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Date of Preparation: April 2010     AN/ISP/2010/015
Nationwide asthma management programme – what role for general practice?

Many of you regular readers of Nursing in General Practice are aware of my interest in caring for people respiratory conditions. The lack of services in primary care for people with asthma and COPD has become increasingly worrying and frustrating. Both of these conditions are prevalent in Irish society affecting 470,000 people and 440,000 people respectively. For many of these people the severity of their condition is mild to moderate with approximately 5% of people falling into the severe classification. People with mild to moderate asthma have the same chance of having an acute asthma attack as those with severe disease and frequently underestimate the impact an acute asthma attack can have. There appears to be a serious lack of awareness of recognising and managing these exacerbations. A recent study in the UK showed that 88% of people would not know what to do if they came in contact with a person experiencing an acute asthma attack. This study followed on from the tragic death of an 11 year old school boy whose asthma symptoms were ignored by his teachers and school authorities. In Ireland, at least one person dies every week from an acute asthma attack which in 2010 is unacceptable.

General practice is no doubt the place to care for people with asthma but why isn’t it happening? Simple things such as checking inhaler technique, checking adherence to prescribed medications and assessing the person’s level of knowledge and how to act should there be a change in their condition should form any asthma consultation. A Finnish study demonstrated a reduction in asthma mortality following the use of a structured asthma programme in Primary Care. Over the last year, the Asthma Society of Ireland has developed and funded a major initiative in Primary Care to improve asthma management and control in Ireland. As a result of this project the HSE has prioritised asthma care and is developing a nationwide asthma management programme. I welcome this programme in whatever format it may take. However, there needs to be communication across both the acute sector and primary care including practice nurses and GPs for its implementation to be successful. The programme needs to be accessible to everyone irrespective of financial means with provisions made to assist people in the burden of cost of medication and peak flow monitoring equipment.

Many practice nurses provide and run asthma services but these services need to be increased significantly nationally in order to reduce mortality and morbidity and to increase quality of life for people with asthma and their families.

Ruth Morrow
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No part of this publication may be reproduced, stored in a retrieval system, or transmitted in any form by any means – electronic, mechanical or photocopy recording or otherwise – whole or in part, in any form whatsoever for advertising or promotional purposes without the prior written permission of the editor or publishers.
The publication of the Nurses and Midwives Bill 2010 announced in April provides for a modern statutory framework for the regulation of the nursing and midwifery professions, according to the Minister Mary Harney. The Minister said “I am very pleased to publish this draft Bill which follows on the regulatory changes introduced for other health professionals in recent years all of which are aimed at supporting and increasing public confidence in the way we deliver and oversee our health services as we continue to ensure that public and patient safety is at the top of the agenda.”

“The wide range of changes proposed in the Bill brings the governance of the Nursing and Midwifery professions closer to the regulation of other healthcare professions and follows on from the Health and Social Care Professionals Act 2005, the Medical Practitioners Act 2007 and the Pharmacy Act 2007.”

The purpose of the new legislation is to enhance the protection of the public in its dealings with nurses and midwives while ensuring the integrity of the practice of nursing and midwifery and recognising the need for due process in relation to dealing with allegations and complaints against nurses and midwives.

It will provide for a modern, efficient, transparent and accountable system for the regulation of the nursing and midwifery professions which will satisfy the public and these professions that all nurses and midwives are appropriately qualified and competent to practise in a safe manner on an ongoing basis.

“These objectives are reflected in very practical new measures included in this Bill. For example, both the new Board, Bord Altranais agus Cnáimheaschais na hÉireann (the Nursing and Midwifery Board of Ireland), is the protection of the public.

The new Board will have 23 members, both elected and appointed, representing nursing and midwifery, educational bodies, members of the public and stakeholders.

Unlike the previous Board, this Board will have a majority of members who are not nurses or midwives.

There will be new streamlined fitness to practise procedures which will include a preliminary proceedings committee which will screen complaints and can refer complaints to the fitness to practise committee or to other procedures if the complaints are not appropriate for the Board’s fitness to practise procedures.

The Bill provides for the resolution of complaints by mediation or other informal means in particular circumstances.

The Bill provides for nurses and midwives to maintain their professional competence on an ongoing basis.

It provides for the Board to establish a competency scheme to monitor the competence of all nurses and midwives in the State.

The Bill recognises midwifery as a separate and distinct profession and provides for the establishment of a Midwives Committee to advise the Board in relation to all matters pertaining to Midwifery practice. It is important to note that childbirth is regarded as a normal physiological event in a woman’s life. Midwives are educated and trained to work with women to provide the necessary support, care and advice during pregnancy, labour and to provide care for newborns.

The Bill also supports midwives in their continuing professional development through the introduction of clinical supervision to enhance and support midwifery practice through peer review. Clinical supervision is a process which allows the midwife to reflect on and consider her/his practice, identify any gaps in their education or practice so that competencies might be maintained while also ensuring that women and babies are in the care of competent midwives.

The Minister will now bring the legislation through the Houses of the Oireachtas with a view to enactment at an early date.
Chronic Pain Ireland launches Charter of Rights

Chronic Pain Ireland, a national support organisation that offers information and support to those living with chronic pain and their families recently launched a charter of rights for people with chronic pain. At the launch Dr Brian McGuire of NUIG presented new research survey findings on the impact of chronic pain in our society.

The ‘PRIME’ study, undertaken by a team from NUIG led by Dr McGuire is the first major survey to be undertaken in Ireland in relation to the prevalence and impact of chronic pain. The results of the survey showed that almost 20% of those with chronic pain experienced very serious levels of pain intensity and disability which interfered with all aspects of social and work commitments.

Speaking at the launch Dr Brian McGuire said, “It is clear from our survey that there is an immediate need to adopt this Charter of Rights for people living with chronic pain. Ireland has an opportunity to be the first country in the world to recognise chronic pain as a disease in its own right. Until that is done little progress will be made in alleviating the horrendous suffering to individuals and their families”.

Gina Plunkett, Vice Chairperson, Chronic Pain Ireland said, “We have been invited to Brussels to launch the charter and what a great pity it is that this Irish drawn up charter will be adopted in Europe before Ireland.” She continued, “The impact on the individual, the individual’s family and friends and can be quite horrendous. It can result in loneliness, feelings of isolation and great uncertainty about the future. Like any serious medical condition early intervention is essential and in many cases could prevent the patient entering a downward spiral. Good communication between GP and patient is essential so that appropriate treatment starts immediately.”

For more information www.chronicpain.ie.

Death – the last workplace taboo

Death was perhaps one of the last great taboos in the workplace, the Irish Hospice Foundation’s, Training and Development Manager, heard at a meeting organised by the Irish Congress of Trade Unions recently.

Breffni McGuinness said that a survey of 34 Irish companies and organisations showed that 88 per cent did not have bereavement policies or guidelines for employees.

In Ireland and the EU there was no official entitlement to bereavement leave for workers – it was entirely at the discretion of the employer. While there were many examples of good local practice both from workers and organisations, they needed to ask why so little was reflected in official policies.

About 30,000 people died each year in Ireland. If only 10 were affected by each death, this meant that 300,000 or about one in 10 of the adult working population was directly affected by death each year.

According to Mr McGuinness, workplaces that were supportive of bereaved employees tended to have increased morale and commitment from workers and reduction in unnecessary sick leave. It really made much sense to support bereaved workers appropriately.

He said it was no longer appropriate to take an ad hoc approach to employee bereavement. It was unfair to workers and it did not benefit the organisation. There was every reason why every workplace should have a clear bereavement policy and bereavement guidelines for employees.

Death and bereavement were part of life. They were very much part of our working life, and they affected workers. Bereavement in the workplace was not something that could be ignored.

Quality and cost of Irish lab services staunchly defended

Safeguarding a high-quality, effective laboratory service which will ensure highest standards in patient care; retaining highly skilled jobs; and delivering a laboratory service that can benefit from, and contribute to, the ‘Smart Economy’; were the key themes being considered at the BioMedica 2010 Conference which is organised by the Academy of Medical Laboratory Science (AMLS) and was held in the RDS recently.

Marie Culliton, President of the AMLS, used her keynote address to highlight previous decisions relating to the sector: “It was short-sightedness that led to the outsourcing of all cervical cytology. Waiting lists for patients have not been shortened. The bottleneck has simply moved from waiting for a result to waiting for a smear to be taken. In addition the competence to provide the service has been decimated within this country. The intellectual capital that took forty years to build up in this country was written off at the stroke of a pen. This decision has led to the exporting of high worth, skilled jobs. This is not smart for a knowledge economy.”

“It is the same short-sightedness that now seeks to transfer a significant proportion of laboratory medicine services from public provision. The HSE’s own policy is for the greater integration of health services. How can the outsourcing of laboratory services to the private sector lead to greater integration?”

Culliton defended the cost and quality of pathology service provision in this country, highlighting that the total cost per test is approximately €6.
GPs are all too aware of the need to have access to accurate patient information in a timely manner. The delivery of safer patient care moved forward recently with the publication of standards to increase the reliability and safety of electronic communication between GPs and healthcare services.

The General Practice Messaging Standards, published by the Health Information and Quality Authority, are technical standards for information systems that outline the way patient information, ranging from blood test results, diagnosis information, referrals and X rays, can be accurately and safely transferred between GPs and primary healthcare services. “This is a significant development for GP patient care. The GPMS provide the basis for ensuring that vital information about the patient is available when and where it is needed. Through these standards, the risk of adverse events can be reduced and the patient referral process can be speeded up” said Professor Jane Grimson, Director of Health Information with the Authority.

Once in place, these standards can help GPs free up more time to dedicate to the delivery of frontline care instead of having to allocate resources to administrative work which impacts directly on patient care. The standards will also prevent the need for duplicate diagnostic testing and enable the faster diagnosis of disease, helping the patient start their journey of care more quickly.

