Diabetes Type 2
Coping with triple therapy

Dermatology
Acne

SF Techniques
Becoming solution focussed

Real Life
Ireland to Africa & back again

HSE
The HSE transformation

Nutrition & Obesity
Part 4 by Anne Diamond

Infection Control
Intravenous therapy

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Epilepsy
Part 1 of 2

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Mintzberg’s talk at UCD Smurfit School reveals Myths of Health Care Management

UCD Michael Smurfit Graduate Business School is hosting a breakfast talk this morning on “Managing the Myths of Healthcare” with one of the world’s best-known management scholars, Professor Henry Mintzberg, Cleghorn Professor of Management Studies at McGill University Montreal. Professor Mintzberg will detail the numerous myths of health care management to an invited audience of senior health care professionals, MBA students and media.

He will discuss a different kind of leadership within the health care industry, illustrating how managers can engage people by stepping down from “on top” of organisations, engaging people and implementing strategies on the ground.

According to Professor Mintzberg:

“It is a long-standing myth that the problems of health care institutions can be somehow fixed by bringing in the “great leader” who makes bold statements and takes dramatic actions. The health sector is lacking in a dynamic approach because it is so top heavy. Effective leaders drive change within the healthcare sector by stepping down from “on top” of organisations and implementing strategies with others often considered separate from their formulation. Such engaging management is needed to drive change in the healthcare sector.”

Professor Mintzberg suggests the increasing demand for competition within the health sector would not exist if the existing system learned the art of cooperation.

Commenting on today’s talk, Dr. Gerardine Doyle, Head of Teaching and Learning, UCD School of Business, and Academic Director MBA Health Care Management, UCD Michael Smurfit Graduate Business School said:

“We are honoured to have such an internationally renowned academic and author at UCD Smurfit School discussing the complexity of healthcare management. Professor Mintzberg’s profound insight into effective leadership within the health sector encourages us to reflect on what constitutes best practice in healthcare management today.”

The talk comes after the recent launch of the new MBA in Health Care Management at UCD Smurfit School.

Shocking statistics show that local health service needs investment not cuts

Alliance Health Spokesperson Kieran McCarthy MLA has hit out at news that more than 2,000 charges of medical negligence have been made against the local health service since 2001 stating that these figures show how ill-judged cost cutting measures are hitting our local health service.

Kieran McCarthy MLA said: “These figures are shocking and illustrate a disturbing trend. I am very annoyed about this culture of cost-cutting which may be leading to corners being cut in the Health service. At the moment there seems to exist a mindset of cutting spending across the board at all costs.

“I also want to pay tribute to local healthcare professionals as they are working hard under extremely difficult conditions. Local staff are being stretched to the limit because of cuts and more must be done to assist them.

“The main priority simply has to be providing the best health service possible, not conducting these constant economy drives which we see in the NHS locally.

“The spotlight will soon be on the new devolved Health Minister. They must tackle this matter head-on and move to improve the service through extra investment.”

HSE committed to tackling MRSA

Tackling MRSA and Health Care Associated Infection (HCAI) is a priority for the HSE and as a result of the Say No to Infection campaign the HSE recently established a new HCAI Governance Group.

Its core objectives are:

To reduce Health Care Associated Infections by 20%
To reduce MRSA infections by 30% and
To reduce antibiotic consumption by 20%

These targets will be achieved through the development of national and local level action plans to reduce the potential for spread of infections between persons in health care settings and to reduce and alter antibiotic use in Ireland.

The group is working:
To provide expert advice to the Health Service Executive and the Department of Health and Children on implementing a national HCAI strategy.
To decided on priority areas for implementation.
HSE Annual Report 2006 - More Patients Treated Than Ever Before

The Health Service Executive (HSE) published its 2006 Annual Report.

The Report illustrates how the HSE, during 2006, delivered an increased level of services within the resources approved including:

- 594,059 inpatients treated;
- 542,671 day cases treated;
- 1,268,991 emergency department attendances;
- 2,778,602 outpatient attendances;
- 62,745 births;
- 11,430,570 home help hours delivered.

Good progress was made in 2006 towards reconfiguring hospital and community based services to improve patient care and safety. 5,300 more people received home care packages and the HSE is now providing long stay care for an additional 1,050 people.

“2006 was the year the HSE started to introduce greater consistency and accountability and thanks to the tremendous commitment and efforts of thousands of staff, we provided many excellent services, many services have improved and others will continue to get better,” said Professor Brendan Drumm CEO of the HSE.

The number of people awaiting admission from Emergency Departments was reduced by up to 60% (despite an increase of 3.3% in attendances) due to the HSE’s Winter Initiative. Furthermore, during the year 80% of people were able to access a GP at night and at weekends through the out of hours GP services.

The Annual Report also acknowledges an under spend of €97.7m in the HSE’s Capital Budget for 2006. However, the Department of Finance sanctioned approval for the HSE to move €71m from its capital surplus to revenue (day to day spending) in 2006 in order to address core service delivery issues such as the cost of additional beds in the community to support hospital services.

The HSE, therefore, had a surplus of €25m and can, with Dept of Finance approval, agree to include this in this year’s capital spend should it be required.

The capital under spend was partially due to the lack of anticipated progress on a number of major projects (e.g. the Mater Misericordiae Hospital project and the National Rehabilitation project). A necessary transition to new and improved capital monitoring and management structures also contributed.

The HSE capital expenditure process is now being actively managed by a newly established Estates Directorate as well as Primary, Community and Continuing Care (PCCC) and National Hospitals Office (NHO) Capital Steering Committees. The Estates Directorate has brought a greater focus and momentum to the planning and development of major capital projects.

“This was a year of real progress and achievement across a broad number of areas. I look forward in the year ahead to further rapid progress and the implementation of the many more new initiatives for the benefit of our patients and clients” concluded Liam Downey, the Chairman of the HSE.
Co-location plan should not go ahead, says economist

The co-location plan needs to stop; more beds without reform will lead to “a black hole”, and the most important development for Irish healthcare is the reform of primary care, according to Prof Dale Tussing, Professor of Economics, Syracuse University, New York and co-author of How Ireland Cares: The case for healthcare reform.

Prof Tussing was speaking at the 4th National Healthcare Conference in Croke Park where he added that it is important to “ease the cap on public employment”.

He said when that cap on public employment “is combined with tax breaks for private investment it yields privatisation of a healthcare system by stealth”.

Responding to Prof Tussing’s call for an end to the co-location plan, Prof Brendan Drumm said it is not in his remit to say it should stop.

“The co-location project…is not a significant issue for me. My job is to run the public health service. I see co-location as being a competitor to the HSE. I think we should be glad of competition and we’ll stand up and we’ll actually be counted in terms of saying we can provide a service every bit as good as what can be provided on a co-located site,” he said.

Prof Tussing also said that the current situation regarding primary care teams is “a long way from the visionary innovation so warmly anticipated when the Primary Care Strategy was published”.

He said primary care is being “pushed off the front pages” by the A&E crisis, patients on trolleys, the co-location debate and the consultants’ common contract.

He added that funding for primary care centres has been slow and the HSE has been creating primary care teams “but seemingly without primary care centres” and the teams may lack the technology and architecture that seems to be needed for modern care.

In a recent response to questions from Prof Tussing, the HSE’s Assistant National Director PCCC, Mr Tadhg O’Brien, said that the planning stage for appropriate modern buildings with appropriate ICT (Information Communication Technology) will commence its planning stage in the current year.

Mr O’Brien added that the HSE could have waited to finance the primary care teams when the centres were complete but the HSE has “gone ahead with the formation of the teams”.

Prof Tussing said that “significant investment in primary care is justified” and “it’s time to get serious about primary care”.

Prof Tussing also called for Ireland to move to “primary care free to all…not only for equity but for efficiency reasons” and said there needs to be universal patient registration (upr).

While Prof Drumm said it was important to get the IT structures in place for primary care teams, he said the priority was getting the teams together.

Staffing crisis at ‘five-star’ maternity hospital

A €75 MILLION maternity hospital has been slammed by patients and staff as “chaotic” and a “conveyor belt” due to a chronic shortage of midwives.

The newly opened Cork University Maternity Hospital is supposed to deliver a “five-star” service, but one patient said it was more like “Fawlty Towers”.

Health Service Executive management have been sharply criticised by midwives and opposition politicians for their failure to ensure adequate staffing levels at the hospital, which opened on March 31.

One senior midwife expressed fears for the welfare and safety of mothers and newborns because of staff shortages, while the INO said staff were forced to practise “conveyor belt” midwifery to cope with patient numbers.

The HSE confirmed it is seeking to hire more than 50 midwives here and in England, Scotland, Greece and Australia. However, the National Health Service in Britain is short of thousands of midwives. Permanent midwifery positions have, meanwhile, been offered to 31 student midwives, due to qualify next September.

New mothers have posted numerous negative comments about the hospital on well-known parenting websites, including Magicmum.

One Magicmum post revealed how one mother who gave birth at

Review of Dublin obs & gynaecology services

The HSE has started a comprehensive review of all existing maternity and gynaecology services in Dublin City, County, and surrounding areas.

The HSE has engaged KPMG Consultants to carry out the review, which will consider the best configuration of hospital, primary, community maternity, and gynaecology services in the region.

When this review is complete the HSE says it will publish an independent report which will include recommendations and an action plan for the development of “consistently high quality, safe and sustainable maternity and gynaecology care services in both community and hospital settings in the greater Dublin area”.

The HSE is now inviting members of the public, health professionals and interested parties to make comments or submissions on the development of maternity and gynaecology services in the greater Dublin area.

According to the Executive, submissions received will inform the work of the review and contribute to the success of the project.

Written comment or submissions can be sent to: dublinobsandgynreview@kpmg.co.uk, or post to: Review of Maternity & Gynaecology Services in the Greater Dublin Area Team, KPMG, 1 Stokes Place, St. Stephens Green, Dublin 2

Submissions should be received by Monday August 6 2007.

Approximately 40 per cent of births nationally per annum take place in the three maternity hospitals: the Rotunda Hospital, National Maternity Hospital, and the Coombe Women’s Hospital in Dublin. The growing requirement for neonatal care will be considered as a vital part of this review, added the HSE.

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The HSE has engaged KPMG Consultant salaries were not rising enough to keep pace with inflation. Staffing levels were low and the HSE was relying on locums to fill gaps. The HSE was not investing enough in IT infrastructure, and there was a major IT failure in 2007 that led to a six-week suspension of services.

The HSE was also criticised for its handling of a major public relations crisis in 2007 when 1,000 patients were left in A&E for more than 24 hours. The HSE was also accused of not doing enough to improve patient safety and reduce the number of deaths in hospital.

The HSE has been under pressure to improve its performance, and there were concerns that it was not doing enough to address the challenges facing the health service.

The HSE has been called to account for its performance, and there were calls for reform of the health service. The HSE was also accused of not doing enough to improve patient safety and reduce the number of deaths in hospital.

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CUMH described the place as “Fawlty Towers”, while another read: “It felt like going to a regular A&E.”

Another mum described the hospital as “disorganised, understaffed, impersonal and chaotic.”

A HSE spokesman said yesterday that CUMH had 376 midwifery and nursing positions approved by the HSE, with 322 midwives and nurses currently based at the Wilton hospital.

Fine Gael Cllr Tim Lombard said: “This hospital was supposed be of five-star standard. Instead, there is a serious shortage of midwives... and mothers have described it as chaotic.”

Irish Nurses Organisation industrial relations officer Patsy Doyle admitted there were lots of problems but remained hopeful they would be ironed out.

“There is no doubt that the people of Cork have been misled by the HSE. Women were promised a service that did not materialise. We have our targeted number of midwives and we will just have to work to try and get that number in place by September. Midwife numbers are going up, but very slowly,” she added.

A HSE spokeswoman said the safety of the unit has never been in question.

“Since opening, CUMH has received six formal complaints and... 50 formal thank-you letters.”

**HSE defends budget underspend**

The Health Service Executive (HSE) insisted patient care improved last year even though it admitted failing to spend nearly a fifth of its €555m budget.

Despite having earmarked €97m for major projects such as Dublin’s Mater Hospital, the HSE said a lack of anticipated progress forced it to hold the money back.

Opposition TDs and the campaign group People with Disabilities Ireland (PwDI) rounded on the HSE accusing it of allowing bureaucracy to block reform.

There were also delays in spending for the National Rehabilitation Centre.

Michael Ringrose, PwDI chief executive, said someone had to be held to account.

“The sense of acceptance of the slow pace of delivery within the public service is simply not acceptable,” he said.

HSE management agreed a deal with the Government to spend €71m of the surplus on day-to-day costs rather than hand it back to the Exchequer.

They are also in talks with the Department of Finance to include the remaining €25m in this year’s budget. It is understood special Government approval is needed.

The HSE offered the following explanation for the massive underspend: “The capital underspend was partially due to the lack of anticipated progress on a number of major projects (such as the Mater Misericordiae Hospital project and the National Rehabilitation project).

“A necessary transition to new and improved capital monitoring and management structures also contributed.”

Despite the spending difficulties, the HSE said there was a 60% drop in the numbers of people waiting for admission from A&E units even though attendance went up 3.3%.

The HSE said spending was now being managed by a new body known as the Estates Directorate which was working alongside the Primary, Community and Continuing Care and National Hospitals Office committees.

“‘The Estates Directorate has brought a greater focus and momentum to the planning and development of major capital projects,’ management said.

But newly-elected opposition TDs were quick to brand it bureaucracy with Fine Gael health spokesman Brian Hayes accusing the HSE of organisational inability.

“The handing back of €90m because other developments are stalled indicates a bureaucratic block to channelling funding to areas of desperate need and it must be explained by the HSE,” he said.

Liz McManus, Labour Party health spokeswoman, said the underspend showed failures at the highest level.

“Around the country patients are suffering for want of sufficient beds, equipment, and healthcare facilities,” Labour’s deputy leader said.

“It is inexcusable that the HSE, as the body established to introduce greater efficiency to the health service, has been unable to spend its not over-generous annual budget for these new facilities.”

Caoimhghin O’Caolain, Sinn Féin’s health spokesman, said it was almost beyond belief the money was not spent as hospitals battled to control superbug viruses.

“Public money for hospital developments has gone unspent while MRSA spreads in our hospitals because we do not have enough single rooms and isolation units to combat this and other serious infections,” Mr O’Caolain said.

“This money should have been used to provide those units.”

Meanwhile, the Irish Medical Organisation said it will go back into talks with Minister for Health Mary Harney on new contracts for consultants.

In its annual report the HSE highlighted achievements in 2006. More than half a million patients were treated in hospital; A&E units dealt with 1.26 million patients; there were 62,745 births; and 11.4 million home help hours delivered.

HSE chief Professor Brendan Drumm praised staff for their work: “2006 was the year the HSE started to introduce greater consistency and accountability and thanks to the tremendous commitment and efforts of thousands of staff, we provided many excellent services, many services have improved and others will continue to get better.”
National Maternity Hospital concerned about future

The National Maternity Hospital, Holles Street, Dublin, is seriously worried about its long-term future, according to its latest annual report.

Writing in the Hospital’s 2006 annual report, Holles Street Master Dr Michael Robson said he believed the Hospital’s view that it should eventually be relocated to a site at St Vincent’s Hospital will be supported by the HSE’s 2007 maternity services review of the Dublin region.

Mr J Brian Davy, the Hospital’s Deputy Chairman agreed that St Vincent’s Hospital would be the preferred relocation option. In the annual report he said there was an “urgent need for the HSE to address this important matter and agree the longer term strategy for the Hospital”.

