and staff of the GMIT.

The posters were of a very high standard and some students wore tee-shirts they designed themselves. Some of the students made a short DVD of an interview with an Occupational Therapist about stress and stress management and other students distributed stress management leaflets to their colleagues in GMIT on the day.

Our experience of participating in this project had many positive aspects in that we learned more about group work, gained an increased awareness of our own stress levels and healthy ways to de-stress!!!

The student group involved in this project were

Mary Glennon	Patricia Hegarty	Irene Collins
Jennie Doyle	Sarah Calvey	Sharon O'Donoghue
Lilly Whelan	Regina Kilcoyne	Leslie Niland
Geraldine Caslin	Grannie Higgins	Elaine Faulkner
Laura Tyson		

GMIT students raise over €1,300 for student hardship fund

Students in the Galway-Mayo Institute of Technology (GMIT) Castlebar have raised over €1,300 for the GMIT student hardship fund from the proceeds of a play they performed in the Linenhall Arts Centre, Castlebar, at the end of April. The play I do not like thee, Dr Fell by Bernard Farrell, was performed by the third year psychiatric nursing class as part of the undergraduate psychiatric nursing degree programme. "The performance was an innovative method of teaching through drama, and GMIT Castlebar is one of the first nursing colleges in the country to undertake this new method of learning," said Geraldine Murray, Head of Dept of Health Sciences, GMIT Castlebar. "The play, a black comedy with strong elements of a thriller and mystery, centres on a group therapy session involving six people. The student actors and staff learned a lot from the performance and the experience. The students acknowledged their local sponsors, who generously gave spot prizes, and everyone who attended whilst also thanking their two directors Margaret Prendergast, GMIT lecturer, and Paul Mekitarian, local actor, for their help and support throughout this whole new learning experience.

Graduation of Registered Psychiatric Nurses from the Higher Diploma in Psychiatric/Mental Health nursing in the HSE

A national nursing recruitment and retention project, supported by the Human Resource Department in the Health Service Executive (HSE) was established in 2005, charged with securing an adequate supply of nurses and midwives to meet the demands of a patient/client centred health service. During this project it became apparent that there was a limited supply of nurses within the east of the country with a psychiatric nursing qualification.

There is also a limited supply of international nurses who are eligible for entry onto the Psychiatric Division of the nursing register with An Bord Altranais (ABA).

Psychiatric nurses work in a broad range of services from in-patient acute, rehabilitation and long stay settings, to forensic, community, day care, care of the older person and child and adolescent. It is essential that sufficient numbers of trained psychiatric nursing staff with the specialist skills and competencies are available to work across the mental health service spectrum in order to provide appropriate care required by these client groups. The implementation of A Vision for Change – Report of the Expert Group on Mental Health Policy (Department of Health & Children, 2006) identifies for the requirement for registered psychiatric nurses to work in community and specialist teams.

To address the identified deficit within the east of the country the Nursing & Midwifery Planning & Development unit in 2007/8, in partnership with the Assistant National Director with responsibility for Mental Health supported and organised the development of a one year postgraduate programme. Requirements and standards were developed by An Bord Altranais for the programme. Dublin City University (DCU) was awarded the tender and developed a full time (one calendar year) Higher Diploma in Psychiatric/Mental Health Nursing leading to registration with An Bord Altranais as a Psychiatric Nurse (RPN). This programme commenced in February 2008 with 46 students.

A photo of graduates on graduation day, Stewart's Hospital, Palmerstown, May 2009.

Annual Delegate Conference 2009 Mount Wolsley Hosted by Carlow Mental Health Services


Psychiatric Nurses Association
Psychiatric Nurses Association

Mater Private Hospital · Dublin

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e-mail: healthcheck@materprivate.ie

Psychiatric Nurses Association, Station House, The Waterways, Sallins, Co. Kildare.
Tel: 045 852300 Fax: 045 855750 Email: info@pna.ie Website: www.pna.ie

Our Vision is to Provide: Dynamic, value driven leadership, developing and maintaining diversity within the Association and maintaining integrity and ethical practice of Mental Health/Intellectual Disability Nursing. Our Association provides leadership to promote Psychiatric/Intellectual Disability Nursing, to improve health care for individuals, families, groups and communities and shape health policy for the delivery of health services. The PNA provides a variety of communications vehicles, to assist members in their growth and development as leaders and facilitate internal and external liaisons for the Association. Providing learning and growth inherent in relationships, partnerships, and networks with advocacy, consumer and other professional groups. Maintaining careful allocation and prudent stewardship of the Association's resources.