KBC Bank Ireland helps raise funds for Temple Street dialysis machine

KBC Bank has raised €32,400 for Temple Street Children’s University Hospital. The money raised will be used to help fund the purchase of a dialysis machine, which is an essential item of equipment at Temple Street Children’s Hospital. As the National Paediatric Dialysis and Renal Unit, Temple Street always needs new haemodialysis and peritoneal machines. The funds raised by KBC will purchase a new dialysis machine for St Michael’s C Renal Ward and will be used to provide children on a waiting list for a kidney transplant the ability to lead a somewhat normal life.

HSE set to introduce vitamin D programme for infants

During this summer the HSE intends to implement a policy that all infants (0-12 months) should be given a daily vitamin D supplement of 5 micrograms (5 µg) vitamin D3 by their parents/guardians, in keeping with Department of Health and Children policy and Food Safety Authority of Ireland recommendations. When implementing the policy the HSE will conduct a public awareness campaign targeting parent/guardians of infants (0-12 months) and pregnant women as well as communicating with key health professionals such as doctors, nurses, midwives, pharmacists and dieticians.

KBC Bank Ireland helps raise funds for Temple Street dialysis machine

Pictured at the announcement of the donation were Denise Fitzgerald, CEO, Fundraising Office, Temple Street Children’s University Hospital and Christine Moran, Executive Director, KBC Bank Ireland.

CORRECTION

A practical guide to the CervicalCheck call/recall process

An error appeared in the above article (Issue 2, Volume 3)

On page 29 the article stated that:

CervicalCheck provides free smear tests to women aged 25 to 40 every three years and every five years to women aged 45 to 60, following two consecutive ‘no abnormality detected’ results.

It should have stated CervicalCheck provides free smear tests to women aged 25 to 44...

We apologise for any confusion.
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‘Living with Dementia’ – a social research programme in dementia care

‘Living with Dementia’ is a social research programme in dementia care that aims to tackle the marginalisation of people with dementia, enhance service provision, and improve quality of life for those diagnosed with Alzheimer’s disease and related dementias. The programme was officially launched in April by the Minister of State with responsibility for Older People and Health Promotion, Áine Brady.

An estimated 40,000 people in Ireland have dementia. In keeping with the ageing population, these figures are expected to increase exponentially in future years.

“Compared with other chronic illnesses such as stroke, cancer and coronary heart disease, dementia is a costly illness, yet in Ireland, Alzheimer’s disease and the related dementias fail to command significant budgetary and political attention,” says Dr Suzanne Cahill, Research Director of the Living with Dementia Programme at Trinity College Dublin.

The TCD Living with Dementia (LiD) programme seeks to impact on policy development and to contribute to the design of best practice models for all those affected by Alzheimer’s disease and the related dementias. It is hoped that by creating closer links between research, practice and educational settings more timely responsive and accessible interventions will be developed to support the unique and complex needs of this very vulnerable population.

The LiD programme has already made available findings with significant implications for policy. A research study estimating the prevalence of cognitive impairment and dementia in Dublin-based nursing homes has been recently published. The implications of having large numbers of residents with cognitive and memory loss problems in residential care are far-reaching and present serious concerns regarding safety, staff-patient ratios, staff training and recruitment and the physical layout of the buildings among other issues.

The only previous study undertaken on this topic in Ireland had been done in 1988, where cognitive impairment prevalence rates of 58% were estimated across nursing homes in the Eastern Health Board area. New findings from the Living with Dementia study have revealed that a large proportion (89%) of these nursing home residents had a cognitive impairment of whom, 42% were severely, 27% moderately and 20% mildly impaired. Only 14% of those surveyed had been originally admitted to nursing homes because of dementia and only 32% had a clinical diagnosis of Alzheimer’s Disease or a related dementia.

This new research programme aims to train five PhD and five Masters students in the field of dementia care in order to improve practice outcomes and promote the independence and dignity of all those affected by dementia.

The Living with Dementia is based in the School of Social Work and Social Policy at Trinity College and is part of the Dementia Services Information and Development Centre based at St James’s Hospital. The research programme is funded by The Atlantic Philanthropies.

For more information on Living with Dementia, click on the enclosed: www.socialwork-socialpolicy.tcd.ie/livingwithdementia

www.healthytravel.ie gives travel vaccine advice

Announcing the launch of a new website, www.healthytravel.ie in Dublin Zoo were Lisa Mclaughlin, Sanofi Pasteur MSD; and travel writer and broadcaster Fionn Davenport. The website advises travellers not to be adventurous when it comes to their health and to visit their GP before going abroad to discuss the appropriate travel vaccinations. The launch of the website coincides with worrying findings that 1 in 4 Irish holidaymakers have fallen ill while travelling abroad.

Erectile dysfunction booklet for men with diabetes

A comprehensive, easy-to-use patient booklet on erectile dysfunction (ED) entitled “Man Matters: Information and advice on erectile difficulties for men with diabetes” has been produced and launched by Eli Lilly & Company Ltd Ireland to support health education activities by health care professionals (HCPs) involved in their care.

The booklet is part of the Man Matters campaign, sponsored by Lilly Ireland, which challenges men to Get Informed; Get Checked; Act and see their doctor as the first step to getting help for any health concerns.

Launching the new booklet were Irish rugby legend Shane Byrne and Dr Kevin Moore, Consultant Endocrinologist.
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Recipients of first Neonatology Nursing Awards

Abbott recently announced the winners of the first-ever Neonatology Nursing Awards. The awards, which recognize excellence and innovation in neonatology research, were presented at Abbott’s sixth annual Neonatal Nurse Study Day in Dublin.

The Neonatal Nurse Study Day is the only national meeting for neonatal nurses, and this year was attended by more than 200 nurses from every maternity centre in the country. The agenda was determined by neonatal nurse managers from the three Dublin maternity hospitals, and contained the most current topics in neonatology. In addition to this year’s Study Day, and in recognition of the high quality research completed by Irish neonatal nurses, nurses were invited to present their research during a poster presentation session.

Joint Winners Mary O’Connor, Clinical Nurse Manager, and Anne O’Sullivan, Advanced Nurse Practitioner, both from the Coombe Hospital, received the award for their study which demonstrated how the provision of oral sucrose combined with swaddling reduced the behavioural and physiological pain associated with the Retinopathy of Prematurity (ROP) test for infants.

The other overall joint winner, Rabekah Prabakaran, neonatal nurse from the National Maternity Hospital, won for her project, “Is noise an issue in the Neonatal Intensive Care Unit (NICU)?” which demonstrated how to decrease overall noise level in the NICU and how to develop unit-specific guidelines and policies in controlling noise levels.

“The standard of the poster presentations is a direct reflection on the commitment to best practice, professional excellence and ongoing learning within the Irish neonatal nurse community,” said Craig Skelton, general manager, Abbott Ireland. “Abbott is delighted to recognise nursing excellence through the awards, and we look forward to next year’s event.”

Another key project highlighted was the Synagis home service, presented by Audrey Patterson, Director of Nursing at TCP Homecare. Under this service, infants prescribed Synagis by their neonatologist or pediatrician can receive their medication in the comfort of their own homes.

Winners of new Arthritis Ireland Easy to Use Design Awards

The winners of the first annual Arthritis Ireland Easy to Use Design Awards, in partnership with Pfizer Healthcare Ireland and NCAD, were announced at a ceremony in Dublin recently. Open to third year Industrial Design students at NCAD, the Awards recognise and encourage innovation in universal design to make everyday products and devices more attractive and usable for everyone, including people living with disabilities.

The Awards were established following research into the difficulties faced by people living with rheumatoid arthritis, on a day to day basis, at home and in the workplace. Over three quarters (77%) of those surveyed reported that they found cleaning and household chores somewhat or very difficult, with similar assessments given to daily tasks such as getting dressed, cooking and socialising by almost half of all respondents.

In what was a unanimous decision by the judging panel – which included entrepreneur Sean Gallagher from RTE’s Dragons’ Den – the overall winners were Alan Harrison from Mayo, and Ben Millett from Roscommon, for their innovative design, The Kug, a clever combination of a kettle and a mug.

The students were inspired to design The Kug after they spoke with people living with rheumatoid arthritis who recounted their frustration and difficulties with everyday household and lifestyle appliances. The Kug offers on the go tea or coffee making while eliminating the need for a kettle, which because of its design and weight is impractical for use for people living with arthritis. The winning students have already had initial discussions with Sean and fellow Dragon, Bobby Kerr, Insomnia, with a view to assist them to take it to market.

Further information on the Arthritis Ireland’s new Easy to Use Commendation Programme can be found on www.arthritisireland.ie

Geraldine O’Connor, Pfizer Healthcare Ireland with the winners of the Easy to Use Design Awards Ben Millett and Alan Harrison and John Church of Arthritis Ireland.
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ViATIM® protects for up to 36 months against both hepatitis A and typhoid fever.1

Travel advice only goes so far...

Avoiding contaminated food and water is good advice. But it’s not always realistic.
New oncology home nurse service launched for renal cancer patients

Pfizer Healthcare Ireland has announced the launch of a home nurse service for patients using Sutent (sunitinib) for the treatment of advanced metastatic renal cell carcinoma (mRCC). The Sutent Patient Home Nurse Service will be available from April as a valuable complementary resource to oncology teams nationwide.

Oncology Clinical Nurse Specialist, Ms Lisa Guinan, will be providing guidance and support to patients who have been prescribed Sutent in all areas regarding their treatment in the home and in the hospital setting.

Ms Guinan, a former oncology clinical nurse specialist at the Bon Secours Hospital in Dublin and cancer information services nurse with the Irish Cancer Society, is available to make patient visits, conduct patient reviews and provide advice and support to patients with respect to their treatment on Sutent.