Meanwhile the Caesarean section rate in Holles Street rose for the tenth consecutive year in 2006 and now stands at 18.9 per cent of deliveries. This, rate, together with a high induction rate, remains a concern and continuously needs to be challenged, said Dr Robson.

A total of 7,986 women gave birth to 8,088 babies each weighing more than 500g, at the Hospital in 2006. This is an increase on the previous year following the Hospital’s lifting of its restriction on delivery numbers in the summer. A cap was introduced in the summer of 2005.

Dr Robson said there are no plans currently to place a cap on delivery numbers this summer.

Of the babies born in 2006, 60 were either stillborn or died during the first seven days of life. The report states that 29 baby deaths were due to congenital anomalies and the corrected infant mortality rate at the Hospital in 2006 was 3.8 per 1,000.

The report also highlighted the Hospital’s financial difficulties. Mr Davy said: “On the subject of finance, 2006 was a normal year in that the Hospital was allocated an inadequate budget at the start of the year.” As usual, we spent the entire year negotiating additional funding for very identifiable matters, which continue to arise year after year. The sooner Irish hospitals move to a situation where an adequate budget is allocated at the start of the year the better.

In such a scenario we can be realistically held accountable for fiscal performance.” Holles Street was also selected as a pilot site in 2006 for a European Working Time Directive (EWTD) NCHD roster project, said the report. Hygiene was also an issue of concern at the Hospital last year.

There is a need to increase the frequency of cleaning in a number of areas of the Hospital, the Hospital’s Secretary Manager Mr Michael Lenihan said in the 2006 report. Cleaning staff have to be provided out of hours, to undertake cleaning duties, he stated. However while the cost of these plans has been submitted to the HSE, no additional funding has been provided, said Mr Lenihan.

Mater faced a €27 million deficit

The Mater Hospital, Dublin, was forecasting a €27 million budget overrun as early as last February, Irish Nurse magazine has learned.

The Hospital was predicting that services would have to be curtailed if further funding was not forthcoming. However, it is understood ongoing talks with the HSE have gone some way to easing concerns. Minutes of the Mater Hospital’s February board meeting reveal the Hospital was initially allocated just under €220 million but its projected expenditure was an estimated €247 million. This is calculated based on a 10 per cent increase on last year’s budget, and meant the Mater was faced with a €27 million deficit.

The Hospital warned the HSE that it would not be possible to scale back expenditure “without affecting patient care and hygiene” at the Hospital.

The roll-out of budgets to Hospital departments was being held up because of the uncertainty, according to the Hospital, and minutes of the March board meeting show there were serious cash flow concerns.

The Hospital Chairman, Mr John Morgan, wrote to HSE CEO Prof Brendan Drumm, as well as National Hospital Office Director Mr John O’Brien, and Network Manager, Ms Angela Fitzgerald warning of the looming crisis.

The minutes describe the funding as “totally inadequate” and a further €27 million would be needed to deliver the level of service achieved in 2006, the Hospital warned.

Unless realistic discussions take place immediately to remedy the situation, the ramifications for the hospital, its patients and staff are considerable,” the Hospital said.

A spokesperson for the Mater Hospital told IMN: “There was a €27 million deficit in March but that has been significantly reduced since then and talks with the HSE are ongoing.”

Changing behaviour can improve your health

The Chief Medical Officer for Northern Ireland has said this is the decade to encourage people to change their eating habits and lifestyles.

In his first report as Chief Medical Officer for Northern Ireland, Dr Michael McBride said: “While the health of the population is improving, not everyone is benefiting from these improvements.”

Dr McBride said: “While health professionals and Government can help in bringing about improvements - all of us as individuals need to take control of our own behaviours and lifestyles, in order to make a real difference.”

Commenting on the alarming rise in obesity Dr McBride said: “Over 20% of Primary One children are overweight or obese. Junk food and a lack of exercise are contributing to the problem.

“The importance of a healthy diet and taking more exercise is well recognised by all of us. We must act now to avoid a future where many of our children could face significant health problems such as diabetes, heart disease and cancer.”

Dr McBride welcomed the ban on smoking in public places saying: “It
will save lives and protect the health of many workers. But we cannot be complacent as 350,000 people here are still smoking. Too many young people still smoke. Northern Ireland has the second highest percentage in Europe of 14 year olds who smoke. We must re-double our efforts to encourage people to kick the habit and avoid serious illness such as cancer and heart disease.”

In his Report, the Chief Medical Officer also highlighted a number of other significant health challenges including binge drinking, poor dental health, the rise in sexually transmitted infections, suicide and mental health saying: “These are issues which continue to challenge us in the medical professional and as a society.”

Many of these issues and the resulting ill health and premature death have a disproportionate effect on people who live in the more deprived areas. Dr McBride said: “Sadly where we live can have a major affect on our health and can determine how long we will live. Those in our community who live in the most deprived areas have the poorest health.”

Medical Council Presses for new premises

The Medical Council was hoping to be given the go ahead by the Government to purchase a new headquarters in Dublin.

During the Council's latest meeting (June 20), it stressed the “urgent need” for a new premises to be purchased quickly, reiterating that the Council’s current home in Lynn House, Rathmines, Dublin, is now too small for the Council’s business.

“If we don’t get a larger building now the current Council will experience serious difficulties in carrying out its work but I have no doubt that the new Council won’t be able to function if we don’t get the new building before then,” Council Vice-President Dr Colm Quigley told IMN.

A new premises in a prime city centre location has been identified by the Council. It is understood that once the new premises is purchased, Lynn House will then be put up for sale.

During last week’s Council meeting Dr John Hillery's resignation as President was accepted and the Council “recognised the enormous work and valuable contribution made to the Council” by Dr Hillery in his former roles as Vice-President and President of the Council.

The Council has named July 23 as the date of the election to elect its new President. Nomination forms are now to be provided to Council members who will have until 5pm July 5 to register their nominations.

The list of candidates was issued to Council members on July 6, and there will be two weeks, with the closing date 5pm on July 19, allowed for them to vote by post. At least two doctors will contest the election for President with Dr Quigley already having confirmed his intention to run along with Mr Brendan Healy.

The Council has reported that it has received no information on the commencement of the new Medical Practitioners Act and has subsequently advised members to make locum arrangements to attend Council meetings up until December 31 of this year.

The Council emphasised that its work is continuing as normal in the interim. However, Minister Mary Harney stated last week that she intends to commence the Act in the next couple of weeks but the Council says a significant lead-in time will be needed before the current Council is dissolved to ensure a smooth and seamless transfer of duties.

Men’s Health

Joint Resource Pack launched

As part of International Men’s Health Week celebrations Cork Health Action Zone (HAZ) and the HSE North Lee Cardiovascular Public Health Nurses have launched a joint resource pack ‘Heart and Lifestyle Health Check’.

The resource pack has been produced to help other groups in Cork & Kerry to organise free Lifestyle Health Checks as one way of engaging men in the wider health debate.

Evidence exists which demonstrates how low social class and low levels of education are linked to impaired health status. Lifestyle Health Checks delivered in designated HAZ Areas can potentially play a vital role in improving men’s health. The Checks which include Blood Pressure and Cholesterol level testing, have previously been delivered in Barbers, Pubs and Clubs in HAZ Areas and have encouraged men to be more flexible in approaching health care staff as it creates for men a space which they are comfortable with, offers privacy and confidentiality and takes place in environments that are comfortable and user friendly.

Bernard Twomey Community Health Worker with the HSE says “This pack is a valuable resource for other groups who wish to engage with men. We hope that other groups will use this pack as a resource to set up heart and lifestyle checks for men in their areas”

Meanwhile, the Council reported that 120 GPs have signed up for its competence assurance pilot and it is encouraging more doctors to do so. The Council needs 200 doctors to participate in the pilot project and the Council’s Director of Competence Assurance Dr Lynda Sisson said that doctors will have until the end of September to sign up to take part.

The Council also wishes to remind doctors that it is currently in the process of reviewing the provisions of the current edition of its Guide to Ethical Conduct and behaviour in preparation for the production of the seventh edition of the booklet. It is now seeking submissions from interested parties on the booklet and the deadline for receipt of submission is Friday, September 7.

New Orthopaedic ICATS Services launched

Orthopaedic services in Northern Ireland are set to be transformed with the introduction of a new system for outpatients.

Launching the Orthopaedics Integrated Clinical Assessment and Treatment Services across Northern Ireland, Health Minister, Michael McGimpsey today said patients will no longer face lengthy waits to see a specialist.

He said: “Until recently, patients were waiting many months or years to see a specialist and then had to endure a further long wait for surgery. This was unacceptable and had to change.

“Excellent progress has been made over the last two years and now no patient is waiting more than six months for an outpatient assessment or for surgery.

“I commend the efforts of health service staff to meet these targets. However, six months is still too long for patients to wait who are experiencing pain and anxiety. That is why I have set more challenging targets to reduce the time patients wait for assessment to no more than 13 weeks by March 2008.
was absent without leave. around a “misunderstanding” of the doctor’s schedules and claims he between all parties”. As previously reported by IMN the case revolved disciplinary charges in a HSE West hospital has been “settled amicably confirmed a case where it was representing a doctor facing serious which will be available shortly at www.imo.ie. The IMO has also them; including on- call arrangements and general health and safety, an advice document for pregnant junior doctors on the issues facing The IMO, on foot of an NCHD Committee request, has prepared an advice document for pregnant junior doctors on the issues facing them; including on- call arrangements and general health and safety, which will be available shortly at www.imo.ie. The IMO has also confirmed a case where it was representing a doctor facing serious disciplinary charges in a HSE West hospital has been “settled amicably between all parties”. As previously reported by IMN the case revolved around a “misunderstanding” of the doctor’s schedules and claims he was absent without leave.

HSE Reneg On Employment Agreement For Newly- Qualified Nurses In Sligo General Hospital

The Irish Nurses Organisation has called upon the Health Service Executive to reverse their policy whereby newly-qualified nurses in Sligo are being advised to join an agency instead of being offered contracts to work in the hospital. This is despite an agreement with the HSE in 2006 that all such students in 2006 and 2007 would be offered six-month contracts.

Noel Treanor, INO Industrial Relations Officer in the North West said:

“This reneging on an agreement by the HSE is a terrible decision and is once more driving locally-trained nurses away. It is all the more ridiculous as management have admitted that employment through an agency is of greater cost to the HSE.”

Mr Treanor went on: “The reasoning given by the HSE is that there is a cap on posts. Therefore, an arbitrary cap imposed by the Department of Finance is having the effect of driving up costs and putting taxpayer’s money directly into the hands of a third party, notwithstanding the impact upon recruitment, retention and the ultimate provision of services.”

Mr Treanor indicated that some newly-qualified nurses had already sought positions in Castlerea, Limerick and Dublin. The INO has urged the HSE to revert to the 2006 agreement and have sought that the issue be raised at national level.

ICN and WMA Welcome the Release of Bulgarian Nurses and Palestinian Physician

The International Council of Nurses (ICN) and the World Medical Association (WMA), today welcomed the news that the five Bulgarian nurses and one Palestinian physician incarcerated for eight years in Libya have been released.

The health professionals had been accused by Libya of deliberately infecting more than 400 Libyan children with HIV. The charges have been definitively disproved by world-leading scientists and HIV experts.

The death sentences that had been handed down to the health professionals last year were dropped and all left Libya for Bulgaria today.

ICN and WMA are calling for support and reintegration into society and work life for the health professionals.

After 2,755 days in prison, the ordeal was finally over for Valia Cherveniashka, Snezhanja Dimitrova, Nasya Nenova, Valentina Siropoulo, Kristiana Valcheva and Palestinian-born doctor Ashraf Alhajouj.

“The medics are back in Bulgaria,” announced radio stations.
Healthcare Associated Infections

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Healthcare Associated Infections are one of the biggest challenges facing today’s Healthcare Professionals - not just fighting threats like MRSA, but also in reassuring the public of our ability to do so. Effective staff training is therefore essential.

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To find out more about our healthcare infection Control training and our other online Clinical Training Courses - visit www.cb-training.com/sih. Alternatively contact our Clinical Director Jane Kennedy on 01899 229 337 or by email jane.kennedy@cb-training.com.

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An Institution of Occupational Safety and Health (IOSH) Healthcare: Risk and Safety Management certificate is awarded, following participants successfully completing the written and practical assessments. Participants have to complete the complete programme to receive this certification. Each day runs from 9.00am to 5.00pm.

Further details:- www.ino.ie
Enquiries/Bookings:- Tel 01 6640641/2

18th October 2007
Asking the Questions – Learning the Lessons
Call For Papers From Midwifery Students
Midwifery Students are invited to present a paper at the Conference. Abstracts to be submitted before Friday, 31st August 2007.

Venue: Armagh City Hotel, Co Armagh

Paper to reflect conference theme.
Please submit a Short Abstract a piece of work / research or information that you would like to share.

Please submit all INO papers to:
Helen O’Connell
Irish Nurses Organisation
The Whitworth Building
North Brunswick St., Dublin 7
Tel: 01 664 0616 Fax: 01 6622334
Email: helen@ino.ie

Please submit all RCM papers to:
The Royal College of Midwives
UK Board for Northern Ireland
58 Howard Street, Belfast BT1 6Pj
Tel: 02890 241531 Fax: 02890 245889
Email: annemarie.oneill@rcm.org.uk

Healthcare Events in and around your area

• 27th September 2007
Annual Palliative Care Multidisciplanary Study Day

Venue:
Richard Carmichael Lecture Theatre
Beaumont Hospital
Dublin 9

Topics:
- Optimising the Care of Patients with ALS/MND
- End of Life Care & Dementia
- Improving Palliative Care in the Community for Heart Failure Patients
- Non-Surgical Management of Bowel Obstruction
- Dealing with Family Upset
- The Patient at Home
- Medications Questions Session

Contact:
Ann Nulty 809339/8092820
email: palliativecare@beaumont.ie

• 4th October 2007
• 8th October 2007
• 9th October 2007
Institution of Occupational Safety and Health Accredited
Four days in acute settings; three days in non acute.

Suitable for all health care managers it is intended for all staff at managerial level working within acute care, primary care, mental healthcare and nursing homes. It is to ensure standardisation of core knowledge across the whole healthcare sector.

A 12 Modules Course to include:
Invitation to Present a Poster
Midwives and Midwifery Students are invited to present a poster at the Conference
Closing Date: Friday, 31st August 2007
Application Forms available from: Helen O’Connell (above address)

• 6th November 2007 GLASGOW
Skills for Nurses 2007
One-Day Event
Skills for Nurses are pleased to announce the latest One day Nursing Exhibitions which will be held in Glasgow.

Venue:
SECC, Glasgow

Previous events have helped many NHS, international recruiters and employers in the private sector to fill posts and the latest events promise to do even better.

As with all our events we have a full range of seminars and workshops featuring prominent speakers and celebrities including Anne Diamond.

This year we are having skills challenges with large cash prizes. Entry is free,

log on to www.scottishirishhealthcare.com to find out more.

Enquiries from Nurses and other Healthcare professionals please contact:
Tracy Hamilton on 01324 411013
or email tracy.hamilton@cb-training.com

Exhibitors please contact:
Scottish & Irish Nurse magazines on
tel. +44 (0)1292 525 970
email. strathayrtd@btclick.com

Due to unforeseen circumstances the event planned for the RDS Dublin is now cancelled.

Brazelton Centre in Great Britain
in collaboration with PMARC and CIHR

STUDY DAY
Understanding Newborn Behaviour
Tuesday, 20th November, 2007
9:30am-4:30pm
St. Cecilia’s Hall, Cowgate, Edinburgh

Fee: £80-00

For registration form and programme, please see:

www.brazelton.co.uk
www.cihr.org.uk
www.pmarc.ed.ac.uk

Or contact:
info@brazelton.co.uk
Telephone:
01223-245791 or 0131 317 3475

• 14th - 15th November 2007
NCNM 7th Annual Conference
7th Annual Conference
Theme: Team-Working to Support Excellence in Patient Care.