Our aims and objectives are:

- To promote and protect the interests of members and in particular to provide professional and industrial leadership for the nursing profession
- To improve statutory rights and benefits of members with improved salaries and conditions of work, through to representing members in relation to work matters.
- To improve career progression and the personal development of our members.
- To ensure a healthy and safe workplace for our members.

MEMBERSHIP APPLICATION FORM

Name: _____
(BLOCK CAPITALS) State whether Mr. or Ms.

Postal Address: _____
_____ (BLOCK CAPITALS)

Date of Birth ☐☐☐☐☐☐☐☐
Day Month Year

Tel. No. _____ (Home or Mobile)

If you are currently or have in the past twelve (12) months been a Member of another Union, please state which Union: _____

I wish to apply for Membership of the ***Psychiatric Nurses' Association of Ireland.***

Signed: _____

Grade: _____
(e.g. Student, Staff Nurse etc)

Qualifications: (please tick): R.P.N. ☐ R.M.H.N. ☐ R.G.N. ☐
R.N.T. ☐ If Other ☐ Please Specify _____

Current Practice Address:

_____
_____
_____

Email Address: _____

Local PNA Branch: _____

Date: _____

Please return signed Mandate to PNA Head Office, Station House, The Waterways, Sallins, Co. Kildare.
This will then be forwarded by Head Office to the appropriate Health Service Executive Location or Employing Authority.

DEDUCTION FROM SALARY MANDATE

To: Payroll Officer _____ (H.S.E. Location/ Hospital). Please arrange to have deducted from my salary the sum of,
Tick Box ❑ Weekly €5.50 ❑ Fortnightly €11 ❑ Calendar month €23.83 *(Subscription Deduction Period must equate with your Salary Payment Period)* ❑ *Yearly €15.00 Associate Membership (Retired Nurses only)* in respect of **Union Subscriptions** and remit this amount to, National Treasurer, Psychiatric Nurses Association of Ireland, Station House, The Waterways, Sallins, Co. Kildare.
Essential info marked * must be filled in

***Signed:** _____ ***H.S.E. Location/Hospital:** _____

***Payroll Ref. No.:** _____ ***Date:** _____

I accept that there may be periodic adjustments to the above level of contribution as determined by the National Executive of the P.N.A. and I also accept that these adjustments may be notified directly to my employer by Head Office of the P.N.A. I also understand that advance notice of any change in subscriptions will issue through a General Circular and that individual advance notice will not be issued.

I further authorise you to discontinue payment of contribution to any other Trade Union with effect from the implementation of this mandate.

I acknowledge that this deduction is made for my convenience and may be terminated by the H.S.E/Hospital at any time. I am aware that the H.S.E./Hospital does not accept any further liability for amounts so deducted and paid over the Psychiatric Nurses Association.

Salary Protection Scheme for PNA members

More cover for your money

Protecting your salary is so important that the PNA has insisted on a membership cost that is within the reach of every nurse, and unlike a typical "off the shelf" Salary Protection Policy, as a PNA member you get all the following benefits as standard.

A Benefits of the Scheme

1 Salary Protection/Disability Benefit:

- An income of up to 75% of salary less any Early Retirement Pension/State Illness Benefit
- Payment of benefit up until age 60
- Flexibility for those not claiming an Early Retirement Pension (ERP) and who have not been granted pension rate of pay
- Full cover option for job-sharers
- Special arrangements for non-Irish national nurses.

2 Death Benefit/Life Cover:

- Death Benefit of three times annual salary (typically €135,000) up until age 65
- Accidental Death Benefit of €15,000
- Children's Death Benefit of €4,000
- Retired Members' Life Cover Plan – option to continue an element of life cover into retirement without medical underwriting
- Spouse's Death Benefit* of 100% of the member's annual pensionable salary (paid to the member if their spouse dies).

3 Specified Illness Benefit:

- Once-off cash lump sum of 25% of salary paid in the event of a "Specified Illness", e.g. cancer
- Single member's Specified Illness Benefit* – an additional once-off cash lump sum of 25% of salary (only payable if you are single at the date the event occurs).

*members can only ever benefit from either option 'Spouse's Death Benefit' or 'Single member's Specified Illness Benefit'.

B Affordable for every member

Here is an example of what the Scheme costs for a full-time nurse who is a member of the Superannuation Scheme paying PRSI on the lower 'D1' rate and paying income tax @ 41%.

Income	'Real' weekly contribution after tax relief
€40,000	€10.71
€45,000	€12.11
€55,000	€14.81

3494 PNA SPS ad 08/09

For more information on the benefits of the Scheme and how you can take advantage of preferential terms of entry before the 31st October, please see insert enclosed or call (01) 408 4195.

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