Ms Orlaith Gavan, Oncology Medical Advisor at Pfizer Healthcare Ireland said: “We welcome Lisa on board as part of the Pfizer Oncology team to promote the well-being of patients receiving Sutent treatment. The Sutent Patient Home Nurse Service aims to bridge the gap between the hospital and home setting in providing optimal care for the patient and practical support for healthcare professionals.”

Sutent, an oral medicine launched in Ireland in 2006 was the first targeted therapy licensed for the first line treatment of advanced/metastatic renal cell carcinoma. It is also licensed for the treatment of unresectable and/or metastatic malignant gastrointestinal stromal tumour (GIST) after failure of imatinib mesilate treatment due to resistance or intolerance. For further information please visit www.medicines.ie <http://www.medicines.ie>

For more information on the Sutent Patient Home Nurse Service, please contact Ms Lisa Guinan, Pfizer Healthcare Ireland on the free phone number 1800 283 061.

Truly Tasty cookbook for adults with kidney diasease

Celebrity Irish Chefs Rachel Allen, Derry Clark, Clodagh McKenna, Neven Maguire, Catherine Fulvio and Kevin Dundon to name only a few, have joined forces with Valerie Toomey to produce a glossy new cookbook entitled Truly Tasty. This is an Irish publication with a true difference written specifically for adults with chronic kidney disease and on dialysis. The catalyst for this book was provided by Valerie who received a kidney donation in 2006 following a number of years on dialysis. “This gave me a second chance at life so to honour my donor I decided on this project”.

This publication is unique as all recipes are created especially for Irish adults on a renal diet and have been meticulously analysed by the Irish Nutrition & Dietetic Institute (INDI). Truly Tasty provides recipes for special occasions with friends and that special weekend treat. Valerie also wishes to fortify Organ Donor Awareness by including an Organ Donor Card into each copy. The project however would not have become a reality without the support of main sponsor, global health care company Abbott, as well as support from the Irish Nutrition and Dietetics Institute (INDI), Bosch, Shire, National Lottery, Amgen Ireland, Shamrock Foods and the Irish Kidney Association.

Before using this book readers are advised to discuss the recipes with their dietitian. All proceeds of the sale of Truly Tasty will go to the Irish Kidney Association and will be on sale in bookshops nationwide.

Craig Skelton, General Manager, Abbott Ireland, Mary Harney, Minister for Health, Valerie Twomey, Truly Tasty, Melissa Sheridan, Senior Product Manager, Abbott Ireland at the launch.
CAVAN/MONAGHAN

PATRICIA JENKINS

We recently had a very interesting meeting in the Errigal Hotel, Cootehill. The topic was post natal care and issues. The speaker was Kate McCabe who is a psychosexual therapist. The sponsor was Sinead O‘Callaghan from Roche.

In April our practice nurse meeting was well attended even though our speaker did not turn up. Tony Fitzpatrick the INMO rep for Cavan and Monaghan was organised to talk to us but he failed to show. The meeting was kindly sponsored by Alison Murphy from SMA.

On the subject of the INMO, the GP practice nurse section holds regular meeting at their headquarters. It gives us an opportunity to network and discuss any issues we might have. Winny McCabe is our representative for Cavan and Monaghan. Thank you Winny for keeping us well informed.

In March our meeting was on cow protein and milk allergy in infants. New research has shown that 7% of babies can have cows milk allergy causing a variety of symptoms. Joanna Hovey, paediatric dietitian from Nutricia Medical gave us a very informative talk enjoyed by all our members. Thank you again to Maura Costello for arranging very interesting practice nurse meetings throughout the year.

Congratulations to Ruth Morrow who recently completed her prescribers’ course. Ruth is an inspiration to us all, making a huge contribution to practice nursing within her own practice and nationally.

Croi are having their annual symposium on Friday 12th and 13th November 2010. It is always well worth going to and this year I know will be no different. Look forward to seeing you all there.

CLARE

AINE LALLY

Our March meeting was sponsored by Milupa/Aptamil and the speaker, Margaret Byrne gave a very interesting and informative talk on infant nutrition and weaning.

We had a great turnout for the April meeting at the Old Ground Hotel, Ennis. It was sponsored by Astellas and the rep was Leona Lau who gave us a brief talk on stress/urge incontinence and some information on how the new drug, Vesitirim works. Following the talk we had a really sociable and enjoyable dinner and evening. It gave us a chance to meet and welcome some new members but also to say farewell to Margaret Barry who has recently retired from general practice. Margaret was a founder member of the Clare branch and contributed in many ways to its activities over the years. We wish her good health and happiness in this new phase of her life.

Summer is here, hopefully! and we will take a break for July and August. Thanks to everyone especially our committee who have contributed so much to our branch. We would like to wish all branch members a great summer.

Margaret Barry’s retirement

Tributes were paid to Margaret Barry at the April meeting of the Clare Branch held at the Old Ground Hotel. Margaret has recently retired from general practice nursing at the medical practice of Dr E Casey, Ennis, with whom she worked for 15 years.

A little tinge of sadness marred what was otherwise a very enjoyable celebration of Margaret’s commitment to her profession, her colleagues and the patients for whom she cared deeply.

Margaret was a founder-member, and Treasurer, of the Clare Branch of the IPNA for many years, and has always been an enthusiastic and active participant in the activities of the branch.

However, travel and hobbies are already filling the space in her waking hours. Margaret’s two sons and first granddaughter live in Hong Kong, and she and her husband, Michael, can now visit them more frequently. As an accomplished floral artist, Margaret also hopes to indulge her creative persona by devoting more time to her passion for flower-arranging.

We wish Margaret good health and happiness in this phase of her life, and know that our good wishes will be echoed by the many patients for whom she cared with her natural kindness and compassion.

Gerry Harty
CARLOW/KILDARE
KATE ATTRIDE

The March meeting of the Carlow/Kildare branch of the IPNA was held in the Clonard Court Hotel in Athy on Tues 16th March. It was well attended by members including secretary Anita Ryan and chairperson Margaret Clancy. The meeting was kindly sponsored by Roche with a very informative talk given by Christine Kelly RGN on women’s health including the menopause and osteoporosis.

Stella Hogan, who was present, had attended NEC meeting in February and reported that CervicalCheck are looking for ideas from nurses on how to access out-of-reach patients. Also anyone who is a trained smear taker should give their details to CervicalCheck so that they can be notified for updates. Up coming study days include diabetic study days on the 5th and 6th May in the Diabetic Day Care Centre in the Mater Hospital.

The IPNA AGM this year is in Ballybofey on the 15th and 16th October. There are flights with Aer Arann from Dublin to Donegal for €50 and the hotel will provide a bus. There is no poster competition this year but posters from the last 3 years can be displayed by booking a stand with Lisa 6 weeks beforehand. Any motions for the upcoming AGM should be submitted to Lisa Nolan before May.

CORK BRANCH
TRISH O’CONNOR

The topic of our March meeting was Urinary Incontinence and was very kindly sponsored by Gretchen Kelleher, Janssen Cilag. Guest speaker, Maura O’Sullivan, Public Health Nurse gave a comprehensive outline of her role in the community in the assessment and treatment options available for those who suffer from urinary incontinence. Maura also imparted some hard earned wisdom which you won’t find in the text books, and which was very much appreciated!

The topic of April’s meeting was Dermatology and was very kindly sponsored by Rachel Cornally, Astellas. Guest speaker, Dr. Hilda Fennell O’Shea discussed dermatology issues pertaining to general mpractice. Given the scale of dermatology cases that come through the door of a primary care clinic this was a very informative and useful presentation.

Looking forward to our next meeting which is scheduled to take place on the 19th May in the Rochestown Park Hotel at 7.30pm. I'd also like to take this opportunity to let ye know that our summer day out is busy in the planning process and is scheduled to take place early June, so keep a space in the diaries.

DONEGAL
ELSIE STEWART

Sincere thanks to Eamonn O’Hara from Abbott who very kindly sponsored our February meeting, held in the Radisson Hotel Letterkenny, at which there was an excellent attendance in spite of the cold weather conditions. Mr David Chaney, Lecturer in Nursing PhD Fellow, University of Ulster gave an excellent presentation entitled ‘Does Patient Education make a Difference’ specifically aimed in this instance at Type 1 adolescent patients. His talk also including an update on the Choice Programme which assists young diabetic patients to determine their optimal insulin dose through carbohydrate counting, resulting in better glycaemic control.

Ms Orla Noonan, Cardiac rehabilitation Co-ordinator, gave us an update on lipid management in CHD again held in the Radisson on 24th March. We were delighted to have Dr Santhosh David, Consultant Cardiologist, Letterkenny General Hospital in attendance who willingly answered many questions from the floor. Many thanks to Abina Flynn MSD and her colleague Angela McKenna who sponsored the meeting, I would like to take this opportunity to thank Abina and MSD for their ongoing support in relation to practice nurse education.

Dr Nadini Ravikumar, Consultant in Obstetrics and Gynaecology, Letterkenny General Hospital, kindly agreed to speak at our April meeting. An excellent presentation on the obstetric care of the patient with diabetes, including preconceptional care, evoked an unprecedented interaction between speaker and members in attendance who work in anti-natal clinics within primary care. We are grateful to Brian Forde, Pfizer for sponsoring the evening.

Congratulation to Ursula Molloy on her recent appointment as Chairperson of the Practice Nurses Section of the INO. Ursula has been very proactive for many years in practice nurse issues, both at local and national level. We wish you and your committee every success recognising the many difficulties ahead due to the present economic restraints.

Sincere thanks to our PDC, Ann McGill, who through emails and text messages, keeps us up to speed with all educational meetings, and relevant information thus enabling us to work competently within our scope of Practice.