Venue:
Croke Park Stadium, Dublin

Time: 08.30-16.00

There is no charge for the conference and lunch will be provided.

Contact:
conference@ncnm.ie:

Conference Organiser
National Council for the Professional Development of Nursing and Midwifery
6-7 Manor Street Business Park
Manor Street
Dublin 7

Events Request
If you have any events you would like highlighted in this section, please forward to:
Hamish Bell (Editor)
email: hamishbell@btconnect.com
Clinical Articles Wanted

At Scottish & Irish Nurse we are always interested in good quality clinical editorial. We’d love to hear from you regardless of whether you’ve had work published before.

Your submission needn’t be a very detailed clinical paper.

For example you can forward:

- A review of a local initiative that has delivered best practice leading to an improvement in patient care.
- Results of an audit or survey that has led to an improved service to patients and their relatives
- An article relating to an area of particular interest to you or involving your specialist area. We are particularly keen to receive articles related to Cardiology, Respiratory, Diabetes, Nutrition, Midwifery, Mental Health, Intensive Care and Dementia
- A service redesign initiative that has achieved demonstrable results
- Or just anything that’s going on locally or that you and your team has achieved that you’d like to share with over 20,000 Nurses fortnightly.

Our articles are typically 1500 words, although there is a fair degree of flexibility, and fully referenced where appropriate.

Don’t worry about pictures and graphics as we can insert these for you.

For authoring guidelines or to submit editorial e-mail: charlie.bloe@cb-training.com
Postal address: Charles Bloe Training Ltd, Editorial Dept, 15 Highland Dykes Drive, Bonnybridge. FK4 1PE.
Or if you have any queries give me a call on 01324 814946.

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Greig Ferguson initially trained as a Royal Marines Commando, undertaking the military Paramedic course in 1992. On attachment he attended Chicago Medical School 1993 at the Rosalind Franklin University of Medicine and Science. Completed initial internship at the Department of Emergency Medicine.

Maureen Benbow MSc BA RN HERC
Senior Lecturer, University of Chester

Kirsten spent much of her early clinical career as Staff Nurse in Coronary Care and Medical High Dependency. She was among the first Nurses in the UK to undertake the role of nurse initiated coronary thrombolysis.

Jamie has spent his career working in the Accident & Emergency environment. He has held Staff Nurse, Deputy Charge Nurse and Charge Nurse Positions before moving onto his current position as an Emergency Nurse Practitioner.

Heather has spent much of her senior clinical career working in Cardiac Care and Medical High Dependency. She is currently a chest pain assessment practitioner at Stirling Royal Infirmary.
Acne is a disease that causes a number of "spots" to appear on the body. It can occur anywhere but classically affects the face, back and chest. This tends to make it very noticeable and can therefore cause a great deal of embarrassment and suffering. In rare cases it can be life threatening.

The main skin lesions to be found in acne are:

Comedones and Scarring
Comedones: Black (Open) or White (closed) heads. The black colour is caused by pigment- rather than dirt- as the patient may fear. These "spots" are rarely caused by any other disease than acne and so are useful in helping to make a diagnosis.

Pustules
These are spots, papules, with a topping of pus.

Nodules:
These are just like papules in that they are solid and raised off the skin but they differ in only one respect. Size. The presence of nodules can be significant as it can raise the severity of the disease and influence the instigation of more aggressive treatments.

Scarring:
Acne can produce a number of different types of scarring. The classic type is the pitted kind that leaves a hollowed (atrophic) "divot" in the skin. Scars can be hyper-pigmented (brown in white skin) or hypo-pigmented (white in darker skin). Scars can be raised-hypertrophic and can be confused with new spots (papules and nodules).

Acne severity can be scored in a number of different ways. A scoring system should take into account the area of skin covered; the size of lesions; the presence or absence of nodules and/or scarring. A simple way to do this is to categorize the acne as mild, moderate or severe. Another thing that should be kept in mind when classifying disease is how badly it is affecting the patients quality of life. Thus someone with objectively mild acne may be severely distressed by the problem.

Many people think that you can "grow out" of acne. This popular belief is because it usually presents in adolescents because this is a time of increased hormone production and consequently increased production of sebum from the glands in the skin making it more oily. In acne the glands then become blocked and infected and inflamed causing the typical eruptions seen. Most teenagers get some degree of acne and many do not require any treatment. Some teenagers and adults have much more severe disease and these groups should seek medical advice to control the disease and in particular to reduce scarring which is permanent. Some reports say that if you have not "grown out" of acne in your thirties then it is less likely that you will. It is however interesting to see that it is very rarely seen in the elderly. Drugs that are known to worsen acne are: lithium, oral contraceptive pills and steroid preparations, to name a few.

Pressure on the skin such as from leaning on face with hands is also a recognised factor.

Treatment of Acne
The good news is that there are a number of effective treatments for acne. They generally consist of antiseptics, antibiotics and retinoids. They can be given in many forms but the most usual is topical (cream forms) or oral. There are numerous topical preparations available and they often include the antiseptic benzoyl peroxide with an antibiotic such as erythromycin or clindamycin. This would often be the first line of treatment. Antibiotic tablets can be added in but it is important to remember that these usually need at least 3 months to take effect and improvements can be seen when these are used for longer periods. One of the most useful drugs in the fight against acne are oral retinoids (isotretinoin) This is a vitamin A derivative and works in many ways to dry up the skin making it less oily and reduce inflammation. It is generally a safe drug but like all medicines has side-effects. It usually dries up lips so plenty of barrier creams should be used. It can affect the cholesterol and lipid levels and can also alter the liver function tests seen in the blood also. This is why patients are monitored with blood tests during treatment. Oral retinoids cause severe damage to an unborn child and so pregnancy should be strictly avoided during treatment and one month after. Oral retinoids can initially flare up the acne and make it worse and so many clinicians start with a lower dose and build it up cautiously. There have been a few reports of depression and rarely suicide in users of Isotretinoin. Most clinicians enquire about this routinely but it has to be kept in mind that there is no hard scientific evidence for this risk and that acne can be a depressing disease in itself and so patients should seek and be offered medical help in the early stages to prevent scarring and disfigurement that may well be preventable.
Becoming Solution Focused in Acute In-patient Psychiatry Wards

Part 1 ______________________________________ Becoming Solution Focused

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This is one of two papers, in which the authors introduce solution focused brief therapy and describe the outcomes of training in Solution Focused (SF) techniques in Ireland.

In this paper, we look at engagement on acute in-patient wards, what it is and what can be done to make this a highly visible element of acute inpatient care. We argue that solution focused approaches can actually promote the quantity and the quality of engagement, as they provide a framework for a conversation and give the worker a range of useful techniques that validate the optimism and hope which form part of many mental health worker’s repertoire.

Practice Context
The authors have “steered” a practice development initiative in three Irish acute in-patient psychiatry sites, in Cork and Kerry between 2004 and 2007. This project is called “Refocusing Acute Psychiatry”. Refocusing has given rise to two national conferences (a third is planned for November 2007) and significant interest from other Irish acute units, the Health Services Executive, the Mental Health Commission, service users and those that represent their interests, chiefly the Irish Advocacy Network.

A central element of refocusing was the introduction of solution focused brief therapy skills, into everyday practice on five acute wards. A total of 10 courses were provided to over 120 staff, the majority of them nurses.

Engagement in Psychiatry
People requiring psychiatric help are commonly vulnerable, needy, disturbed and sometimes disturbing. This is particularly so for people who are hospitalised. Consequently, they require a high level of engagement from workers, including supportive interventions, one to one time and a range of social and therapeutic activities.

However, there are clear indications from professional, service user and independent sources that acutely ill people rarely receive this level of service, particularly in-patients. Instead, patients might receive little more than a few minutes per day with a worker (Mind, 2000). There is often a lack of structured group activities (Sainsbury Centre, 1998) and relationships with staff have been described as “passing” (Higgins, et al 1999) i.e. lacking in depth and not likely to help patients in their recovery nor helpful to the the staff in assessing and planning care appropriately. Yet there is good evidence to show that when nurses and other direct care workers do engage with patients, this input is highly valued by patients (Jackson & Stevenson, 1998).

There are numerous reasons for this lack of engagement, at personal, attitudinal, cultural and systemic levels. Also important and less difficult to grasp are lack of time and lack of availability of trained staff. Nurses routinely experience a high degree of “emotional labour” (Smith, 1992). The challenges inherent in working closely with distressed people and the possibility of an adverse event takes its toll on staff and may lead to distant, disengaged social behaviour and a lack of therapeutic availability.

Hence a “catch 22” is created, in which illness emerges, requiring engagement and close staff involvement. This engagement may be distressing to staff and is therefore avoided, leaving clinical needs unresolved and nurses frustrated with what remains of their role, a custodial / paternalistic guardian role that in some cases means little more than surveillance, risk assessment and the completion of medical orders.

One step towards resolving this catch-22, is an approach to engagement that is perceived as useful by patients and staff and which does not make excessive demands on the staff, it must be usable within the very short time that patients stay on the acute wards and suitable for use at a time when patients are at their most ill. Finally, this approach needs to be “trainable” in a short period of time, in order to reduce staff time away from practice and improve cost effectiveness.

Solution focused communication skills fit the bill in each case, as they are brief, may be trained in short and inexpensive workshops (for example the workshops described in this report take just two days, or in one case just a single day) and may be used in almost any social context, from a momentary encounter, for example over a drinks trolley to a more formal, sessional engagement of up to 40 minutes or so... There are almost no contraindications to the use of solution focused techniques other than the usual judgments an experienced worker may make about the patient’s mental state.

Are Nurses “Therapists”? Not unless their job title and training is to the level of “nurse therapist”. Most ward-based staff would not view themselves as “therapists” or describe themselves as such. Indeed, were they to do so there would be significant regulatory, grading, supervision and training issues. Instead of being therapists, most workers would probably wish for nothing more than a simple set of skills that could be dipped into and used in the course of their everyday work, without significant change to the pattern of their working day. This last point is crucial; it is pointless to train staff in skills that their workload does not permit them to use, a point which is still being learned by educators, commissioners and graduates of lengthy psychological interventions courses. We prefer the notion of “solution focused conversation” as it seems more appropriate and the word “therapy” can be intimidating and may also have unhelpful legal connotations. Some nurses may be therapists but solution focused conversation is something that all direct care workers in psychiatry can engage in. With a few days training workers may use solution focused conversation to construct meaningful and therapeutic dialogue even with people who might be very unwell, disorganised or who may have a very limited span of attention. So what does it involve?

Being Solution Focused
The solution focused approach is both radical and simple. Being solution focused means the worker seeks to elicit, amplify and reinforce patient strengths and resilience factors, in contrast to the deficit / illness model in which most of us have been socialised. The worker begins by seeking to collaboratively develop a vision of “preferred future”, i.e. to develop a picture of the patient in the near future when things are beginning to improve, this often motivates the patient and reminds them that they have often taken some steps towards their goal already, promoting their sense of competence. One of the fundamental techniques used to elicit this powerful vision of the future is the “miracle question”, see inset box below.

The Miracle Question
The miracle question is a technique that builds, enhances and maintains co-operation. It enables the client to develop a vision of how life might be if their immediate problems were diminished or absent. Patients and workers usually like this question as it builds rapport and provides structure, direction and meaningful conversation that are positive and constructive.
Suppose that tonight, after our talking together, you go home and fall asleep. While you are sleeping something happens that takes away the problems that brought you here today. When you wake up in the morning what will be some of the first things you will notice that will be different that tell you this miracle has happened?

Patient and worker then work with this motivation within a spirit of optimism, hope and a belief that change and improvement is possible. This sort of interaction may be termed a “constructive conversation” which is founded on the belief that simply talking about problems, deficiencies and deficits will not be sufficient to mobilise change in the patient, indeed this sort of conversation can just “dig you in deeper” as one nurse commented to us.

Solution focused conversations are structured (see inset box) and make comparatively light demands on the worker. Consequently staff experience reduced emotional labour and work strain when using solution focused techniques (Bowles, et al 2001) and are more likely to engage and to continue doing so, experiencing a sense of worth and a much needed reminder of their own value, as therapeutic agents.

Elements of a session
1. Introductions – who you are, how you like to work, the importance of taking a short break before the end of the session
2. Problem-free talk
   This is gentle conversation about whom and what matters to the client, how they spend their time, how were things before they became less well). It indicates an interest in the person rather than the problem, it provides evidence of their resources and their past successes / achievements.
3. Business questions, called this because they are about getting down to business, these include:
   How will we know this session has been useful to you? Followed by questions as to the patient’s own goals and hopes for the immediate and near future.
4. Miracle question (see above)
5. Scaling - A measure of progress against client goals
6. Exception questions - Questions that seek to identify what the client is already doing to move towards their preferred future (what aspects of the miracle are you already doing or experiencing?) and ways they have of coping with set-backs or ongoing difficulties.
7. Break - A chance for you to consider the main points learned during the session and to decide on the feedback.
8. Feedback - Providing client with a constructive message regarding useful things they are doing and may be prepared to do in future. Acknowledgement of difficulties involved and the hard work needed.

The relationship between “recovery” and solution focused approaches

Summary
Structured, high levels of engagement make for more therapeutic, calmer and more constructive therapeutic relationships. Solution focused techniques are quick, easy and cost effective to learn. They provide a structure for effective, brief interventions with a wide range of patients, including the very ill and are effective in promoting collaboration and patient responsibility without making a huge drain on the worker. Effectiveness across the spectrum of mental health problems is comparable with other brief therapies and likely to be superior to long term in-depth approaches, without the significant resource that such therapies require in training and supervision. In short, SFT is effective, cost effective and well liked by workers and those with whom they work. In the next section the trainability of SFT is discussed.

References
Midwife Denise Byrne age 33, from Dublin, Ireland, spent three months working in a clinic in a camp in Chad for refugees from the neighbouring Central African Republic, delivering babies to some of the poorest mothers in the world.

“As we drove away from the camp for the last time, my heart was aching. Three months in Chad; it wasn’t long, but it was long enough to let the people and the place get under my skin and make a permanent home there. The journey from the base in Goré to the camp - the 0 km which I traveled numerous times a day, and which I was now doing for the last time, had always been a time of introspection for me. A time to analyse my day’s work: on the way there what my plans would be; on the way back what I had achieved; or - often - what I didn’t get the chance to achieve. The decisions I made: could I have done more? Should I have done anything different to save that life? Questions that would often torment me, that I never seemed to have adequate answers to.

Before leaving to Africa with Medecins Sans Frontieres, I had been working as a community Midwife in one of Dublin’s main maternity hospitals. Our focus was to provide a holistic and natural approach to childbirth by offering the option of a homebirth or hospital birth in a non clinical setting.

I knew before going to work in Africa it was going to be difficult. But nothing could have prepared me for the poverty and the lack of resources I witnessed when I reached Chad. Until I arrived, there had been no maternity services in the camp. Most women would have their babies at home attended by a traditional birth attendant (TBA) who has this role often by virtue of the fact she had 10 children herself. These TBAs had no medical training, very little understanding of basic hygiene practices eg. Handwashing, they had no gloves and no instruments to work with, and they used some very outdated and dangerous practices.

If women were having difficulties in childbirth eg. Prolonged labour or bleeding they were sent to the clinic in the camp by the TBA where they were looked after by nurses who had very little midwifery experience. The maternity facility consisted of a cordoned off area in a large tent. It was big enough for a bed and a table and two people. It was stifling hot at least 5 degrees hotter than the temperature outside which often reached 45°C. There was no sterilisation of instruments in place. My first birth in the camp saw me sweating flies off a baby’s head as it was crowning and still in the birth canal.