Our next meeting is scheduled to take place at the end of May, details and venue to be announced soon.

GALWAY
MAUREEN DELANEY

‘Emergency Situation in General Practice’ was the topic for our first meeting of 2010. We met on the 11th February in the Claregalway Hotel. Our guest speaker was Dr Gerard Flaherty from University Collage Hospital with our meeting being generously sponsored by Rhona Keaveny from Roche Diagnostics.
A well attended meeting was held in the Radisson Hotel, with thanks to the Pfizer representatives, Brian Forde and Triona O’Halloran. Our speaker was Teresa Moore, Continence Nurse Advisor in Merlin Park Hospital. Her topic on the night was Enuresis and Promoting Continence in the Community.

In April we reconvened in The Clayton Hotel with Bernadette Daly, Psychotherapist and Eleanor Comer, Forensic Nurse from the Rape Crisis Centre in Galway. It proved to be an informative and thought provoking evening. Our thanks once again to Deirdre O’Neill of Aptamil.

On Thursday 13th May, we plan to take a summer recess from our meetings with the next meeting to be held in September in the Claregalway Hotel. Ruth O’Brien of Novartis has kindly sponsored this meeting with Dr Sean Dineen, Consultant Endocrinologist in University Collage Hospital. The topic he hopes to discuss on the evening will be Diabetes 2010.

Our meetings have changed to the second Thursday of each month, to encourage members to attend. I am delighted to say our attendance this year to our meetings have improved and I look forward to even greater participation in September.

May I on behalf of all the Galway I.P.N.A members take this opportunity to wish you all a healthy, happy and, hopefully, sunny summer.

KERRY

MARY BRICK

Our March meeting was sponsored by Kevin Dinan and Anita Cotter of Eli Lilly. Mary Joe Staunton of IT Tralee gave us an overview of their ongoing training of medical secretaries. They are delighted with the support they are getting from the GP practices in Tralee and the surrounding areas.

Donal Twomey of MD Elite Ambulances enlightened and updated us on ‘The approach to trauma management and cervical spine control’.

We had practical demonstrations with great participation from our group. He check listed, upgraded and updated our emergency bags for our practices. We were all delighted with Donal’s presentation and would love to have him back in the near future.

Our April meeting was held in The Carlton Hotel Tralee. It was sponsored by Rachel Cornally of Astellas Pharma. Rachel gave us a presentation on Protopic for the treatment of atopic dermatitis. Our guest speaker was Gerry Christie chief medical scientist in Pathology in Kerry General Hospital. He covered a great deal of pathology but delved especially into blood electrolyte results and their meanings. It was a very entertaining talk as well as being informative.

Marie Courtney, Professional Development Co-ordinator gave a brief talk to inform everyone about her forthcoming meeting in Kerry General Hospital Education Centre. This meeting was well attended and dealt with applying for CNS status.

Our next meeting is our last before we break for summer. It is on Wednesday 12th May in The Carlton Hotel. We wish you all a great holiday break whether it be ash bound or abroad.

MIDLANDS

KERRIE MARTIN

Our April meeting was held in the Mullingar Park Hotel kindly sponsored by Sinead Flynn, of Novartis. Unfortunately I was unable to attend this meeting however I heard that Sinead gave an excellent presentation on wound care followed by an introduction to Onbrez.

Our last meeting before we break for the summer took place in the Tullamore Court Hotel on 11th May kindly sponsored by Aideen French of Bayer. Aideen was unable to attend the meeting on the evening so Cathy Ball took her place. Cathy gave an excellent presentation on the menopause.

Congratulations to Una Ghee on the birth of her new baby Chloe. Thanks to Gillian Redmond who is kindly taking my place as chairperson for the next year. Enjoy the summer.

WICKLOW

MARY FINNEGAN

We held our last meeting before our summer break on Monday 10th May in Bray. The meeting was very kindly sponsored by Lisa McLaughlin and Niamh Bird from Sanofi Pasteur. The guest speaker was Dr Paul Mooney who lectures in travel medicine in the RCSi. Dr Mooney gave us a very informative presentation and update on travel medicine and vaccines. The talk provoked a lot of questions from the audience which he was more than happy to answer.

We welcomed several new members to that last meeting, and our small branch of just 15 has now expanded to 46! It is lovely to meet so many new nurses, and to have a chance to network. We look forward to some very productive and interesting meetings over next year.

Pfizer are kindly sponsoring a Basic Life Support update for a group of our branch on 27th May in Glenview Hotel, and many thanks to Aoife Nolan from Pfizer for arranging same.

The branch will meet again in September: date and speaker to be confirmed.

Thank you to all who have attended meetings since last September, and to the hard working committee. Enjoy the summer break and hope you all have an opportunity to get away at some stage for a well earned break (volcano ash permitting!).
Maternal death –
the role of CMACE Ireland

EDEL MANNING, CMACE IRELAND COORDINATOR

The establishment of CMACE Ireland has marked a significant step forward in supporting a culture of patient safety in Ireland and ensuring the continuous improvement of healthcare services.

Funded and endorsed by the HSE, CMACE Ireland is a stand-alone office working in partnership with CMACE UK in carrying out confidential enquiries on all maternal deaths in Ireland. The remit of CMACE Ireland does not currently include child health enquiries.

CMACE Ireland was launched as the Confidential Enquiry into Maternal and Child Health (CEMACH) Ireland in April 2009 by the Minister for Health and Children, Mary Harney.

On 1 July 2009, in partnership with CEMACH UK, the organisation changed its operational title to the Centre for Maternal and Child Enquiries (CMACE).

Objectives
- To assess the main causes of, and trends in, maternal deaths.
- To learn lessons by identifying any avoidable or sub-standard factors which may be causally related to adverse outcomes.
- To make recommendations concerning the improvement of clinical care and service provision that will save yet more mothers’ lives, and reduce the numbers who suffer severe maternal morbidity.
- To produce a triennial report.

Background
Global maternal deaths for 2005 showed that, of the estimated total of 536,000 maternal deaths, 99 per cent occurred in developing countries. Ireland was reported as having the lowest maternal mortality ratio of 1 per 100,000 live births in 2005.¹

However, it is known that, in the absence of active case ascertainment, under-reporting and misclassification of maternal deaths occurs in developed countries.¹⁻⁴ Maternal deaths can occur in units other than maternity units and in the community.

Although reported maternal deaths are rare in Ireland and the UK and some maternal deaths are unavoidable, there is evidence that women are still dying needlessly. Deaths can be prevented in the future only if lessons are learnt and acted upon, a process that begins with confidential enquiries into such cases.⁵

Confidential enquiries into maternal deaths have been carried out in the UK for over 50 years and are presently under the auspice of the Centre for Maternal and Child Enquiries (CMACE) UK. CMACE UK produces a triennial report that currently covers all cases of maternal death in England, Wales, Scotland and Northern Ireland.

The overwhelming strength of successive enquiry reports has been the impact their findings have had on improving standards of care and clinical governance in the UK maternity service and further afield.

From January 2009, Irish maternal mortality data has been included in the CMACE UK’s triennial report.
‘Ireland was reported as having the lowest (global) maternal mortality ratio of 1 per 100,000 live births in 2005.’

Definition of maternal death
‘A maternal death is a death occurring during pregnancy or within 42 days of delivery, miscarriage, termination of pregnancy or ectopic pregnancy from any cause related to, or aggravated by, the pregnancy or its management.’

This definition is currently under international discussion. There is a growing trend to collect data on maternal death up to one year after delivery, miscarriage or abortion. This is particularly the case with respect to cases of peripartum cardiomyopathy and deaths due to suicide.

Classification of maternal deaths
• Direct – deaths resulting from obstetric complications of the pregnant state.
• Indirect – deaths resulting from previous existing disease or disease that developed during pregnancy and not due to direct obstetric causes.
• Late – deaths occurring between 42 days and one year after the abortion, miscarriage or delivery (includes direct and indirect causes).
• Coincidental – deaths from unrelated causes which happen to occur in pregnancy and the puerperium.

(Lewis G. Saving Mothers’ Lives. 2007.)

Role of health professionals

Notification
Notify CMACE Ireland in the event of a maternal death occurring during or within one year of the pregnancy. Maternal deaths can occur in units other than maternity units and in the community.

A dedicated CMACE Maternal Death Notification Form will be available in all maternity units and acute hospitals, as well as from the CMACE Ireland office/website.

Confidential enquiry
Provide the CMACE enquiry with a full and accurate account of the circumstances leading up to the maternal death with supporting records.

Learn the lessons
All health professionals in maternity units and the community should be aware of and, where applicable, implement recommendations contained within the triennial report.

Enquiry process
The enquiry process is based on a two-stage process of Irish data collection and assessment of the case followed by a central (UK) assessment to enable aggregation into a fully anonymised overall triennial report.

The confidential enquiry into maternal deaths does not preclude the necessity for a local enquiry into maternal death or critical incident review. Results of these reports should be made available to CMACE as part of the documentation for its review process.

Irish and central assessors?
The Irish and central assessors are multidisciplinary clinicians who work independently of CMACE but contribute to the Maternal Death Enquiry. Nomination is by the relevant multidisciplinary faculties.

Biographies of the Irish assessors can be accessed on the following website: http://www.ucc.ie/en/cmace

Confidentiality and the enquiry process
Confidentiality is assured in the enquiry process:
• Through a process of anonymisation of data prior to assessment of the reported case.
• CMACE Information Security Guidelines safeguard any identifiable data for the duration it is held.
• No disclosure of information to unauthorised people or agencies.
• No discoverability; before publication of the triennial report, all documentation is destroyed and all electronic data is irreversibly anonymised.
• Current data protection legislation places no bar on the disclosure of patient information concerning maternal deaths to CMACE.

Triennial reports: Saving Mothers’ Lives

• Seventh and most recent triennial report.
• Leading causes of maternal deaths.
• Top 10 recommendations and auditable standards.
• Key issues and lessons for specific health professionals.
• Executive summary for midwives.

– MMR in the UK 2003-2005 identified by death certificate data alone = 7 per 100,000 maternities
– Proactive inclusive approach of UK Confidential Enquiry 2003-2005 identified = 14 per 100,000 maternities

(Lewis G, Saving Mothers’ Lives, 2007.)
‘Although reported maternal deaths are rare in Ireland, there is evidence that women are still dying needlessly.’
new horizons in the treatment of RA

At MSD our commitment has always been to improve the lives of patients living with rheumatic disease. It’s a focus that has established us as a leading company in rheumatology research, development and patient care — and one that will guide us in years to come.
Abdominal bloating\textsuperscript{†} bothering your patients?

Digestive discomfort such as bloating can be a normal experience of everyday life, which may be more bothersome or frequent for certain individuals. Abdominal bloating can also affect up to 96% of people with IBS, and is often ranked as their most bothersome symptom.\textsuperscript{1} Some people may have to loosen their clothes or see distension of their abdomen along with the feeling of bloating. In extreme cases a patient’s girth may increase by as much as 12 cm.\textsuperscript{2}

Activia is a probiotic yogurt which contains the exclusive probiotic strain \textit{Bifidobacterium lactis} DN-173 010 (Bifidus ActiRegularis).

Activia has been scientifically proven to help improve slower digestive transit\textsuperscript{3,4,5,6} and help support digestive comfort\textsuperscript{1,7,8} when at least one pot is eaten every day for at least 14 days as part of a healthy balanced diet and lifestyle.

\textbf{First probiotic study to demonstrate a reduction of abdominal distension\textsuperscript{†} in women with constipation-predominant IBS (IBS-C)\textsuperscript{1}}

In a recent, randomised, double-blind, controlled trial of 34 women with IBS-C, women who ate two 125g pots of Activia daily for 4 weeks compared to those who ate a non-fermented dairy product control showed that:

\begin{itemize}
  \item Percentage change in maximal abdominal distension was reduced by up to 76% \textsuperscript{1}
  \item A significant reduction in overall severity of IBS symptoms (P=0.032) and abdominal pain/discomfort (P=0.044) \textsuperscript{1}
\end{itemize}

\textsuperscript{†}Abdominal bloating and distension are part of digestive discomfort

\url{www.probioticsinpractice.co.uk}

\textbf{References}

Ear irrigation is a frequently performed procedure and is largely delegated to nurses in primary care settings. Research indicates that nurses often have had no formal training in the safe management of ear care problems, and often the only training received is to observe another and then put into practice (Rodgers, 2000). The inappropriate use of equipment in assessing and treating ear care problems has significant risk management issues. It is important that nurses are made aware of current best practice in this area. It is estimated that about one third of all elderly people have problems caused by a build up of ear wax at some time. Excessive wax needs to be removed before it becomes impacted, which can give rise to tinnitus, hearing loss, vertigo, pain and discharge. Given that we have an increasing elderly population, new approaches to ear care services needs to be considered when planning for services.

Background
Access to ear care training was an identified need within the practice nursing arena from the time the Professional Development Co-ordinators for Practice Nursing (PDCs) first came into being in 2001. Whilst the Royal Victoria Eye and Ear (RVEE) Hospital, Dublin provided an ear care programme, it was unable to accommodate the large numbers of practice nurses requesting this education. Nor were many practice nurses in a position to travel on two separate occasions to Dublin to avail of this training. This required the PDCs to seek other options, and so sourcing the training through an English company was an acceptable alternative. To this end in 2005, Rosemary Rodgers from the Primary Ear Care Centre in England came over with her husband and business manager Don and travelled throughout Ireland delivering her one day Clinical Excellence in Ear Care Study day. These visits were enabled by the PDCs with funding from the National Council for the Professional Development of Nursing and Midwifery and the HSE. Rosemary and Don came again in 2006, 2007 and 2008. The programmes were well received and evaluated positively overall. M&K (UK) also delivered training in the north west of the country in 2008. However, these arrangements were no longer sustainable or indeed suitable for current practice requirements.

Linking with practice development colleagues from areas such as Older Persons Services, A&E, Intellectual Disabilities and Mental Health has also identified a need to develop nursing services in ear care for these areas. By expanding their scope of practice to include ear care, nurses working in these areas contribute to service improvements for clients, in that services can be delivered in the most appropriate setting and within an acceptable timeframe. Access to ongoing education and training in ear care in an Irish context was required and adapting a strategic approach to this development was a pragmatic decision made by the PDCs. Previous arrangements were no longer adequate, suitable or sustainable in the long term.
We are delighted to report that nurses around the country will now have access to a nationally approved standardised Irish programme.

Developments in 2009
As the Royal Victoria Eye & Ear Hospital (RVEE), Dublin is the national centre of excellence for ear care in Ireland it was an obvious starting point for the National PDC group in researching available options. In January 2009, the chairperson of the National PDC group approached the School of Nursing in the RVEE to explore the possibilities for the development of a standardised national ear care education programme. Chris Huet as principal tutor in the RVEE School of Nursing was open to this exploration and assigned then tutor, Elspeth Finlay to work with the national group to develop an appropriate programme. During 2009 a number of PDCs worked closely with Elspeth and this collaboration lead to mutual agreements with the first ‘Train the Trainers’ ear care programme taking place in October 2009. The outcome of this is that we now have twelve nurses trained as Ear Care Trainers and the first programmes are due to be delivered commencing later this month with a number of additional programmes available throughout 2010.

We are delighted to report that nurses around the country will now have access to a nationally approved standardised Irish programme being delivered locally either through the Centres for Nursing and Midwifery Education or by the PDC thus making best use of available resources which are geographically accessible to all.

For further details on the availability of the programme in your area, please contact your local Professional Development Co-ordinator for Practice Nurses or your local CNME.

Patricia McQuillan
Kathy McSharry
On behalf of the national group of the Professional Development Co-ordinators for Practice Nurses

The Transformation Programme (HSE, 2007) has six priorities. Priority Two states that; “Primary, Community and Continuing Care services will be reconfigured so that they deliver optimal and cost effective services” (p11). This translates for the client as the ability to easily access a broad spectrum of care services locally. Each client is entitled to expect high quality care measured against transparent standards. Nurses working in the aforementioned clinical areas, who are interested in expanding their scope of practice by providing nurse-led ear care services, will have the necessary and appropriate professional support to progress this service development with access to an established national ear care training programme. Nurses trained in ear care reduce treatment costs, reduce the use of antibiotics, educate patients in ear care, increase patient satisfaction, and raise ear awareness. (Br J Gen Pract. 1997 Nov;47 (424):699-703)
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The MSD Science Centre is a medical education initiative which provides high quality, balanced continuing medical education to Irish doctors. All MSD Science Centre initiatives are developed in partnership with independent medical specialists and General Practitioners. The MSD Science Centre is provided as a service to the Irish medical community by MSD.
Mental Health – Part 1

Jigsaw – overview of Galway’s system for promoting mental health in young people

JOHN FITZMAURICE, PROGRAMME MANAGER, GALWAY JIGSAW

Jigsaw Galway is a new support service for young people aged 15 to 25 years living in Galway City and county. The primary aim of Jigsaw is to provide a community-based system of care that supports young people and helps them achieve better mental health and well-being. With a strong emphasis on early intervention, its Mary Street location in the centre of the city serves as a drop-in and referral centre, ensuring that when young people with significant needs seek help, they obtain an immediate response from an individual who listens to them, determines what level of assistance may be required and ensures that they receive that assistance.

COMMUNITY SUPPORT
One of the key steps in working with any young person is to identify the natural supports (family and friends) and community-based supports available to them. The focus is on working with young people from a strengths-based perspective, and developing the capacity of the individual and those around them. A central strategy within Jigsaw is to ensure that supports offered to young people and families are done within the context of their overall community supports.

JIGSAW’S SERVICES
In its first year of operation Jigsaw has served over 500 young people. Services provided can be categorised under three broad headings:

- 30 per cent – brief intervention (engagement with support worker for one to three sessions)
- 30 per cent – prolonged engagement. This is based on engagement with a support worker for a period of between six and eight sessions. A process of goal attainment scaling is used based on goals and outcomes that the young person wants to achieve.
- 40 per cent – case consultation/case management. In this instance, there may be several services involved in the young person’s care and it may or may not be appropriate that Jigsaw gets directly involved with the young person. Jigsaw’s role in this context is to ensure that there is a co-ordinated plan in place for the young person’s care at both a service level and community level.
One of the most heartening things about Jigsaw to date is the level to which young males have engaged with the service – 53 per cent of service users are male.

I believe that this is down to a number of factors: young people’s direct involvement in the planning, design and delivery of the service; the quality environment and supports on offer; ease of access; and, most importantly, word of mouth.

Word of mouth is a crucial selling point for Jigsaw Galway, as Jigsaw is a ‘product’ that we are selling to young people. Once they walk through that door or pick up the phone, they will make up their minds very quickly as to whether this is a service they want to use or not. More importantly, they will make up the minds of those closest to them, such as friends and family.

REFERRAL SOURCES
The importance of word of mouth is demonstrated by the fact that over one-third of referrals to Jigsaw are self-referral, a figure which continues to increase, with another 20 per cent coming from parents or family members. Other referral sources include health services (21 per cent), schools and colleges (9 per cent) and community-based services (15 per cent).