Some of the women could travel 80 kms or more to get to the clinic. Some of them had fled their villages in fear, arriving with not even shoes on their feet, having left all their hard earned belongings, their beloved homes and worst of all, murdered family members behind. The maternal mortality statistics for the population of women I looked after (ie. the Central African republican population) are amongst the worst in the world.

- Life expectancy for a woman is 40 years of age.
- 1:15 women will die in childbirth.
- 3:10 children will die before the age of 10.
- There is a 13% incidence of AIDS.
- 2/3’s of the population live on less than $1USD per day.(UNICEF 2005)

15 year-old Hawa, one of the most beautiful women I have ever seen, came into the clinic one day in premature labour. She was accompanied by her sister, mother and grandmother. She was very frightened and crying. As she didn’t speak French I had to send for someone who could translate for me. In the meantime I did a cursory examination, she was burning with fever which later turned out to be malaria, which would account for why she had gone into premature labour.

The labour had started 3 hours previously. Her grandmother knew there was a problem as Hawa had a small bleed and she could see the baby was still small and so brought her to the clinic.

Infection in pregnancy can be a very common inducer of labour. In the western world due to excellent ante natal care we can diagnose infections before they become a threat to the fetus. However in Africa due to poor medical care, limited resources, lack of education and displacement due to wars, ante natal care is often neglected. Malaria is the biggest killer in Africa and is especially dangerous in pregnancy. One of my first tasks after arriving was to start an ante natal clinic and provide education and medical prevention of malaria. It was hard for me to establish how many weeks pregnant she was as she had such a tiny frame and absolutely no idea when her baby was due. As I did not have the luxury of ultra sound scanning to estimate the baby’s size, I had to rely on a measuring tape. By measuring from the top of the bump (the fundus) down to the pubic bone the measurement in centimetres is roughly equal to the weeks of pregnancy. Hawa measured at 33 cms thus indicating to me she was at least 7 weeks off term.

There was nothing I could do to stop the labour. She was already 6 cms dilated and her waters had broken.

Being in a refugee camp we had no oxygen, no incubators, not much of anything really. I didn’t hold out much hope for this baby’s survival. I explained this to Hawa and her mother and grandmother who were with her. They accepted it stoically, and put their faith in God. They just wanted Hawa to be safe and well - I promised them she would be. Baby Hawa Jnr. was born weighing all of 1.2 kilograms, with the finest set of lungs I had heard in a long time. Even though she was very small my attitude changed: this baby had a very good chance, she was strong, alert and in very good state. I explained this to Hawa and her mother and grandmother who were with her. They accepted it with a sense of relief.

I suggested putting a feeding tube through the baby’s nose into her stomach to feed her breast milk as she was too feeble to suck. It would mean that Hawa and her baby would have to stay in the camp for at least a month. A family conference was held - for a Peul family conference was held - for a Peul family - for the baby to be brought to the clinic. baby to be brought to the clinic. They agreed and on the day that long was finally heard of. They are a nomadic people and not given to staying put for a long period of time. They asked what the baby’s chance of survival would be if Hawa took her straight home. I told them it was very slim as the baby would not be able to feed since she couldn’t suck. But I explained that if Hawa stayed with me, there would be a very high chance she would be able to go home in a month with a healthy baby. A decision was eventually reached: Hawa and Hawa Jnr. would stay!

The next six weeks were frustrating. The nurses repeatedly explained to Hawa the importance of feeding her baby every three hours with...
the correct amount of milk, while she just wanted to go back to her family. She shed a lot of tears. Many people were uncertain that the baby would make it. But - finally - Baby Hawa Jnr. went home weighing 2.2 kilograms and sucking very well.

The whole family came to escort her home - about twenty people. Her hair was braided and sweet-smelling oils were rubbed into her skin. Baby Hawa wore a new gleaming white baby-grow that I had given her (my mother sent over regular supplies of baby clothes). It was about ten sizes too big! Her head was shaved except for the obligatory tuft in the centre. Her eyebrows were painted in kohl, which gave her a slightly hysterical look but of course made her look even more gorgeous! Amidst songs, dancing, hugging, kissing and hand clapping, the procession left the clinic and danced their way home.

My thoughts are interrupted by the car radio. It is the midwife in the camp calling me back. She has a woman in labour and there is a problem. We turn the car around and go back to the camp and I laugh to myself thinking that my work will never finish. I still have to pack my bags and be ready to leave at midday.

It is already 10.30 and we are an hour away from our house.

I arrive back at the camp. The woman is pregnant and in labour with her seventh child. She has been in labour for two days but lives in one of the villages far from the camp. Her family had just carried her for two hours. It is clear the woman is in obstructed labour and the baby’s heartbeat is very slow. I was so thankful that a month previously MSF had started a surgical programme an hour’s distance from the camp.

We set off along the worst of roads, this poor woman exhausted and contracting strongly. I radioed ahead and when we got to the hospital the surgical team were ready and waiting. When the baby was born it wasn’t breathing and his heart rate was less than 60. How wonderful to have a paediatrician taking control of things! When the baby let out its first very disgruntled cry, I could hear his grandmother outside crying her thanks to God.

I had to run - it was already 11.45 and I still hadn’t packed. I checked on the mother while the surgeons were sewing her up - she was very happy and tired. I rushed to say goodbye to the grandmother, and she clasped my hand in hers.

I made it back to the house with not much time to spare, threw my bits into my back pack and started off for my long journey home. I don’t think I will be able to put in adequate words the myriad of emotions I experienced coming home. The joy at seeing my fiance, family and friends, coupled with the sense of sadness and guilt at leaving behind all those I had worked with and cared for.

What would their future would be?

I remember one of my first days back home walking down the main street in our town and wondering what felt so strange, then it struck me, no one was smiling, no one was greeting me with ‘hellos’, everyone looked stressed and cross!! In Chad despite the poverty, the grief and the harsh living conditions, people always smiled, they had time for each other, they cared about each other, and they appreciated the small joys that a day can bring, joys that we often take for granted. They really understood the concept of living for the moment because all they had was the here and now, the future is so filled with uncertainty, even down to not knowing if they would have food for dinner.

Starting back in work was like starting as a new midwife again. I had a completely different attitude to childbirth. No longer did I take for granted that women and babies are generally healthy and well. I had always preached ‘pregnancy is not an illness’ yet now I felt the contrary. For many women in Africa pregnancy is a death sentence for them or their baby or sometimes both.

It took me some time working with my fantastic colleagues, assisting in the safe delivery of healthy babies for me to get back that joy and celebration of midwifery. One thing is sure, I take nothing for granted and I appreciate every day that I was born in a wealthy country.

When I left Chad I left a huge portion of my heart there, and every day it’s pulling me back, the tugs seem to be getting stronger. I think it’s about time to start dusting the old back pack down!
A Management problem.

Type 2 diabetes creates a management problem. The number of people with impaired glucose intolerance in Britain is increasing and up to 72% of them may proceed to type 2 diabetes. 2 million currently have the diagnosis with the number anticipated to reach 3 million within the decade. (Diabetes UK 2005) The increase in prevalence of this disease is driven by

- advancing age
- increase in obesity,
- related impairment in glucose tolerance
- insulin resistance in the population (Diabetes atlas 2003)
- decreased beta cell function
- insulin resistance.

The Management Challenge

These patients unlike type 1 diabetics, who do not produce enough insulin, often produce insulin but their bodies cannot respond to it properly i.e. they have become resistant to their own insulin. The body does not efficiently use the insulin it produces to control blood glucose levels, which promotes hyperglycaemia and with it, the micro and cardiovascular changes associated with the disease. This trend and the need to prevent serious complications, causing much morbidity and premature death, have determined Government initiatives promoting early, effective intervention, to halt progression of this illness (BMA 2006).

Gps. bear the brunt of this therapeutic challenge and overburdened, have frequently responded by delegating attached nursing staff to intercede on their behalf. Many Practice Nurses have acquired the skills and competence to identify and manage potential diabetics and primary care diabetic clinics run by nurses are well established. However, Gps’ and nurses struggle to manage these patients appropriately and make the best use of their knowledge and skills within the practice protocols.

Appropriate therapy.

Metformin a biguanide, is widely accepted as first line oral treatment of type 2 diabetes is now available. New agents more directly target the underlying pathophysiology of a condition, now understood to be a combination of insulin resistance and pancreatic islet dysfunction (Barnett A. 2006). Mode of drug action.

Metformin - inhibits hepatic glucose production

• Increases hepatic insulin sensitivity
• Reduces lipotoxicity
• Lowers production of hepatic glucose

Sulphonylureas

• Stimulate insulin secretion
• Stimulate insulin biosynthesis

Thiazolidinediones

• Increase muscle insulin sensitivity
• Stimulate favourable at distribution
• Suppress free fatty release
• Improve insulin sensitivity. (Heine J 2006)
control and target. and third line applications will find satisfaction in treating patients to of drug regime progression and differing modes of action of second control and reduction in patient risk,. Nurses with an understanding but the options make for a more certain satisfactory treatment out- care remains a complex exercise. Development of new classes of drugs and despite improved understanding of the condition, good patient The management of the diabetic patient has always been a challenge The use of three medications together can bring significant contraindications. Glitazones should not be used if there is Contraindications. Glitazones should not be used if there is HBA1c is above 7.4 %. Glitazones can cause weight gain but may lead to dramatic improvement in HbA1c Full effect may take three months to appear. They target a fundamental defect of type 2 diabetes. Initially insulin resistance develops leading to hyperinsulinaemia, but as the disease progresses pancreatic beta cell mass reduces, insulin levels fall, which cause a rise in blood glucose. The glitazones act on an intranuclear hormone receptor (PPARgamma ) directly targeting insulin resistance. They also have similar efficacy in blood glucose lowering to metformin and sulphonylureas but also improve blood pressure and lipid profiles, with a reduction in serious cardiovascular endpoints. Their usefulness in second and third line therapy has been established but a as well as weight gain a side effect is peripheral oedema and they should not be used in anyone with a history of heart failure. If metformin treatment titrated up to 2 G. daily is insufficient, a glitazone or sulphonylurea can be added second line . If two agents at maximal dose are insufficient to control hyperglycaemia, all three can be used together. With sulphonylureas working within a few days, metformin a few weeks and glitazones in a few months, there is continuing need for prolonged close monitoring. This task usually falls to the practice nurse who requires an understanding of drug mechanisms and regimens to provide good patient care. A recent report (PROActive2006)has shown sustained beneficial impact on glycaemic control when pioglitazone is added to metformin and sulphonylureas and sometimes insulin therapy can be avoided or postponed with this combination. The dual therapy gives patients greater glycaemic control with some being able to drop the metformin or sulphonylurea from the regimen over a 3 year period of treatment(Charbonel B.2006) PROActive. (Prospective pioglitazone clinical trial in macro vascular events ) has also shown in a randomised, double blind, placebo controlled, outcome study (S238 people with both type 2 diabetes and macro vascular disease ),that an oral glucose lowering agent has beneficial impact on the risk of occurrence of some cardiovascular events. The incidence of recurrent stroke was reduced by 47% and combined risk of myocardial infection, death or stroke by 28%. Patients with diabetes are at increased risk of stroke with the risk 2-4 times higher than in the general population. (Stokes1987) a consideration when contemplating preventive treatment. The Chicago study also showed a halt in the progression of atherosclerosis in the carotid artery, as indicated in carotid artery intima thickness, in type 2 diabetes patients taking this drug) (a thickened carotid artery intima-media layer is a surrogate marker for heart attack and stroke) Most of those had no clinical evidence of disease.(CHICAGO 2006). This product has now been approved for use in triple therapy with metformin and sulphonylureas and is no longer contraindicated for use with insulin The use of three medications together can bring significant improvement in diabetic control in those not reaching target with dual therapy. Current metformin or sulfonylurea dose can be maintained or initiation with a thiazolidinedione, such as pioglitazone started at 15mg daily and increased in increments to 45 mg daily to obtain glycaemic control. The use of three drugs in a regimen may dismay some prescribers but, if agents with different actions which complement each other are likely on sound evidence, to establish good glycaemic control, then they should be utilised to achieve mandated targets. If despite this multiple therapeutic approach hyperglycaemia remains uncontrolled, then insulin treatment will be required. Contraindications. Glitazones should not be used if there is current or history of cardiac failure hepatic impairment. use with insulin should not be used with non specific anti inflammatory presentations They can cause fluid retention and weight gain but no drug adjustment is needed in elderly patients. The management of the diabetic patient has always been a challenge and despite improved understanding of the condition, good patient care remains a complex exercise. New classes of drugs for glucose lowering has added uncertainty to therapeutic approaches, but the options make for a more certain satisfactory treatment outcome. The demands of triple therapy can be daunting for prescribers and treatment monitors. Its application can however bring glycaemic control and reduction in patient risk. Nurses with an understanding of drug regime progression and differing modes of action of second and third line applications will find satisfaction in treating patients to control and target.
IPA’s MA celebrates its tenth birthday

This year, the Institute of Public Administration’s MA in Healthcare Management programme will celebrate ten years of activity since its first graduates were conferred in 1997. The MA programme aims to improve participants’ understanding of healthcare management and of key disciplines relevant to management and to enhance participants’ potential contribution to the Irish health sector.

In the last decade, MA graduates have included personnel from all parts of the health services and notably many nurse managers from areas such as acute hospital services, community services, long-term care and nurse education. Lecturers on the MA programme have also included a very wide range of healthcare practitioners from Ireland and overseas.

The MA course, which is accredited by the National University of Ireland, is a two-year part-time programme delivered on a distance learning basis. The course is designed for managers already working in the health sector. MA students attend seminars mostly at weekends and receive extensive programme material. The course seeks, particularly through classroom discussion and group work, to tap into the extensive knowledge and experience of the course participants. The distance learning delivery method facilitates busy health professionals and managers who nevertheless wish to pursue further study.

Year One is divided into two semesters and is devoted to the study of key disciplines in public management – for example, economics, financial management, managing human resources and organisational analysis.

In Year Two, which is also divided into two semesters, MA students focus on healthcare management and take courses in health strategy and policy, comparative healthcare, managing for health and social gain and health economics and finance.

In the second semester of Year Two, students must also complete a dissertation on a current healthcare management issue – i.e., do their own research on a current issue.

For further information about the programme, please contact acrehan@ipa.ie or tosullivan@ipa.ie or call the IPA on telephone 01 2403600.
The Institute of Public Administration is the Irish public sector management development agency. This autumn, we offer the following National University of Ireland (NUI) accredited programmes catering to the educational and career needs of staff in the Irish Health Services. Managers, administrative and technical personnel across all disciplines in the Health Services have undertaken these programmes as an integral part of their professional development.

**CERTIFICATE IN HEALTH SERVICES**

This programme will familiarise you with the current health service reform process and major health policy documents. It provides a comprehensive understanding of the Irish health service, health and related legislation and current service issues affecting the key programmes and care groups.

It is designed for staff from all disciplines working in the health services who wish to broaden their understanding of the structure and function of the Irish health system. This programme would also benefit staff coming from other health systems who wish to familiarise themselves with the Irish health service.

**DIPLOMA IN HEALTHCARE MANAGEMENT**

This 18-month programme addresses the core areas of management competency for health sector managers such as: *planning & managing resources; being a leader; creating team spirit; influencing people and events.*

The Diploma will be of interest to those who have recently moved into management roles in the health sector, or existing managers who wish to formalise and develop their management skills in a healthcare context. Students of this Diploma who gain a merit or distinction will be admitted to the third year of the Institute’s BA programme.