While the age profile of those accessing Jigsaw spans the 15 to 25 year age range, it is worth noting that 38 per cent of young people accessing support are between the ages of 16 and 18 years. Seventeen years represents the age at which young people are most likely to access Jigsaw (14 per cent). Young people between the ages of 19 and 25 years represent 44 per cent of those accessing Jigsaw.

SEEKING SUPPORT
Presentations to Jigsaw vary greatly. The nature of a drop-in brings its own challenges in that, to some degree, you have very little control over what comes through the door. In this sense, it can be hard to maintain the early intervention ethos. However, this is seen as one of the major strengths of Jigsaw, in that young people and parents feel strong enough and confident enough in the service to walk through the door and seek the support they are looking for.

The most common presentations to Jigsaw have included issues within families, relationships with peers and feelings, such as low mood, low self-esteem, anger or frustration. Other common presentations include isolation, physical stress, anxiety and problematic behaviour, such as abuse of alcohol or drugs.

SPECTRUM OF SERVICES
Interventions employed within Jigsaw range from relationship building, anxiety management, problem solving to substance misuse counselling and conflict resolution. As Jigsaw is evolving so too is the spectrum of services provided. Apart from the multi-disciplinary team on site, sessional supports are ever increasing in the form of GP services, psychology, complementary therapies, art therapy and other forms of group therapy.

Central to the evolution of the service is the belief that it is not about creating something new but about enhancing and using what is already in place. This is certainly borne out by the extent to which health and social services collaborate with Jigsaw on a day-to-day basis.

JIGSAW.IE
Other service developments over the past 10 months include the completion of the Jigsaw website (www.jigsaw.ie) which acts as a vital access point for young people as well as a point of information for parents, services and community providers. The development of an online data management system ensures that monitoring and evaluation on a daily basis is to the forefront of Jigsaw’s work.

At a broader level Jigsaw is actively engaging and working with communities (based on primary care networks) to prioritise the needs of each community to ensure that young people have access to appropriate supports at a community level.

EVERYONE’S BUSINESS
While the level of referral to Jigsaw continues to increase, one of the key challenges now is to maintain and build capacity. Fidelity to the approach and concepts that underlie Jigsaw is central to ensuring that it maintains its principles and ethos. The necessity of making mental health everyone’s business is crucial for ensuring that communities have the capacity to value and support young people in a long-term sustainable way.

The Jigsaw model, developed by Headstrong, is being implemented in partnership with the HSE and Mental Health Ireland.

‘One of the most heartening things about Jigsaw to date is the level to which young males have engaged with the service.’
DYNAMIC PROFESSION
The profession of nursing is a dynamic one and has seen many changes through the years. Jigsaw is a brief intervention service that was designed to support young people between the ages of 15 and 25 years around achieving optimal mental health. Practice nursing is very compatible within brief intervention services as the nurse is in an ideal position to treat, educate, advocate, liaise and support clients through whatever problem they may present with.

HOLISTIC APPROACH
In Jigsaw, practice potentials are constantly changing, developing and adapting to suit the needs of young people aged 15 to 25 years. The practice nurse is required to take on many roles and use a varied skills base for working with this client group. Some of these roles include being a clinician, an advocate, a gatekeeper for other services, collaboration, health education, liaison with significant persons and services and general support. Working within Jigsaw requires you to work with clients using a holistic approach. It is essential that you meet the young person where they are at, at that present moment in time. For example, if a young person is seeking medical attention, it is not necessarily the time to educate them on the dangers of their drug-taking habits. Also, if someone is without accommodation, this may need to be addressed before any further work is done with that young person.

INTUITION IS THE KEY
It is essential, while working in this setting, to make every effort to be non-judgmental, to offer support around issues and to give information when required. Intuition is the key to working with clients in this context. It is hugely important to pick up on cues as this may be the only window for you to offer someone help and respond appropriately. For this to happen it is crucial to allow people space and time to express their needs.
Clinical review

Practice Nurse’s Role
To help demonstrate some of the ways in which the practice nurse’s role works in Jigsaw, two cases and the actions taken in each case are outlined below. Names and specific case details have been changed to protect the clients’ identities.

Case A. Lizzy
Lizzy is a 19-year-old female who presented to Jigsaw as she was very worried she might be pregnant.

On taking her history, Lizzy stated that her last menstrual period was one month ago and she had not had sexual intercourse since her last period. She had had a possible episode of unprotected sexual intercourse two months previous at a party (but her period had occurred since then). She was taking the oral contraceptive Pill at the time but had vomited at the party and was very worried about the absorption of the medication. She was very concerned she was pregnant.

On talking to Lizzy, I asked her if her period was late and she stated no, but she explained she couldn’t get it out of her head that she was pregnant. She was requesting a pregnancy test. It was explained to her that it was highly unlikely she was pregnant from the information she had given but to allay her concerns, a pregnancy test would be carried out. A pregnancy test was done and the result was negative. When this was told to Lizzy she didn’t believe the result.

On discussing this with Lizzy, she spoke about her fears of getting pregnant because of the problems she had at home with her parents. From listening to Lizzy, it became more evident from what she was saying that she was under severe stress and suffering from anxiety which she had had for years. She stated that she worried all the time that there were different medical things wrong with her. Also she had issues with her weight and had very low self-esteem.

On talking to Lizzy further, she felt the problems she was having were coming from difficulties she was having with her mother. By the end of the session, Lizzy decided to come back to Jigsaw and attend for a number of weeks to develop skills to cope with her anxiety and to receive support for some of the family problems she was experiencing.

Case B. Brian
Brian is a 22-year-old who presented to Jigsaw complaining of a sore throat.

On examination, his throat did not appear red or swollen but he appeared to be distressed. I spoke with Brian about how he was feeling and he said he felt like he had a lump in his throat for the last few weeks. He stated that he felt under a lot of pressure as he had been experiencing difficulties with his girlfriend over the last few months and they had been arguing quite a lot and that he was feeling unable to cope with things.

Brian went on to explain that he had no family support and his girlfriend and a few friends were all the support he had. Brian had a very traumatic childhood and had never really spoken to anyone about it. He experienced night terrors on most nights and, as a result, was unable to sleep.

He explained that the only way he could sleep was by smoking “a couple of joints”. He also spoke about blacking out when he got very nervous and stressed and suffered from severe anxiety attacks.

On asking Brian what he would like from Jigsaw, he stated that it would be good to talk to someone about things and that he would like to get some help for his anxiety and sleep. Brian was offered a range of different therapies on offer at Jigsaw to help with the issues he identified.

Taking Time to Listen
The cases discussed above are just two of the examples of clients who present to the practice nurse on a daily basis. They have been presented here to aid further understanding of the practice nurse’s role within this setting. The main point in the two cases is that, for both people, listening, time and picking up on cues, allowed them to voice their real concerns and allowed these to be addressed.

It is often found in this setting that young people may present with a general medical complaint. They may do this often to test the reaction they will get from the service; if they find they are being listened to and that the person appears to have time and is not rushing them, they may decide to discuss other, more problematic, issues.

Jigsaw’s Team
Within Jigsaw, the practice nurse is supported by a multidisciplinary team to whom clients can be referred for further therapies. The team meets weekly to discuss all cases to decide the best courses of action for each young person.

The team comprises of:
- Programme manager
- Clinical team lead
- GPs
- Psychologist
- Support workers
- Information and support officer
- Counsellor
- Art therapist
- Complimentary therapist

Each case is dealt with individually, using alternative approaches specifically designed to meet that young person’s needs.

“A pregnancy test was done and the result was negative. When this was told to Lizzy, she didn’t believe the result.”
Dental and oral awareness – part 1

**DR AT PAPATHOMAS**, BDS (UNIVERSITY OF SHEFFIELD),
PRINCIPAL DENTIST OF WILLIAMSTOWN DENTAL CENTRE, WATERFORD

There are numerous occasions when the medical team will look in the mouths of patients. There are many conditions of the teeth and soft tissues that the medical team may notice during this examination and may be able to advise on, or pass on to dental colleagues.

In this first article, we will discuss dental development and decay and common anomalies in dental development that are easily recognised.

In part two in this series, I will discuss other common conditions of the soft tissues and their management.

### Dental decay (dental caries)

Dental caries is exceptionally common and is the most common chronic childhood disease. In the majority of cases, it can go undetected until the latter stages of pain and infection. Dental caries can develop in both deciduous and permanent teeth. As soon as the teeth erupt and appear in the mouth, they are vulnerable to decay.

Dental caries is caused by bacteria which are normal commensals in the mouth. The bacteria which cause dental decay are *Streptococcus mutans* and *Lactobacillus*.

For dental caries to develop, the following are required:

- Plaque.
- Refined carbohydrates (sugars).
- A susceptible tooth.

A full complement of primary teeth consists of 20 teeth and the permanent teeth are 32 in total, including the wisdom teeth. The ages at which these teeth begin to appear are approximately as follows:

- Central incisor: four to six months.
- Lateral incisor: 8-14 months.
- Canine: 14-24 months.
- First molar: 10-20 months.
- Second molar: 20-36 months.
- First adult tooth erupts: five to six years.