**DIPLOMA IN HEALTH SERVICES POLICY**

The Diploma has been designed as a development of, and follow-up to the Certificate in Health Services. It will provide a more in-depth and analytical treatment of the health services and build on the foundation coverage of health services and policy provided by the Certificate.

The course is intended to be another important step in the career development path of health care staff who are working in the context of the current reform process in the Irish Health Services. Graduates of this Diploma can progress to year 3 of the IPA’s BA programme after first completing a bridging studies course.

**BA & MA IN HEALTHCARE MANAGEMENT**

These programmes aim to raise the level of analysis in Irish healthcare management and thereby to enhance participants’ ability to manage effectively at the most senior levels of the Health Sector.

The BA is a four year part-time programme that is delivered via distance education or attendance at evening lectures. The Masters programme is a two year part-time programme that is delivered through a blend of distance education and attendance at weekend seminars/workshops.

**ACCREDITED CERTIFICATE AND DIPLOMA PROGRAMMES**

In addition to the above Health specific courses, the IPA offers an innovative suite of accredited programmes in the following areas. Many of these programmes are offered on a distance learning basis and are accredited by the NUI and/or other professional bodies. Programmes are offered at Certificate and/or Diploma level in:

- Audit Skills
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- Human Resource Management
- Management Development
- Managing Change
- Managing Modern Public Service Delivery
- Organisational and Workplace Mediation
- Personal Effectiveness and Managing Performance
- Project Management
- Public and Strategic Procurement

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Tel: 01 240 3666  Email: training@ipa.ie  Web: www.ipa.ie/training
The Health Service Executive Transformation

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Introduction
Over the last number of years the Health Service Executive of Ireland has been in a state of reform. This stemmed from the Brennan report (2003) which identified an absence of any organisation responsible for managing the health service as a unified national system, systems which were not designed to develop cost consciousness among those who make decisions to commit resources and provide no incentives to manage costs effectively, insufficient evaluation and analysis of existing programmes and related expenditure and inadequate investment in information systems and management development. Thus the then Irish Health Boards reformed into the current Health Service Executive. It has now been recognised that in order to sustain this reform its objectives need to be re-aligned in light of the current health care climate in which we live and learn.

It is recognised that the population of Ireland is ageing with an estimated life expectancy of 87yrs by 2036 (Central Statistics Office). While this longevity is welcomed it also brings extra health care requirements. Longevity does not necessarily equate with health in that people may be growing older but this may be in a poor state of health. Further to this the society in which we now live also demands high standards of care and a readily accessible health service. Thus the reform programme has been re-named the “Transformation Programme 2007 – 2010”. This three year plan focuses its goals on “enabling people to live healthier and more fulfilling lives”. The vision for the future is to provide accessible services thus raising public confidence whilst recognising the pivotal role which staff can play and thus be proud of their work. Following wide consultation with all stakeholders, six transformation priorities have been identified:

- Develop integrated services across all stages of the care journey
- Configure Primary Community & Continuing Care (PCCC) services to deliver optimal & cost effective results
- Configure hospital services to deliver optimal & cost effective results
- Implement a model for prevention & management of chronic illness
- Implement standards based performance measurement
- Ensure all staff engage in transforming health & social care

These priorities clearly outline the changes which need to be made across all levels of organisation of the health service executive.

Organisational Change
Coghlan & McAuliffe (2003) believe that for healthcare organisations to work in harmony, all levels within the organisation need to work together and need to have the knowledge and skills to effectively manage each level and between each level. There are four main levels in organisational change: the team level, the individual level, the organisational level and the inter-departmental level. Each level has a task to do in order to achieve successful transformation. The individual is responsible for bonding, the team focuses on functioning, the inter-departmental level coordinates and the organisation adapts. It has clear that the “Transformation programme” has recognised these layers in order to successfully navigate organisational change. It is believed that a particular type of leadership focus will be required in order to achieve these aims.

Explaining “Transformation”
Transformational leadership has been recognised as the method of leadership most appropriate to healthcare (Sofarelli & Brown, 1998; Demings, 1987 & Kouzes & Posner, 1995). The principles of transformational leadership include: vision, trust, participation, learning, diversity, creativity, integrity and community (Brown, 1996). Burns (1978) offers that this style of leadership seeks to satisfy needs and that it involves the whole person and the follower with the result that there is a mutual relationship between both the leader and the follower. Transformational leadership uses charisma in achieving its goals. It is believed that a leader with charisma can provide a vision and direction for his/her followers. Encouragement and praise for achievements are essential in the success of this style and lead to the gained trust and respect from the team thus improving the motivation and overall morale of all those being led. Looking to the HSE’s “Transformational Programme” it is stated that respect for colleagues and praise for successes will be fundamental in the future management of the organisation. It is thus clear that the elements of this reform programme hinge very tightly on a transformational leadership ethos.

Transformational leadership requires flexible and adaptive people (Hein, 1998). Effective leadership thus requires an ability to put financial and human resources together to create added value for the consumer and the employee.
This has been shown to require flexible organisational forms and good quality relationships whilst maintaining the ability to experiment with new ways of working and avoiding hierarchy. Leaders inspire staff to contribute to the organisations mission. The new mission for the HSE is to enable people to live healthier and more fulfilled lives and its vision is for easy access of services, customer & staff confidence and staff pride.

Going forward: The way we work

The HSE transformation programmes has identified that to be successful the actions and behaviours of its staff must be consistent and must reflect the HSE values. Health Care organisations across the world require staff to be flexible, innovative and dynamic in response to the ever-changing health and social care needs. Motivation therefore is a key element in sustaining that drive. Abraham Maslow (1954) is considered the guru of motivation and he identified the “hierarchy of needs” which recognised that physical needs are met first then all other needs are consecutively met with the general aim of reaching self-actualisation. The identified factors are essential in motivating staff included individual attention, achievement of goals, and personal growth and development. This begs the question: how does one motivate employees, in the face of increased demands and potentially less resources? It is offered that if employees feel secure, needed and appreciated enhanced motivation and commitment is possible. The HSE transformation programme recognises that in order to achieve success that all members of staff should respect the skills and abilities of others, use feedback to motivate each other, share resources and actively support each other; be interested in the development of those we work with, be flexible and courteous and aim to be innovative and lead by example. Rolland (1989) offers that motivation will be enhanced if nurse managers support and facilitate the development of clinical nurses’ professional autonomy thus contributing to a more innovative and dynamic workforce with a greater quantity and quality of work and lower absenteeism and staff turnover rates.

Conclusion

It remains to be seen if the HSE can deliver on this “Transformation Programme” but it is stated clearly that all employees across the executive are responsible for effecting these reforms and that we must “seek solutions, not excuses, set challenging goals and do what we say we will do, maximise resources, be accountable and deliver on our responsibilities”.

References

Last week I claimed a breakthrough in my fight to get fit and lose weight. I ran 3km every day, something I thought I’d never do. Now I’m wondering (though please don’t hold me to it yet) if I’ll ever be able to run a fun-run or even a mini marathon, perhaps even this year?

Before I get too excited, though, let me quickly remind myself that it wasn’t quite a continuous run; it was three minutes running followed by two minutes walking, so completing the 3km in thirty minutes or so. But it’s a major milestone for me, because I remember adding a ten second run to my daily walk just six months ago, and feeling that I’d die from exhaustion. I really did sit on the edge of the treadmill, purple faced and panting, thinking of reporting myself to the RSPCA for cruelty to beached whales and almost giving up. But I stuck at it, added five seconds every fortnight and, it worked! Perhaps I wouldn’t have stuck at it so grimly if I hadn’t had a buddy, in this case my trainer, Steve.

It helps if you have someone else egging you on (not nagging you, just encouraging your own ideas!). Anyone who might have watched me in that awful programme on ITV (Celebrity Ugh Club), will remember that I really hate being told what to do. And I loathe even more being ordered to do it. But I wanted to prove to myself that I could jog. Besides, I would go to the gym, and walk for thirty minutes, whilst watching slim, lithe, young ladies do a quick ten minute run, work off more calories than I did in my half hour of walking, and then buzz off. That’s for me, I thought. If I can get my daily exercise into a ten minute jog, then I might be able to fit it into my daily routine, as the experts recommend.

A buddy is also great for stopping you from fooling yourself. You can’t boast you exercise every day, or you eat a totally healthy diet, if you have a buddy who knows that she last saw you at the gym six weeks ago and then you were helping yourself to a chocolate muffin at the coffee bar!

According to a recent study in America, we weight losers are brilliant at deluding ourselves.

They asked 11,000 seriously overweight adults about their eating and exercising habits. Three quarters of them said they had healthy diets and 40 per cent of them reckoned they did vigorous exercise at least three times a week. When their families were asked about them, it appeared that these men and women were kidding themselves.

Former President Bill Clinton admitted the same when he recently launched a ten year initiative to reverse America’s obesity epidemic. (It requires millions upon millions of people and a long time frame.)

Interesting what he said about babies, because American studies show that their babies are getting bigger and bigger; and paediatricians are wondering whether intervention, at baby clinic level would be intrusive or helpful.

True, many chunky babies grow into slim, healthy adults. But if a baby comes from a family which is predisposed to obesity, should questions then be asked about the family’s lifestyle and eating habits?

No-one’s suggesting putting babies on diets, but does a family’s eating habits become ingrained in that infant from day one? And should we be thinking of ways to stop bad habits taking root? Or is that Nanny State gone too far?

I keep quoting studies from America (because, let’s face it, that’s where the obesity volcano started and is still erupting) but this week, there was more research from Bristol and Glasgow universities showing a distinct link between childhood obesity and watching TV. Perhaps Nanny State has to find a way to lure us from our TV sets and play (and exercise) outdoors, though with the tragic disappearance of little Madeline McCann, I suspect more parents will prefer to keep their children inside, passively ogling The Teenies.

It’s clear that we can no longer afford to talk about the child obesity epidemic without factoring in screen time, and the Americans have even come up with an initiative for that, a family based programme called “Switch”, working with schools and communities to give kids advice about food, something to do, and a reason NOT to watch TV all the time! I must say, I rather like the slogan - “Switch what they Do, View, and Chew!” We’re going to need that sort of thing here very soon. I hope Bill Clinton comes with it!
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Infection Control

Deborah has worked as an infection control nurse since 1998, working both inside and outside the NHS in both acute and non-acute settings. She now works outside the NHS for a national organisation across England, Scotland and Wales.

Specific learning objectives for this section:

By the end of this section the student will be able to:

• Describe some of the devices that may be used to administer IV Therapy
• Describe the main routes of infection in IV Therapy
• Describe the technique for the insertion of IV devices and their subsequent care

The use of any intravenous lines is associated with several complications including infection. These can be infections at the site of insertion, bloodstream infections, tunnel infection or endocarditis. Sources of infection are both endogenous (from organisms already on or in the body) and exogenous (originating outside the body) in nature and can be due to intrinsic or extrinsic contamination.

Intrinsic contamination is that which is present prior to the use of the IV device such as due to poor storage, for example.

Extrinsic contamination is that which is introduced during use of the device, including insertion and removal, such as through poor practice.

In addition to this, there are three main routes by which micro-organisms might gain access to the IV system:

• Extraluminal – microbes gain access via the outside of the catheter into the insertion site
• Intraluminal – microbes are introduced directly into the catheter, giving set or fluids
• Haematogenous – when microbes from other areas of the body are transferred by blood flow

Types of IV device

There are several different IV devices which can be used for a variety of purposes such as the administration of fluids and drugs and patient monitoring. These include:

• Peripheral venous catheters (PVC) – the commonest method of delivering IV therapy, usually for short-term use (up to 3 days) in a peripheral vein
• Peripherally inserted central catheter (PICC line) – used for up to a month
• Non-tunneled central venous catheter (CVC) – for venous access and monitoring, typically short-term
• Tunneled central venous catheter – usually for long-term IV therapy with a lower risk of infection

Insertion Sites

The site of insertion of an IV device can affect the risk of subsequent infection. In order to minimise the risk of infection, the following recommendations are made, as long as not medically contraindicated:

• Peripheral venous catheters (PVCs) – upper rather than lower extremities, avoiding areas of flexure
• Central venous catheters (CVCs) – the subclavian has a lower risk of infection compared with the femoral or jugular sites

Infection Control when Inserting an IV Device

Insertion of any IV device mentioned above requires an aseptic technique. Hands must be decontaminated prior to placement of an IV device. Local policies may vary.

Peripheral Venous Catheters

1. Collect all required equipment
2. Select IV device of correct size for length of requirement and purpose of device. Choose the smallest practical gauge of catheter as large gauge catheters may occlude blood flow, cause irritant or chemical phlebitis or friction or mechanical phlebitis
3. Confirm patient’s identity and communicate what you are about to do
4. Decontaminate hands
5. Wear clean gloves
6. Position patient and select insertion site
7. Apply tourniquet
8. Disinfect skin for at least 30 seconds with an alcohol wipe and allow to dry (ICNA 2001)
9. Remove catheter from packaging
10. Insert into vein with bevelled edge up
11. Secure in position using an appropriate dressing that is transparent, self adhesive, sterile and semi-permeable
12. Secure in position using an appropriate dressing that is transparent, self adhesive, sterile and semi-permeable
13. The following should be documented following insertion/removal of a peripheral catheter: Date of insertion, type of device inserted, type of insertion, site, name of person inserting, date of removal, reason for removal, name of person removing, culture results, daily inspection of site
Central Venous Catheter (CVC)

1. Select the appropriate device
2. Decontaminate hands
3. Wear sterile gloves and protective clothing
4. Carry out in a designated clean area wherever possible
5. Disinfect skin. The epic Project recommends the use of alcoholic 2% chlorhexidine gluconate (in 70% isopropyl alcohol) solution for this and allowing the area to dry before inserting the device. For patients with a chlorhexidine sensitivity, alcoholic povidone-iodine is recommended
6. Select the appropriate site
7. Maintain principles of asepsis
8. Following insertion, secure with appropriate dressing and document

Selecting a CVC

- Wherever possible, a single lumen catheter should be inserted unless multiple ports are essential for patient management
- If TPN is being administered via a CVC, one CVC or lumen should be used exclusively for that purpose
- If long-term vascular access is anticipated (3-4 weeks), a tunnelled catheter or implantable vascular access device should be used
- A CVC which is impregnated with an antimicrobial/antiseptic agent may help prevent catheter related bloodstream infections in short term central venous catheters where the patient is at increased risk of a catheter related bloodstream infection (CR-BSI)

IV Catheter site care - general principles

For all devices, the following guidelines for management apply in order to minimise the risk of infection, though local policies may vary:

- All sites should be observed at least daily for signs of infection such as erythema, tracking, oedema/swelling, heat, pain/tenderness, purulent drainage
- All lines should be checked for patency before each use by flushing with 5 mls 0.9% saline
- If any signs of infection are noted, the line may need to be removed
- The number of manipulations of the device and any attached lines should be kept to a minimum. An attempt should be made to determine the number of lumens required and the number kept to a minimum.
- Hands should be decontaminated and gloves worn prior to any line manipulation
- Access ports should be disinfected according to local policy (usually with alcoholic chlorhexidine gluconate) before and after accessing the device.

- Any equipment in contact with the device and lines should be sterile
- If a cap is removed, it should be replaced with a sterile one. All components used must be compatible.
- Where a PVC needs to be replaced, it can either be inserted over a guide wire in the existing site or in a new site, depending on whether the catheter is being removed because of infection.
- It is advised that 0.9% normal saline be used to flush and lock catheter lumens unless otherwise recommended by manufacturers.
- When a vascular device is replaced, all connecting tubing should also be replaced
- IV tubing can be replaced every 72 hours unless otherwise indicated e.g. disconnection
- IV tubing used to administer blood or blood products should be replaced either at the end of the infusion or within 12 hours of starting, whichever occurs first. Administration sets for total parenteral nutrition are changed every 24 hours although this may be extended to 72 hours if the solution only contains glucose and amino acids.
- In-line filters are not routinely recommended for the prevention of infection in CVCs.
- IV site dressings should be replaced as clinically indicated. A transparent non-occlusive, semi permeable dressing is preferable. Sterile gauze dressings may be used in the presence of excess exudates or sweating although this may limit inspection of the puncture site. An alcoholic chlorhexidine solution is used to clean the insertion site and surrounding area during dressing changes in CVCs. Check compatibility of cleansing solutions with the catheter material
- IV tubing used to administer blood or blood products should be replaced every 72 hours unless otherwise indicated e.g. disconnection
- Administration sets for total parenteral nutrition are changed every 24 hours although this may be extended to 72 hours if the solution only contains glucose and amino acids.
- In-line filters are not routinely recommended for the prevention of infection in CVCs.
- IV site dressings should be replaced as clinically indicated. A transparent non-occlusive, semi permeable dressing is preferable. Sterile gauze dressings may be used in the presence of excess exudates or sweating although this may limit inspection of the puncture site. An alcoholic chlorhexidine solution is used to clean the insertion site and surrounding area during dressing changes in CVCs. Check compatibility of cleansing solutions with the catheter material

Care of a CVC in the Community Setting

One aspect of the NICE guidelines (2003) was the care of patients with central venous catheters. The principles are the same as those in acute care including hand decontamination, the principles of asepsis and the type of dressing that should be used.

Work based activities

- Identify the main IV dressings and devices used to administer IV therapy in your area and discuss their qualities with senior staff and the suppliers representatives
- Observe an experienced member of staff as they undertake the insertion of the various IV devices outlined in this section
- Make a point of reading your local policy on IV Therapy and the management of IV devices

References
ICNA (2001) Guidelines for preventing intravascular catheter related infection

www.scottishirishhealthcare.com 29
Introduction
Pressure ulcers are a major cause of morbidity in the population, yet it is largely an unseen problem. It is known that the treatment and prevention of pressure ulcers is costly to health services, but as yet there is still little information on precise costs. Moreover, there is a cost to patients of pressure ulceration, both in financial terms, but also in terms of their quality of life. This paper will review some of the key evidence in respect to both the costs to society and the costs to individual patients.

Measuring the burden of pressure ulceration on relatives and carers
It is important examine both the costs of providing the health services to patients suffering from the disease in question, but also to determine the costs to patients and relatives since care falls increasingly outside the formal health services, and on to patients and their families. Indirect costs should be derived from estimates of lost production by the patient or family members caused by the disease, losses to society caused by the patient being unable to function to their potential, and quality of life issues, particularly problems associated with pain, poor mobility, discomfort and distress. Relatives and carers provide substantial support to health services, without which it is argued that health and social services would collapse under the burden if such informal care was not available. In is estimated that some 6.8 million people in the UK could be defined as carers. These carers provide support and care to relatives and friends who are unable to care for themselves independently. In England the value of informal carers providing care in the community is estimated to be £57 billion per year.

The Financial Costs of Pressure Ulceration
The costs of pressure ulcer care and prevention are largely unknown, perhaps due to the fact that it is a condition largely secondary to other diseases. However, there has been a long-standing interest in estimating the costs of pressure ulcers, sometimes using these costs to calculate which other services (surgery and bed stays) could instead be provided.

In 1993, the UK government commissioned accountants Touche Ross to provide them with an estimate of health service costs of pressure ulcers. They used existing research where available and expert opinion where necessary to provide a theoretical cost of prevention and treatment of pressure ulceration in an average 600 bedded hospital. Different models were proposed, depending on whether the hospital was high or low cost, and depending on whether there was an active prevention strategy with treatment, or treatment alone.

The final estimates indicated that with a treatment strategy alone a low cost hospital would spend £901,000 (€644,000) per year on pressure ulcers whilst a high cost hospital would spend in the region of €1,614,000 per year in 1993. When including a prevention strategy into the care of patients the low cost hospitals used a similar budget (€901,000), but the high cost hospitals used €3,794,000.

Most the excess cost associated with prevention was consumed by additional nursing time spent assessing and turning the patients. This report concluded that the cost of pressure prevention and treatment would cost the UK health service approximately 0.4-0.8% of the total annual budget. This analysis was limited in that it only estimated costs in the acute (hospital) services and was unable to estimate costs in the community. Moreover, there was no attempt to estimate indirect costs, costs to patients, nor any value placed on the patients’ quality of life.

A more global investigation of cost of pressure ulceration was undertaken in the Netherlands, examining the costs in different care settings including home care; nursing homes; general hospitals and university hospitals. Prevalence figures for different pressure ulcer stages were determined from estimates given by the Health Council for the Netherlands on Pressure Ulcers. These were combined with expert opinion (Dutch Society of Pressure Ulcer Experts) to determine personnel time, extra days of care, use of special beds and medical materials. Both low and high estimates were given to indicate the potential range of costs. Costs were dependent not only on ulcer stage, but were also highly dependent on where care took place. As an example of this mean low and high daily costs of stage II pressure ulcers were highest when treated in a university hospital (low €71.6, high €110.2) and lowest in the general hospital (low €23.7, high €25.1) with conversion factor €1 = $1.3. Home care was similar to University Hospital costs whereas nursing home care was similar to that of the general hospital costs. The authors estimated annual costs of pressure ulcer care to be in the range €371 million to €1,695 million per annum for a country with a population of just 16.5 million, or 1% of the Dutch health care budget.

More recently, a model of costs of pressure ulcers has been developed in the UK, which adopted a more epidemiological approach. It also looked at different health states for pressure ulcers, namely normal healing; critical colonisation, cellulitis and osteomyelitis. Each health state and pressure ulcer grade was ascribed a cost based on the research evidence and/or expert opinion. The average cost of healing the different pressure ulcer grades was estimated at €1,489 for a grade I, €6,162 for grade II, €10,238 for grade III and €14,771 for grade IV. In the UK (population 60 million) annual incidence (new cases) was estimated at 140,000 for grade I, 170,000 for grade II, 50,000 for grade III and
50,000 for grade IV based on available incidence data. By combining average costs and number of cases the total cost of pressure ulcers was estimated at €214 million (grade I), €1047 million (grade II), €544 million (grade III) and €670 million (grade IV), giving a total cost of all pressure ulcers at €2,473 million. This is equivalent of approximately 2.6% of the total current NHS budget.

As expected most cost (90%) was associated with nursing time, though in-patient stays accounted for 8% of overall costs and 30% for grades III and IV. Cost for antibiotics, dressings and pressure relieving equipment was all relatively low.

Other studies have concentrated on specific costs of pressure ulceration. In Australia a study was undertaken to examine the bed days lost to pressure ulceration in 2001-2. It was estimated that a pressure ulcer led to an extra 4.31 days per patient leading to 398,432 bed days lost and an opportunity cost of AUS$ 285 million (£170.7 million) in a population of 20.3 million.

Costs to the patient: Quality of life

Health related quality of life (HRQoL) is an important measure of the impact of a condition on the patient’s physical and mental well being and their ability to function socially. While most clinicians would accept that HRQoL is an important measure to determine the impact of disease on the patient relatively few studies have been undertaken to assess this. One influential qualitative study used a phenomenology approach to determine the impact of the condition on 8 subjects who mostly were suffering (or had suffered from) a stage IV pressure ulcer in the USA. Key themes identified were:

- Perceived aetiology of the ulcer
- Life impact and changes
- Psycho spiritual impact
- Extreme painfulness associated with the PU
- Need for knowledge and understanding
- Grieving process

The pressure ulcer had effects on the patients in terms of their physical, ability, their ability to function socially, their financial situation, changes in their perceived body image, and loss of independence and control of their own lives. Patients who had an ulcer for longer than six months experienced pessimism and a poorer adherence to treatment, which left them feeling depressed and frustrated. Coping with the pressure ulcer was difficult, and patients felt isolated, particularly when they were often left in a side room on their own. Patients felt humiliated that health care professionals were seeing parts of their body which were normally kept private. The odour from the pressure ulcer made them feel dirty and they often resorted to deodoriser to mask the smell. Financial costs were associated with having to miss work, for medical care, prescriptions and travel. The theme of living a restricted lifestyle was examined more recently, with more detail given for the impact on families.

Pain associated with the pressure ulcer appears to have a substantial impact on patients and their lives. In the study by Szorall 84% of patients with a grade II to IV experienced pain, even at rest, with 18% reporting this as excruciating. In addition 88% reported pain at dressing change. Only 6% reported pain relief being prescribed, with nursing staff frequently denying the pain their patients’ experienced.

A further study was undertaken using a generic quality of life tool (SF-36) in 60 patients in the community. Compared with the general population, patients with pressure ulcers experienced greater problems with physical and social functioning. At present no studies have examined utility scores of patients with pressure ulceration to determine the potential deficit associated with the condition and the potential cost in terms of QALYs (Quality adjusted life years).

Discussion

In the area of pressure ulceration there has been some interest in the evaluation of outcomes of treatment, but very little attention to the overall cost of care, nor impact on the patients’ quality of life. Surprisingly, health services do not appear to be aware of the financial burden that pressure ulceration causes. As an example, the €2.5 billion spent on pressure ulceration is equivalent to the cost of treating mental health in the UK or all community health services. The cost estimates are highly dependent on the incidence of pressure ulcers, although few studies have been undertaken on a population basis to determine this important aspect of pressure ulcer evidence. The results from studies so far undertaken have shown that pressure ulcers lead to a clear deficit in quality of life, though again, these are based on small local studies of patients.

There is a clear need for governments to understand that pressure ulceration causes a major financial burden on them and on patients’ lives. Until the magnitude is appreciated it is hard to push for cost effective treatments and prevention strategies on a national basis to rationalise the care of patients who suffer from this distressing condition.

References.
INTRODUCTION

Deep Venous Thrombosis or DVT’s are not acutely life threatening per se however they are associated with complications, which can be acutely fatal [1]. Venous thrombosis is a condition in which a blood clot (thrombus) forms in a vein. This clot can limit blood flow through the vein, causing swelling and pain. Most commonly, venous thrombosis occurs in the “deep veins” in the legs, thighs, or pelvis. When this occurs, it is called a deep vein thrombosis, or DVT.

DIAGNOSIS

If the patient’s history, symptoms, and physical exam suggest a venous thrombosis, tests are needed to establish a diagnosis [2,3]. Diagnosing DVT — Tests used to establish a diagnosis of DVT may include compression ultrasonography, contrast venography, magnetic resonance imaging (MRI), computerized tomography (CT scan) and a blood test called D-dimer.

D-dimer — D-dimer is a substance that is often found to be elevated in the blood of people with venous thromboembolism or PE. It can be used to eliminate the possibility of deep venous thrombosis. If the D-dimer test is negative and the patient is thought to be at low probability of DVT or PE on the Wells score, DVT or PE are unlikely and further testing may not be needed [4].

RISK FACTORS

There are a number of factors that increase a person’s risk of developing a venous thrombosis. At least one risk factor can be identified in over 80 percent of patients who develop a venous thrombosis. An increased risk of developing a blood clot is sometimes referred to as a “thrombophilia” or a hypercoagulable disorder [1,5,6].

• Previous surgery (especially orthopaedic surgery and neurosurgery)
• Cancer
• Pregnancy (Hypercoagulable state)
• Obesity
• Use of certain medications (e.g., Oral Contraceptive Pill, HRT)
• Imobialisations or prolonged bed rest
• Cancer
• Heart failure
• Elevated blood levels of homocysteine (genetic)
• Certain disorders of the blood, such as polycythaemia vera
• Kidney problems, such as nephrotic syndrome
• Antiphospholipid antibodies (antibodies that affect the clotting process)
• A previous episode of a clot in the leg (deep vein thrombosis) or PE.

Smoking and increased age may also increase the risk of venous thromboembolism, but it is not clear what role these factors play.

SIGNS AND SYMPTOMS

There are signs and symptoms of DVT and PE; these may be caused by the thrombus, or maybe related to another condition. In most cases, testing is needed to determine if a clot is present [7,8]. Deep vein thrombosis — Classic symptoms of DVT include swelling, pain, warmth and discoloration in the involved leg however this pain occurs in 50% of patients and is usually nonspecific. Pain may occur on dorsiflexion of the foot (Homans sign) [9]. Homans’s sign is described, as discomfort in the calf muscles on forced dorsiflexion of the foot with the knee straight has been a time-honoured sign of DVT. However, this sign is present in less than one third of patients with confirmed DVT. The Homans’s sign is found in more than 50% of patients without DVT and therefore is very non-specific [10].

Pulmonary embolism - The most common symptoms of pulmonary embolism are difficulty breathing, chest pain while taking a deep breath, cough and coughing up blood. The most common physical findings are an increased rate of breathing, abnormal lung sounds heard with respiration and a rapid heart rate [11,12].

TREATMENT

The treatment of deep vein thrombosis and pulmonary embolism is similar. In DVT, the main goal of treatment is to prevent a PE [13]. Other goals of treatment include prevention of further clot extension, prevention of a recurrence of thrombosis, and the prevention of complications, such as the post-thrombotic syndrome and chronic high blood pressure in the vessels between the heart and lungs (pulmonary hypertension).

The mainstay of treatment for venous thrombosis is anticoagulation [11,12]. Other treatments may include thrombolytic therapy or inferior vena cava interruption. If a reversible risk factor, such as immobility, exists in a particular patient, the clinician may opt to treat the patient until the risk factor is resolved.

• Patients with a first episode of venous thrombosis without an apparent cause should be treated for a minimum of six months.
• Patients who have recurrent venous thrombosis should be treated for a minimum of 12 months.

Treatment may be continued indefinitely in patients with three or more episodes of venous thrombosis and in patients with a risk factor that cannot be reversed [10].

PREVENTION

Surgical patients — Certain high-risk patients undergoing surgery (especially orthopaedic surgery and cancer surgery) may be given anticoagulants to decrease the risk of blood clots. Anticoagulants may also be given to women at high risk for venous thrombosis during and after pregnancy [14].

In surgical patients with a moderate to low risk of blood clots, other preventive measures may be used. For example, some surgical patients are fitted with inflatable compression devices that are worn around the legs and periodically filled with air; these exert gentle pressure to improve circulation and help prevent clots [15]. Low risk and some moderate risk patients may be asked to graduated compression stockings. For all patients, walking as soon as possible after surgery can decrease the risk of a blood clot.

REFERENCES & FURTHER READING

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Epilepsy

What is an Epilepsy Syndrome?

Part 1 of 2

Introduction

According to Temkin (1971), the words “epilepsy” and “epileptic are Greek in origin and have the same root as the verb “epilambanein”, which means “to seize” or “to attack”. Epilepsy therefore means seizure. If epilepsy means seizure then it is unfounded and confusing to talk about “epileptic seizures”. Either word would do. Hence in ancient times the word “epilepsy” was used to denote both the disease and the single attack.

People have known about epilepsy for thousands of years but have not understood it until recently. The ancient Babylonians wrote about the symptoms and causes of epilepsy 3000 years ago. They thought that seizures were caused by demons attacking the person. Different spirits were thought to cause the different kinds of seizures. From the time of Hippocrates on, physicians were well acquainted with the fact that the attacks had a tendency to repeat themselves, and epilepsy was therefore classified among the chronic diseases.