### Childhood dental decay

Some facts about childhood dental decay and its consequences are as follows:

- Childhood caries is five times more common than asthma.
- Dental caries is more prevalent in the lower socio-economic classes.
- If decay in deciduous teeth is left untreated, this will result in dental abscesses with the possibility of damage to the underlying permanent dentition.
- The primary teeth have a functional role in the child’s development and healthy teeth allow for proper chewing and are important in allowing good pronunciation and speech habits.
- By preserving the deciduous teeth, they will guide the permanent teeth and reduce the risk of orthodontic problems in later years.
- By preserving the deciduous teeth, this will maintain the dental arch integrity and prevent drifting of teeth and help to keep a child socially ‘acceptable’ and reduce teasing by peers.
A typical recommended dental care programme would be as follows:

- **Aged four to six months** – it is advised that parents start brushing the child’s teeth on a daily basis twice a day until seven years of age. Use children’s toothpaste from six months to two years, 500ppm fluoride.
- **12 months** – wean from breastfeeding or from the bottle. Move onto a feeding cup. Avoid on-demand feeding at night as this can lead to early childhood decay. Water is the only safe drink at night.
- **24 months** – start using a pea-sized amount of fluoridate toothpaste when brushing, 1,000ppm fluoride. At this stage, the child should have his or her first visit to the dentist to evaluate dental development, oral hygiene and oral habits.
- **30-36 months** – last of 20 primary teeth erupts. If the teeth are tight together, parents should floss at night before brushing. Encourage stopping the use of the soother or thumb-sucking habits well before the arrival of the child’s first permanent tooth.
- **Five to six years** – first primary lower front tooth is lost, being replaced by the first permanent incisor. Four upper and lower front teeth are lost and replaced by the time the child has reached eight years of age. During the transition, six-monthly dental check-ups are advised. A remouldable gum shield should be worn during contact sport to protect the permanent front teeth from injury.
- **Six years** – first permanent molar erupts at the back of the mouth. Include in daily cleaning, suitable for fissure sealing when fully erupted.
- **12-14 years** – orthodontic treatment commences, i.e. braces for children who have crowding or a mismatch in jaw sizes. Special small brushes and superfloss used to clean the teeth while the braces are on. Fluoridated mouth rinse used daily.
- **12-14 years** – a custom-made gum shield should be worn for contact sports to prevent injury.
- **18 years plus** – four wisdom teeth or third set of permanent molars erupt (one-third of people are missing one or more of the wisdom teeth).

In order to prevent or reduce the risk of dental caries, we revert to trying to eliminate one or more of the three requirements necessary for decay which are plaque, refined carbohydrates and a susceptible tooth.

**Plaque:** plaque can be reduced by having a good oral hygiene regime of brushing and flossing and regular professional cleaning.

**Refined sugars:** care with diet and reduced snacking in between meals will help to reduce the risk of decay.

**Susceptible tooth:** fissure sealant – a dental treatment applied to the valleys, groves and pits to prevent decay. It consists of a clear or white liquid which is painted onto the fissure before being set by a curing light. The sealant then stops plaque and food being in contact with the tooth.

**Fluoride** – despite all the debates on this topic, the major fact is that exposure to the optimal amount of fluoride results in a reduction in decay. Fluoride can be taken systemically or topically. It can be taken in drinking water, toothpastes, mouthwashes, varnishes, gels, tablets or in slow-release devices.

**Common conditions during dental development**

**Eruption cyst/eruption haematomas**

These are associated with erupting primary and permanent teeth. They appear as bluish and translucent, dome-shaped, soft-tissue lesions overlying an erupting tooth. An eruption cyst results from fluid accumulation within the space surrounding the erupting tooth. When the fluid in the cyst is mixed with blood, the cyst is referred to as an eruption haematoma. No treatment is typically needed, because the tooth erupts through the lesion, which disappears spontaneously.

As soon as the teeth erupt and appear in the mouth, they are vulnerable to decay.
**Pericorinitis**
This is a painful inflammation of the operculum (the overlying gum), over an erupting or impacted tooth. It is a relatively common condition, particularly in the young adult age group. It is most common around the lower third molar. The patient will often have limited opening (trismus) and may also have a fever and lymphadenopathy.

The management of this condition involves the debridement of the gum flap +/- antimicrobials (effective against anaerobes). In some cases, it may be necessary to extract the offending tooth.

**Tetracycline staining**
Tetracyclines are taken up by the developing teeth if they are administered to the pregnant or nursing mother or to children less than 10 years of age. They are characterised by definite bands of staining which are typically at the necks of the teeth. In severe staining cases, these can be covered with porcelain veneers in adulthood.

**Tauri (mandibular and maxillary)**
**Torus mandibularis** is a bony exostosis growth in the mandible along the surface nearest to the tongue. Mandibular tori are usually present near the premolars. In approximately 90 per cent of cases, this is bilateral. The prevalence of mandibular tori can be up to 60 per cent.

**Torus palatinus**
Torus palatinus are palatal tauri seen in up to 20 per cent of the population, typically in the midline vault of the palate. Tori are usually a clinical finding with no treatment necessary. It is possible for ulcers to form on the area of the tori due to trauma. The tori may also complicate the fabrication of dentures. If this is the case, they can be surgically removed or reduced.

**By preserving the deciduous teeth, they will guide the permanent teeth and reduce the risk of orthodontic problems in later years.**
Symbicort 400/12 bd + tiotropium:

- Reduces severe exacerbation rates by 62% vs. tiotropium alone
- Provides rapid improvements in morning symptoms

**Dosage and Administration:**

**Asthma:**

Adults (including elderly): 1 inhalation twice daily. Not intended for the initial management of asthma. Dose should be individualised. If an individual patient requires dosages outside recommended regimen, appropriate dosages of beta₂-agonist and/or inhaled corticosteroid should be prescribed. When symptoms are controlled, therapy should be reduced to the lowest effective dose, which could include once daily. Lower strengths are available for the Symbicort maintenance and reliever therapy regimen. Children under 12 years: Not recommended. (A lower dose Symbicort Turbohaler is available for use in children 6 – 11 years COPD; Adults: 1 inhalation twice daily. Contraindications, Warnings and Precautions etc.: Contraindications: Hypersensitivity (allergy) to budesonide, formoterol or lactose (which contains small amounts of milk protein.). Warnings and Precautions: If treatment is ineffective, or there is a worsening of the underlying condition, therapy should be reassessed. Treatment should not be stopped abruptly. Sudden and progressive deterioration in control requires urgent medical assessment. Patients should have their rescue medication available at all times. Therapy should not be initiated during an exacerbation. Serious asthma-related adverse events and exacerbations may occur and patients should continue treatment but seek medical advice if asthma symptoms remain uncontrolled or worsen after initiation with Symbicort. As with other inhaled corticosteroids, systemic effects may occur, particularly at high doses prescribed for long periods. These may include adrenal suppression, growth retardation in children and adolescents, decrease in bone mineral density, cataract and glaucoma. Potential effects on bone should be considered especially in patients on high doses for prolonged periods that have co-existing risk factors for osteoporosis. Caution when transferring patients who have required high dose emergency corticosteroid therapy in the past or prolonged treatment with high doses of inhaled corticosteroids or oral corticosteroids or in a situation likely to produce stress (e.g. elective surgery). Recommend monitor height of children on long-term inhaled corticosteroids. Observe caution in patients with thyrotoxicosis, pheochromocytoma, diabetes mellitus, untreated hypokalaemia or severe cardiovascular disorders. Re-evaluate use (dose/need for use) in patients with pulmonary TB or fungal/viral infections in airways. Observe caution in patients with prolongation of the QTc-interval. As with other beta₂-agonists, hypokalaemia may occur at high doses. Particular caution recommended in unstable or acute severe asthma as this effect may be potentiated by xanthine derivatives, steroids, diuretics and hypoxia. Monitor serum potassium levels. Hypokalaemia may increase the dispersion towards arrhythmias in patients taking digitalis glycosides. In diabetic patients, consider additional blood glucose monitoring. Interactions: Concomitant treatment with itraconazole, rifonavir or other CYP3A4 inhibitors should be avoided unless the benefits outweigh the systemic side effect risks. Not to be used when patients are taking digitalis glycosides. Pregnancy: Concomitant treatment with itraconazole, rifonavir or other CYP3A4 inhibitors should be avoided unless the benefits outweigh the potential risks. **Side-effects:** Common: Palpitations, candida infection in the oropharynx, headache, tremor, mild irritation in the throat, coughing, hoarseness. Uncommon: Tachycardia, nausea, muscle cramps, dizziness, agitation, restlessness, nervousness, sleep disturbances, bruises. Rare: Cardiac arrhythmias, e.g. atrial fibrillation, supraventricular tachycardia, extrasystoles, immediate and delayed hypersensitivity reactions e.g. extravasation, urticaria, pruritus, dermatitis, angioedema and anaphylactic reaction, hypokalaemia, bronchospasm. Very rare: Angina pectoris, signs and symptoms of systemic glucocorticosteroid effects e.g. adrenal suppression, growth retardation, decrease in bone mineral density, cataract and glaucoma, hyperglycaemia, taste disturbances, depression, behavioural disturbances (mainly in children), variations in blood pressure As with other inhaled therapy, paradoxical bronchospasm may occur in very rare cases. Treatment with beta₂-agonists may result in an increase in blood levels of insulin, free fatty acids, glycerol and ketone bodies. Package Quantities: Each Symbicort Turbohaler contains 60 inhalations. Legal Status: Prescription only medicine (POM). Marketing Authorisation Number: PA 970/283. Marketing authorisation Holder: AstraZeneca UK Limited, 800 Capability Green, Luton, LU1 3LU, UK. Further information available on request from: AstraZeneca Pharmaceuticals (Ireland) Ltd., College Park House, 20 Nassau Street Dublin 2. Telephone: (01) 6087100 Fax (01) 6796960. Adjudged Prescribing Information prepared: 0809. Symbicort and Turbohaler are Trade Marks of the AstraZeneca group of companies.

The aim of the poster is to raise awareness of the unique challenges that exist for women in their midlife and to facilitate healthcare workers to act as advocates for this group. In Chinese, the characters that form the word ‘crisis’ mean both ‘danger’ and ‘opportunity’. Levinson (1990).

Background
Jacques (1965) holds that many people experience more or less of a ‘midlife crisis’ when the fires of enthusiasm and optimism begin to abate and when the discrepancies between aims and achievements dawn on them. Some change their career or their sexual partner in an attempt to regain their sense of youth and purpose.