According to Wylie (2001) epilepsy is a common chronic neurological condition affecting 1-3% of the population at some stage in their lives. Epilepsy is defined as a neurological condition characterised by recurrent epileptic seizures unprovoked by any immediately identifiable cause. Sander and Shorvon (1996) define an epileptic seizure as the clinical manifestation of an abnormal and excessive discharge of a set of neurons in the brain. The prevalence of epilepsy is approximately 5 per 1000 of the population and the incidence is about 50 cases per 100,000 of the population per year Wylie (2001). Glynn (2001) in a recent review suggested that in 1998 there were 30,448 people affected by the disorder in the Republic of Ireland. This was corroborated by independent analysis of the rate of epilepsy in Ireland (Liggan and Delanty 2002). However because of the stigma surrounding the condition it is impossible to extract exact figures.

Classification

By the time of Galen in the second century AD some progress had been made towards classifying epilepsy into three categories:

1. Epilepsy due to an idiopathic disease of the brain.
2. Epilepsy due to sympathetic involvement of the brain originating from the cardia.
3. Epilepsy due to sympathetic involvement of the brain originating from any other part in the body.

Many authors then followed with similar and alternative views, some of which are still being used today to some extent. The longstanding debate about classification of epileptic seizures shows no sign of abating and remains a subject about which there is still no general agreement, it remains work in progress.

Opinions about what can be regarded as a satisfactory classification of epilepsy syndromes and seizures appear to differ amongst health professionals. There are those who favour inclusion of all syndrome and seizure types and there are those who are minimalists and would prefer a simplistic classification. The most important milestone in modern epileptology has been the recognition of epileptic diseases, seizures and syndromes. The first attempt to categorise them in an international classification was published in 1970 by Merlis. The Commission on Classification Terminology of the ILAE, 1985, adopted the classification and definitions from this meeting in 1985 and remained essentially the same in the revised proposal of 1989. Commission on this classification was based on two major features; firstly, whether the predominant seizure type is focal or generalised and second, whether aetiology is idiopathic (with genetic disposition), symptomatic (structural) or possibly symptomatic (cryptogenic). These divisions shaped the first two major groups of epilepsy syndromes; a third group covered syndromes with seizures of uncertain types (often the case with nocturnal seizures) and a fourth covered seizures associated with a certain specific situation (fever, drugs, metabolic imbalance).

Seizures themselves too have been classified into two groups to aid categorization. This includes partial seizure and the generalised type of seizure. The two groups can then be further subdivided in to simple partial seizures, complex partial seizure and secondarily generalised seizures and the generalised group can be further divided into the absence, myoclonic, tonic, atonic and tonic-clonic seizures. If a clear clinical presentation is made by an accurate witness account then this too can aid the diagnosis and syndrome type.

The most recently proposed diagnostic scheme by the ILAE and Engel (2001) is divided into five parts or axes, organised to facilitate the diagnostic studies and therapeutic strategies to be undertaken in individual patients. It maintains focal and generalised epilepsies, does not specify on syndromes of uncertain origin and replaces “seizures with a specific situation” with “conditions with seizures that do not require a diagnosis of epilepsy”. Also the categorization rightly considers and lists “Diseases frequently associate with epileptic seizures or syndromes”.

The definition of a medical syndrome by Panayiotopoulos (2002) is “a distinct group of syndromes and signs which, associated together, form a characteristic clinical picture or entity”, while “a disease has common aetiology and prognosis despite individual modifications”. Similarly, in the epilepsies, the recognition of non-discriminatory collection of symptoms and signs requires the study of detailed clinical and laboratory data.

Panayiotopoulos (1999) stated defining the type of epilepsy should now be considered mandatory as it offers the best guide to both management and prognosis.

Epilepsy is not a single disease unit, epilepsies are many diseases and as a result patients, their families and carers deserve and are entitled to and informed diagnosis, prognosis and information on the best management available as different syndromes require different treatment and the failure to treat appropriately could have fatal consequences. Bendlis, Luders (1996) and Panayiotopoulos (1999) concur that the inclusive diagnostic label of epilepsy instead of a precise seizure and syndrome categorisation endangers patients with epileptic seizures medically and socially. For example Panayiotopoulos (1999) states to unify a child with temporal-lobe epilepsy and a child with childhood absence epilepsy as having “epilepsy” simply because they both have seizures is medically incorrect and negligent.
The diagnosis is ultimately made on the clinical picture but characteristics to include age of onset, familial history, medical history, treatment to date and seizure description also aid the classification. Even though some symptoms prevail and may indicate the underlying condition, no single symptom or sign can be considered conclusive. The process of disparity requires close investigation of the clinical data before a list of possible diagnosis can be interpreted and the diagnosis made. Investigations also need to be considered to include routine blood tests and urine tests.

**Electroencephalogram (EEG)**

Electroencephalogram (EEG). Fig. 1 Of the laboratory testing EEG and correct brain imaging are the most important. An EEG is safe and inexpensive, is one of the most important and less invasive tests preformed and can be a vital tool in the diagnostic process of epilepsy when preformed and read by experienced and proficient staff and should not be underestimated.

It is important for the professional to recognise the importance of getting the diagnosis of the particular syndrome correct as it has many advantages. Firstly as already recognised the information disseminated to the patient when correct leads to correct management, compliance with medication and better understanding of the condition. It may also teach the professional more about how this particular syndrome related to different medication. With the introduction of newer Anti-epileptic drugs (AED’s) classifying has now become more important than ever as we now know that some AED’s when given to a wrong syndrome type can have disastrous consequences on morbidity and mortality.

Classifying epilepsy syndromes have many other advantages to include educating the patient about the particular syndrome they are likely to have, stressing the dos and don’ts in relation to lifestyle issues. Now that we are living in a more legal orientated medical world the importance of correct diagnosis and management must be stressed. To conclude the importance of genetic counselling.

Idiopathic generalised epilepsies demand different treatment strategies to focal epilepsies Panayiotopoulos (2001). Disregarding this piece of information may result in unnecessary deaths and injury.

**Juvenile Myoclonic Epilepsy**

Juvenile myoclonic epilepsy (JME) is one of a type of the idiopathic generalised epilepsies (IGE) under the newer classification by Engel (2001). It is thought to be genetically determined, but the exact mode of inheritance is not clear. There is a positive family history in 50% of cases or less. JME may be responsible for about 10% of all epilepsies; exact figures may be higher as it is still an under-diagnosed and under-appreciated syndrome Renganathan and Delanty (2002). It is a common occurrence to see patients with a non-specific diagnosis of a “seizure disorder” for many years until the correct diagnosis is reached.

According to Panayiotopoulos (1999) the syndrome comprises of a triad of absences, jerks and generalised tonic clonic seizures (GTCS) shows a characteristic age related onset. Absences, when feature, begin at the ages of 5 and 16 years. Myoclonic jerks appear between 1 and 9 years later usually around the age of 14-16 years. GTCS can occur some time later. The prevalence is about 8-10%, with males equalling females.

Panayiotopoulos et al (1994) concur that in the typical absence seizures they differ from those of childhood absence or juvenile absence epilepsy the myoclonic jerks often appear and are more prominent after awakening. They are most often subtle restricted to the upper limbs and extremities, however they too maybe violent and cause the person to fall to the ground. GTCS usually follow the onset of the myoclonic jerks. Delgado-Escuta and Enrile-Bacsal state that the myoclonic jerks tend to cluster and often with an accelerating frequency and severity may precede GTCS.

The most important part of any diagnosis is the clinical history and especially an accurate eyewitness account. Panayiotopoulos (1999) suggests that videoing an account of the seizure episode could benefit the diagnosis. An epilepsy syndrome as we know is made on clinical grounds and only on occasion in conjunction with medical investigations. When trying to elicit information about this syndrome it is sometimes important to demonstrate mild myoclonic jerks of the upper limbs and to ask some questions about a history of dropping things and clumsiness particularly in childhood.

Seizure provoking factors include late nights to include sleep deprivation, excessive alcohol intake and in some cases photosensitivity. Other common triggers include mental stress, emotional stress and excitement.

The rate of misdiagnosis of JME is as high as 90% according to Panayiotopoulos et al (1991). Factors responsible include lack of experience with JME, failure to extract a history of myoclonic jerks, misunderstanding of absences as complex partial focal seizures, misapprehension of jerks as focal motor seizures, and high prevalence of focal EEG abnormalities.

JME is easy to diagnose because of a characteristic clustering of myoclonic and other generalised seizures of idiopathic generalised epilepsies (IGE), precipitating factors and EEG expressions. Patients affected are otherwise normal and there is no mental or physical deterioration if properly diagnosed and treated. The myoclonic jerks are often characterised by short, bilateral and usually symmetric synchronous muscle contractions primarily involving the upper limbs.

**Differential Diagnosis**

As regards other IGEs juvenile absence epilepsy may be confused and difficult to distinguish with JME as it may manifest with similar clinical and EEG manifestations. The main differences are that absences with severe loss of awareness, not the myoclonic jerks are the main type of seizures in juvenile absence epilepsy. Myoclonic jerks if they do appear are random and do not cluster as in JME.

JME may also be confused with idiopathic generalised epilepsy with generalised tonic-clonic seizure only as more often then not the patient usually presents at their local accident and emergency following a general tonic-clonic seizure (GTCS). GTCS overall appear to happen on awakening and at times can be accompanied by jerks or absences. Trigger factors like JME include sleep deprivation, fatigue and excessive
also concluding that Sodium Valporate may not be the best drug of choice as it has been established that this medication may not be the medication of choice should depend on the severity of the JME. However in the recent past by clinicians that the drug of choice to treat this syndrome is Sodium Valporate but this can be very hazardous in severe cases, as treatment is often lifelong. It has been well documented that medication of sodium valporate may cause many side effects. Efficacy and adverse reactions have to be carefully balanced in treatment. Idealistically the goal of treatment with anti epileptic drugs is to achieve freedom from seizures, and may help with the understanding of the condition and reduce the morbidity of the condition. The management of JME is also type specific, once diagnosed counselling by an epilepsy specialist is necessary. Advice to include avoidance of precipitating factors is essential. This includes many lifestyle changes to include a regular sleep pattern; avoiding late to bed and enforced early morning waking, over indulgence of alcohol and avoidance of emotional stress are of major importance. Compliancy with medication is essential and cannot be over emphasised as often forgetting regular medication can lead to the patient having a GTC seizure. The avoidance of illegal drug use should be negotiated as the person with JME is usually diagnosed as an adolescent and understanding the concept for compliance is essential at this time and may help with the understanding of the condition and reduce the morbidity of the condition.

Other general lifestyle issues to include the law about driving, avoidance of ladders and heights along with other general safety information should be embraced.

As already suggested we are aware that JME is genetic and advise on genotyping should be offered.

Epilepsy
Prognosis

The prognosis with JME once correctly diagnosed can be quite hopeful. Although JME has been described as a benign condition, it should be recognised that any condition that places the person at risk of a GTCS also carries the risk of increased morbidity or mortality. All seizures are probably lifelong, although improving after the fourth decade of life. However, if not properly diagnosed and categorised the epilepsy syndrome may vary from mild myoclonic jerks to severe and frequent falls that may cause severe injury and recurrent burns. In a 5 year review by Panayiotopoulos et al (1994) 66 of 70 patients (91%) referred to a specialised epilepsy clinic were misdiagnosed at the time of referral and 22 (30%) were initially misdiagnosed by the specialised clinic. Overall Failure to identify the correct syndrome type led to incorrect drug treatment.

According to Panayiotopoulos et al (1994) seizures are well controlled with appropriate medication in up to 90% of the patients. Conversely according to Gelisse et al (2001) 410 patients with all three types of seizures are more likely to be resistant to treatment.

The management for JME is also type specific, once diagnosed counselling by an epilepsy specialist is necessary. Advice to include avoidance of precipitating factors is essential. This includes many lifestyle changes to include a regular sleep pattern; avoiding late to bed and enforced early morning waking, over indulgence of alcohol and avoidance of emotional stress are of major importance. Compliancy with medication is essential and cannot be over emphasised as often forgetting regular medication can lead to the patient having a GTC seizure. The avoidance of illegal drug use should be negotiated as the person with JME is usually diagnosed as an adolescent and understanding the concept for compliance is essential at this time and may help with the understanding of the condition and reduce the morbidity of the condition.

Other general lifestyle issues to include the law about driving, avoidance of ladders and heights along with other general safety information should be embraced.

As already suggested we are aware that JME is genetic and advise on genotyping should be offered.

Management

Ideally the goal of treatment with anti epilepsy syndrome is to have the patient seizure free, on one medication and with no side effects. Efficacy and adverse reactions have to be carefully balanced in these cases, as treatment is often lifelong. It has been well documented by clinicians that the drug of choice to treat this syndrome is Sodium Valporate as it treats the absences, myoclonic jerks and GTCS. The dose should depend on the severity of the JME. However in the recent past it has been established that this may not be the medication of choice for many women of childbearing potential as it is not without its side effects to include weight gain, hair loss and polycystic ovaries Betts and Fox (1999). The establishment of multiple pregnancy registers are now also concluding that Sodium Valporate may not be the best drug of choice for women of child bearing potential and alternatives need to be considered.

These may include the use of clonazepam for myoclonic jerks, however it may not be useful to suppress GTCS. Pheonobarbitone may also be of some use in the treatment of JME. Of the newer anti-epileptic medication levetiracetam and lamotigine maybe highly efficient but the latter may in fact exaggerate myoclonic jerks. Controversial medications include carbamazepine, vigabatrin and tiagabine.

In a recent review by Parayiotopoulos (2001) sodium valporate controls absences in 75% of patients, GTCS in 70% and myoclonic jerks in 75%. Lamotigine controls absences in possibly 50-60% and GTCS in 50-60% but may worse myoclonic jerks.

It should be emphasised that this treatment maybe likely to change with the introduction of newer anti epileptic treatments.

Conclusion

In conclusion with the advancement of all the published classifications of epilepsy syndromes this now allows for an enhanced prognostic value, recognition, an accurate diagnosis and prompt management and treatment of seizure disorders which, in turn leads to achieving adequate seizure control. It also helps the clinician to avoid assumption and further disseminates the correct information so in fact there are no different standards with quality of care.

The disadvantages of classifying the epilepsy syndromes include that although two individuals may present with similar histories and previous diagnosis, the similarities may in fact obscure the differences and lead to miss management. Restriction may also lead to miss classification and the wrong treatment.

Current classification would suggest that the emphasis should be directed towards the diagnosis of epilepsy rather that the current theme of how to treat it. But it remains to be seen how long before our minds are changed and we need to classify again.

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Preventing a Crisis!

Subclinical Signs of Impending Doom

**Conference Speaker**

**Carol Whiteside, MSN, PhD**, has been a nurse in the U.S. for over 35 years. She is a clinical nurse specialist and a cardiovascular nurse specialist. Carol has been a staff nurse, cath lab manager, nursing supervisor and director of education. She previously worked in a trauma unit, medical surgical unit, cardiac ICU, medical ICU, adult and pediatric open heart surgery, neonatal ICU and a burn unit.

She has also educated nurses internationally and is an extremely talented and entertaining presenter. Carol has also been a preceptor and a clinical nursing instructor. Additionally, she is a nurse entrepreneur presenting courses in critical care topics, EKG interpretation, ACLS, critical thinking and a variety of other nursing topics. Carol has been a sought-after speaker for many years. She has the unique ability to combine her vast clinical background and information with critical thinking strategies. You will leave with the skills and techniques to anticipate the subclinical signs of impending doom and therefore improve the care you provide your patients.

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1. Recognize the signs of compensation in the human body before illness appears.
2. Interpret what is happening in the body physiologically when the heart rate and respiratory rate go up.
3. Identify the components of cardiac output.
4. List three signs of left heart failure and describe the physiology behind them.
5. Describe two symptoms that differentiate ARDS from other forms of respiratory failure.
6. Identify the level of oxygen to be given a CO2 retaining COPDer in crisis.
7. Recognize three ways that CHF differs from the other forms of shock.
8. Explain two ways in which benign and malignant headaches differ in their presentation.
9. Relate four signs found through the look test indicating a change in the patient’s condition.
10. Describe the physiological mechanism driving the changes seen in patients after surgery.
11. Identify the first sign of compartment syndrome.
12. List three components of “painting the picture”.

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**Drugs Feature**

**Lipid Lowering Drugs**

**Cholesterol** is a fat-like substance (lipid). About 80 percent of cholesterol is manufactured in the liver and the remainder consumed in cholesterol-rich foods such as dairy products.

Lipids play important roles in nutrition and health. However, there is also considerable awareness that abnormally high levels of certain lipids, particularly cholesterol (in hypercholesterolaemia) are risk factors for heart disease and other cardiovascular diseases.

The Statins (or HMG CoA reductase inhibitors) form a class of drugs that are used to lower cholesterol levels in individuals with existing cardiovascular disease or who are at risk of developing this. Treatment for high cholesterol generally centres on reducing levels of low-density lipoproteins (LDL) or ‘bad’ cholesterol.

**The Statins include the following drugs:**

- Atorvastatin
- Fluvastatin
- Pravastatin
- Rosuvastatin
- Simvastatin

**Mode of action:**
Statins lower cholesterol levels by inhibiting the enzyme HMG CoA reductase, an enzyme that is involved in cholesterol synthesis in the liver. Inhibition of this enzyme in the liver stimulates LDL receptors thereby resulting in an increased clearance of LDL from the bloodstream.

**Indications:**
Statins are considered for all patients with symptomatic cardiovascular disease or patients considered to be at risk such as:

- Angina
- Myocardial Infarction
- Peripheral Vascular Disease
- Non-haemorrhagic Stroke
- Transient Ischaemic Attacks
- Diabetic Patients
- Prevention of cardiovascular disease in asymptomatic patients considered to be at high risk. Cardiovascular risk can be determined using tools such as Joint British Societies risk chart.

**Cautions:**
Statins are used with caution in patients with a known history of liver disease and excessive alcohol intake. Patients with underactive thyroid should have this managed before treatment is started.

**Contra-indications**
Statins should not be used in patients with known active liver disease or during pregnancy.

**Side effects:**

- Reversible myositis (inflammation of skeletal muscles) This is indicated when there are symptoms such as muscle pain and a rise of the creatine kinase enzyme (CK) level.
- Headache
- Altered Liver Function Tests (LFT’s) Consequently LFT’s should be carried out before commencing treatment and again 1-3 months later. Ongoing monitoring of LFT’s is done every 6 – 12 months thereafter. The statin should be discontinued if serum transaminase levels rise to and persist at a level of 3 times upper levels.
- Gastrointestinal effects such as pain, nausea, diarrhoea
- Rash
- Hypersensitivity reactions

**References:**
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Australia’s strong economic performance over the last decade is clearly seen through its economic growth, low inflation, low unemployment and low interest rates. The Australian economy is open and competitive, aided by a dynamic private sector and a skilled, flexible workforce.

The Australian Government seeks skilled workers & professionals to fill shortages created by the growing Australian economy. 97,500 work rights visas will be made available between July 2006-June 2007, allowing skilled workers to work and live in Australia.

Over 150,000 jobs are advertised each week, and the current unemployment rate at its lowest level in 10 years. Australian Government statistics confirm 89% of Skilled Visa holders gain employment within 6 months.

Australia is often referred to as “The Lucky Country”, with its spacious surroundings, high standard of living, excellent health and education systems, temperate climate, wide and varied landscape, political and economic stability, and a general quality of life envied by many around the world.

The appeal of Australia is evident in the large number of people who migrate under the Department of Immigration and Citizenship (DIAC) Migration Program every year. Over 100,000 people will migrate to Australia every year for the next four years, further enhancing the existing multicultural population.

Despite being the sixth largest country in the world, Australia has a lot of space but not many people. It has the lowest population density in the world - only 2.5 people per square kilometre - a far cry from the packed cities of other countries! Aussie lifestyle is arguably the finest in the world and is the number one reason that most people flock to its sandy shores to live and work.

Australia’s not a place where you stand on the sidelines and simply watch - there is so much on offer for you to see, do, and experience.
Overseas educated nurses must be able to speak English for working in Australia. Nurses from countries where English is not the first language are required to complete and pass either the Occupational English Test (OET) for Nurses or the International English Language Testing System (IELTS).

There are two levels of nurse in Australia: registered and enrolled nurses. Registered nurses are educated in degree level courses at universities. Enrolled nurses are primarily educated through advanced certificate or diploma level courses in colleges of technical and further education.

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Canada has had a publicly funded system of hospital and medical care since 1968. The majority of nurses work within the publicly funded sector of health care, a minority work in the private sector and a small number of nurses are self-employed.

Because health is a provincial jurisdictional area, the health care delivery system is not centralized and there is no one place where nurses can apply for work. They must apply directly to individual employers.

The Canadian Hospital Association publishes a large directory that lists and gives addresses for hospitals, health centres, nursing homes, health associations and health education programs. This directory may be available through a public library or Canadian Consulate.

The nursing employment situation in Canada is improving after several years of health care restructuring and hospital downsizing. Nurses with skills and experience in specialty areas (e.g., emergency, critical care and operating room) and those willing to work in smaller communities or isolated communities are in the most demand. The Canadian Nurses Association is predicting a continued shortage of nurses for the future.

Unlike many other countries the registration of nurses does not occur at the national level. In order to practise nursing you must be licensed or registered in the province or territory in which you will work.

Licensing or registering bodies can also provide information about employment opportunities. They may have a referral service or be able to direct you to appropriate journals to find advertised positions or employer contacts.

Canadian provinces and territories, with the exception of Québec, require that you write the Canadian Registered Nurses Examination as part of the registration or licensure process. At present, this examination can only be written in Canada on the recommendation of a provincial or territorial nurses association. The Canadian Nurses Association publishes The Canadian RN Exam Prep Guide, which you will find useful in preparing for the exam. Québec nurses have their own exam.

You require language proficiency to become registered or licensed in Canada. Bilingualism (French and English) is an asset. Candidates must have knowledge of French to practise in Québec. In New Brunswick, Manitoba and Ontario, candidates must be proficient in either French or English. Employment and nursing education programs for unilingual French speaking nurses are available in Québec and in certain areas in New Brunswick, Manitoba and Ontario. In these provinces the Canadian RN exam may be written in either French or English. In the other provinces and territories of Canada proficiency in English is the requirement.
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Religion, others are respected. In hospitals the main language spoken is English. Both countries are convenient for holidays elsewhere in the Middle East such as Jordan and Egypt as North Africa and much of Europe.

Most expatriate nurses receive six to eight weeks annual leave—plenty of time to travel back to visit family and friends in the UK as well as having holidays further afield.

As a strict Islamic country, Saudi Arabia does not have clubs, bars, and cinemas, but eating out is a popular leisure activity, while compounds housing expatriate workers organize their own entertainment, and the British Embassy also organizes social events. Workers also have access to excellent recreational facilities, and shopping in the major cities is excellent. The UAE is a more relaxed and cosmopolitan society, with around 75% of its workforce coming from overseas. The UAE is an increasing popular holiday destination famed for shopping, dazzling modern architecture and watersports—particularly in Dubai. This means it offers excellent leisure and recreation opportunities including a range of watersports, desert safaris and sand surfing, while the shopping opportunities are legendary.

In both countries expatriate nurses are offered free accommodation close to the hospital they work in. Since most nursing contracts are for single people, this is in shared apartments. Hospitals usually provide free transport to and from work.

When thinking about working abroad, UK nurses tend to choose from a relatively short list that includes the US, Canada, Australia, New Zealand and Ireland. But there are also opportunities in the Middle East, which are well worth considering.

Most UK-trained nurses who spend time working in the Middle East go to the United Arab Emirates (UAE) or Saudi Arabia. A range of benefits, such as tax-free accommodation and airfares, tax-free salary and generous annual leave make these countries attractive destinations.

Nurses wishing to work in Saudi Arabia or the UAE need to be sponsored by a hospital. The best way to obtain sponsorship is via a nursing agency operating in the region, which will also organize work permits. With modern healthcare services the Saudi and UAE recruit both general and specialist nurses usually on one-year or two-year contracts. While they are off the beaten track for many UK-trained nurses going to work overseas, Saudi Arabia and the UAE offer professional opportunities, financial benefits and the chance to experience life in a totally different environment.

All contracted workers are provided with free healthcare while in Saudi. Quality is also high in the UAE, which has one of the lowest infant mortality rates in the world and state-of-the-art technology to carry out complex specialist procedures.

Women in the UAE have more freedom than in Saudi Arabia, and have equal rights in terms of education and job opportunities, and although Islam is the official religion, others are respected. In hospitals the main language spoken is English. Both countries are convenient for holidays elsewhere in the Middle East such as Jordan and Egypt as North Africa and much of Europe.

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Nursing in America

The United States is attracting over a million immigrants a year - a greater number than at any time in its history. Nearly eleven million newcomers have made their home here during the past decade. Those serious about working in America need to know how to go about acquiring a green card or visa that will grant them both residency and employment rights in the USA.

If you’re a nursing professional looking for a change in lifestyle, new opportunities or simply a career that stands out from the others, you could find everything you’re looking for in America.

Currently experiencing a major shortage of trained Nurses, employers in the USA now place a high value on overseas nursing professionals, offering them a variety of opportunities that just can’t be found in other countries. And because working abroad demonstrates real self-motivation and adaptability to change, it’s a move that will only help to boost your career prospects back home - should you ever decide to return.

Add to all this the chance of choosing a new home that perfectly suits your lifestyle needs, and you’ll understand why so many Nurses are crossing the pond to start a new life in the States.

Generally speaking when we think about America we think about a first world country where the standard of living is incredibly high, employment opportunities abound and where one can live a good life in a free thinking society.

Naturally enough these features of the American way of life are highly attractive to immigrants from across the world.

In a country as geographically and demographically diverse as the United States, you will find great variety in the landscape, climate, culture and lifestyles. Some of the most breathtaking sites of natural beauty in the world are located in the States. There are large metropolitan cities, sprawling suburban towns and countless rural communities.

Under the guidance of its membership, the National Council of State Boards of Nursing, Inc. (NCSBN) develops and administers the national nurse licensure examination - NCLEX-RN (®) (the National Council Licensure Examination for Registered Nurses).

This examination is used by the Boards of Nursing to test entry-level nursing competence for licensure as a Registered Nurse. The NCLEX-RN examination is provided exclusively as a computerized adaptive test and may be taken in many countries outside of the U.S. – go to www.pearsonvue.com and click on Locate a Test Center for details on a test center close to you.

Working in a U.S. hospital introduces nurses to cutting edge technology; the ability to work with top-notch professionals; terrific benefits; respect by patients, peers and administrators and the chance for increased responsibility. Enhance your career by doing something many others only dream of. Come to America and work among the world’s finest health care professionals. The U.S. hospital — it’s waiting for you!

America has always been known as the land of the free, a place where theoretically anyone from any background can achieve anything! A country seemingly without personal restrictions and one that promotes liberty and freedom of speech so vociferously, America naturally draws thousands of applications for residency and working visas annually.

Working in a U.S. hospital introduces nurses to cutting edge technology; the ability to work with top-notch professionals; terrific benefits; respect by patients, peers and administrators and the chance for increased responsibility. Enhance your career by doing something many others only dream of. Come to America and work among the world’s finest health care professionals. The U.S. hospital — it’s waiting for you!
Many of US industries are the leaders in their particular field and so are its academic institutions. It remains one of the world’s leading economies, politically it is the most powerful country on earth and it is a trendsetter in many ways.

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Nurses can seek financially rewarding careers in US hospitals, sponsors of the immigrant visa also known as the green card. The nurse applies for a US license and appears for the NCLEX exam successfully making them eligible for the green card sponsorship. The green card process can take anywhere from 15 months to 24 months.

UniHealth America, a US healthcare staffing and recruitment company based in London, offers a very unique opportunity for nurses who wish to fast track their US career, a special work visa for nurses only and approval time is approximately 3 months. Sue Semlani, Managing Director of UniHealth America says “Working in the US is a very attractive proposition for nurses however the wait for the green card process can be long and enduring, alternatively nurses can avail of the special visa for nurses H1C offered by a couple of US hospitals through UniHealth America”

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Would you like to work as an Emergency Advanced Nurse Practitioner in the North East?

The Health Service Executive North East is in the process of developing a plan for a new regional Hospital and re-configuring services under the HSE Teamwork Programme. These changes will improve access to care while improving the quality of pre-emergency and emergency care through telemedicine systems linking all frontline staff and emergency services.

As part of this Programme the HSE plans to develop comprehensive Minor Injuries Services in Our Lady of Lourdes Hospital Drogheda, Our Lady’s Hospital Navan, Louth County Hospital Dundalk, Cavan General Hospital and Monaghan General Hospital.

The development of Advanced Nurse Practitioners (ANP) roles in the Emergency Department is recognised as an important component of the HSE Transformation Programme for the North East. Advanced practice in nursing is carried out by practitioners who are competent, accountable and responsible for advanced levels of decision making through management of a particular caseload. Advanced practice in nursing has developed nationally and internationally in the interests of providing more comprehensive, holistic and effective care. ANPs must meet the criteria set out by the National Council for the Professional Development of Nursing and Midwifery (www.ncnm.ie).

Applications are invited for:
ANP (Emergency) candidates for Our Lady of Lourdes Hospital Drogheda, Our Lady’s Hospital Navan, Louth County Hospital Dundalk and in Monaghan and Cavan General Hospitals.

• Applications are invited from Nurses with a post registration qualification in Emergency Nursing (for example Higher Diploma) and four years’ post-registration experience in Emergency Nursing who wish to avail of sponsorship arrangements in order to undertake a master’s degree with a view to being accredited into an ANP in Emergency Minor Injuries in one of the above hospitals. The masters degree must contain an appropriate clinical module or a separate module must be undertaken either concurrently or subsequently.

• Applications are also invited from Nurses who meet the National Council criteria for ANP (Emergency) posts.

If you would like to discuss or require further information please contact: Mary McCarthy or Rose Lorenz, Nursing and Midwifery Planning & Development Unit, St. Brigid’s Complex, Ardee, Co. Louth. Tel: 041 6853206
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An important part of the IBTS is the participation in, and encouragement of, new research and training in matters relating to blood transfusions and the preparation of blood products. We pride ourselves on being at the forefront of new practices and techniques in the process of managing our blood clinics. We are seeking talented individuals to whom we can offer a truly rewarding career.

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- Staff Nurses
  - Temporary, Full-Time & Part-Time positions
  - National Blood Centre, Dublin.

**Blood Collection Clinic**
- Staff Nurses
  - Temporary, Full-Time & Part-Time positions
  - D’Olier Street, Dublin.

The closing date for receipt of applications (5 copies) is **5pm, 10th August 2007** and these should be sent to the Human Resources Department, National Blood Centre, James’s Street, Dublin 8.

**Specialist Medical Officer**
- Permanent Full-Time
  - Munster Regional Transfusion Centre, Cork.

The closing date for receipt of applications (3 copies) is **Monday 20th August 2007** and these should be sent to the Human Resources Department, Munster Regional Transfusion Centre, St Finbarr’s Hospital, Douglas Road, Cork.

Interested applicants should visit the IBTS website [www.ibts.ie](http://www.ibts.ie) for the application form, job description and further information. Additional queries can be directed to human.resources@ibts.ie DOH salary scales and Location Allowance applies.

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