Characteristics
Individuals experiencing a midlife crisis are said to have some of these feelings;
- Search for an undefined dream or goal.
- A deep sense of remorse for goals not accomplished.
- Desire to achieve a feeling of youthfulness.
- Need to spend more time alone or with certain peers.

The transitional phase of life from youth to age is quite hard to negotiate. If people are unwilling to relinquish the love affair with their own youth, the result will be vanity, rigidity, unhappiness and stagnation.

Erikson’s seventh stage concerned the task of developing the ego quality of generativity. If this task is not completed successfully self-absorption and stagnation are the result.

Challenges include;
- Physiological changes.
- Changing home life.
- Empty nest syndrome.
- Elder care.
- Reintegrating into the workforce.
- Spousal re-adjustments.

This generation of women may not have the same family and community supports of previous generations: they are expected to cope with even greater demands with fewer resources.

Take each day at a time and remember to take time out for yourself.

The role of the practice nurse
The role of the practice nurse is to recognise the unique patient/client opportunity to empower women at this challenging time of their life. Women may present to general practice with a variety of health concerns that may mask other emotional, psychological and social needs.

To be aware of the woman as a complex multi-dimensional individual living within a social construct of family, work and community, that may require additional supports to cope in these challenging midlife times. This issue is hidden largely due to the perception that women in midlife appear to effortlessly glide swanlike through the demands of motherhood, wife, carer, and career.

Practice nurses can empower and enable women by acting as advocate and resource to women in their midlife, offering holistic support. It is important for us as practice nurses to know the limits of our competence and involvement while liaising with the GP, primary care team and other external agencies.

As practice nurses it is important that we use effective listening and attending skills to communicate that we value that person and what they are experiencing. Information plays an important part in successful treatment and prevention of symptoms, promotion of coping skills and promotes feelings of empowerment.

References
## WOMENS HEALTH RESOURCE LIST
### National Patient Support Groups

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Address</th>
<th>Telephone Numbers/Email/Website</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ACCORD</strong></td>
<td>Clare Curran, 39 Harcourt Street, Dublin 2.</td>
<td>Tel: 01-4780866, Email: <a href="mailto:marriagepreparation@dublin.accord.ie">marriagepreparation@dublin.accord.ie</a>, Website: <a href="http://www.accord.ie">www.accord.ie</a></td>
</tr>
<tr>
<td><strong>Alcoholics Anonymous</strong></td>
<td>General Service Office, 109 South Circular Road, Leonard’s Corner, Dublin 8.</td>
<td>Tel: 01-4538998, Fax: 01-4537673, Email: <a href="mailto:gso@AlcoholicsAnonymous.ie">gso@AlcoholicsAnonymous.ie</a>, Website: <a href="http://www.alcoholicsAnonymous.ie">www.alcoholicsAnonymous.ie</a></td>
</tr>
<tr>
<td><strong>Aware</strong></td>
<td>72 Lower Leeson Street, Dublin 2.</td>
<td>Tel: 01-869300, Fax: 869333, Email: <a href="mailto:info@aware.ie">info@aware.ie</a>, Website: <a href="http://www.aware.ie">www.aware.ie</a></td>
</tr>
<tr>
<td><strong>Breereavement Counselling Service</strong></td>
<td>Dublin Street, Baldoyle, Dublin 13.</td>
<td>Tel: 01-8391766, Email: <a href="mailto:bereavement@eircom.net">bereavement@eircom.net</a>, Web: <a href="http://www.bereavementireland.org">www.bereavementireland.org</a></td>
</tr>
<tr>
<td><strong>Bodywhys – The Eating Disorders Association of Ireland</strong></td>
<td>PO Box 105, Blackrock, Co. Dublin.</td>
<td>Tel: 01-2834963, Helpline: 1890 200 400, Email: <a href="mailto:info@bodywhys.ie">info@bodywhys.ie</a>, Website: <a href="http://www.bodywhys.ie">www.bodywhys.ie</a></td>
</tr>
<tr>
<td><strong>Crisis Pregnancy Agency (CPA)</strong></td>
<td>4th Floor, 89-94 Capel Street, Dublin 1.</td>
<td>Tel: 01 8146292, Email: <a href="mailto:info@crisispregnancy.ie">info@crisispregnancy.ie</a>, Website: <a href="http://www.crisispregnancy.ie">www.crisispregnancy.ie</a></td>
</tr>
<tr>
<td><strong>Cervical Screening Programme (Irish)</strong></td>
<td>South West Wing, Mulgrave Street, Freepost LK 407, Limerick.</td>
<td>Tel: 061 4613900, Fax: 061 481810, Email: <a href="mailto:icsp@mailh.hse.ie">icsp@mailh.hse.ie</a>, Website: <a href="http://www.icsp.ie">www.icsp.ie</a></td>
</tr>
<tr>
<td><strong>Counselling and Psychotherapy (Irish Association for)</strong></td>
<td>8 Cumberland Street, Dun Laoghaire, Co. Dublin.</td>
<td>Tel: 01-2300061, Fax: 01-2300064, Email: <a href="mailto:iacp@irish-counselling.ie">iacp@irish-counselling.ie</a>, Website: <a href="http://www.irish-counselling.ie">www.irish-counselling.ie</a></td>
</tr>
<tr>
<td><strong>Cura</strong></td>
<td>30 South Anne Street, Dublin 2.</td>
<td>Tel: 01-671 0598, Fax: 01-6710886, Email: <a href="mailto:curadublin@eircom.net">curadublin@eircom.net</a>, Website: <a href="http://www.cura.ie">www.cura.ie</a></td>
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</tr>
<tr>
<td><strong>GROW, World Community Mental Health Movement in Ireland</strong></td>
<td>30 South Anne Street, Dublin 2.</td>
<td>Tel: 01-671 0598, Fax: 01-6710886, Email: <a href="mailto:curadublin@eircom.net">curadublin@eircom.net</a>, Website: <a href="http://www.cura.ie">www.cura.ie</a></td>
</tr>
<tr>
<td><strong>Heart Foundation (Irish)</strong></td>
<td>4 Clyde road, Ballsbridge, Dublin 4.</td>
<td>Tel: 01-6685001, Fax: 01 6685896, Email: <a href="mailto:info@irishheart.ie">info@irishheart.ie</a>, Website: <a href="http://www.irishheart.ie">www.irishheart.ie</a></td>
</tr>
<tr>
<td><strong>Mental Health Ireland</strong></td>
<td>Mensana House, 6 Adelaide Street, Dun Laoghaire, Co. Dublin.</td>
<td>Tel: 01-2841166, Fax: 01-2841736, Email: <a href="mailto:information@mentalhealthIreland.ie">information@mentalhealthIreland.ie</a>, Website: <a href="http://www.mentalhealthIreland.ie">www.mentalhealthIreland.ie</a></td>
</tr>
<tr>
<td><strong>Osteoporosis Society (Irish)</strong></td>
<td>33 Pearse Street, Dublin 2.</td>
<td>Tel: 01-6774267, Fax: 01-6351698, Email: <a href="mailto:info@irishosteoporosis.ie">info@irishosteoporosis.ie</a>, Website: <a href="http://www.irishosteoporosis.ie">www.irishosteoporosis.ie</a></td>
</tr>
<tr>
<td><strong>Rape Crisis Centre</strong></td>
<td>Dublin: 70 Lr. Leeson Street, Dublin 2.</td>
<td>Tel: 01-6649111/1800778, Email: <a href="mailto:rcc@indigo.ie">rcc@indigo.ie</a>, Website: <a href="http://www.drrc.ie">www.drrc.ie</a>, Fax: Cork 5 Camden Place, Camden Quay, Tel: 0171-4505577/1800 496496, Email: <a href="mailto:info@sexualviolence.ie">info@sexualviolence.ie</a>, Website: <a href="http://www.susalviolence.ie">www.susalviolence.ie</a></td>
</tr>
<tr>
<td><strong>The Centre for Prevention of Self Harm or Suicide</strong></td>
<td>Pieta House, Old Lucan Road, Lucan, Co. Dublin.</td>
<td>Tel: 01-6010000, Fax: 01-6283835, Email: <a href="mailto:mary@pieta.ie">mary@pieta.ie</a>, Website: <a href="http://www.pieta.ie">www.pieta.ie</a></td>
</tr>
<tr>
<td><strong>Women’s Aid</strong></td>
<td>Everton House, 47 Old Cabra Road, Dublin 7.</td>
<td>Tel: 01-8684721/1800 341 900, Fax: 01-868 4722, Email: <a href="mailto:info@womensaid.ie">info@womensaid.ie</a>, Website: <a href="http://www.womensaid.com">www.womensaid.com</a></td>
</tr>
<tr>
<td><strong>COSC – The National Office for the Prevention of Domestic, Sexual and Gender-based Violence</strong></td>
<td>Department of Justice, Equality and Law Reform 2nd Floor, Montague Court, Montague Street, Dublin 2</td>
<td>Tel: 01-4768680, Fax: 01-4768619, Email: <a href="mailto:csoc@justice.ie">csoc@justice.ie</a>, Website: <a href="http://www.cosc.ie">www.cosc.ie</a></td>
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This was an entry for the branch poster award 2008
Abstract submitted by Marie Courtney and Amina Parkes
Implementing nurse prescribing: a case study in diabetes

This UK paper, from the Division of Health and Social Care, University of Surrey, is a report of a study exploring the views of nurses and team members on the implementation of nurse prescribing in diabetes services.

Nurse prescribing is adopted as a means of improving service efficiency, particularly where demand outstretches resources. Although factors that support nurse prescribing have been identified, it is not known how these function within specific contexts. This is important as its uptake and use varies according to mode of prescribing and area of practice.

A case study was undertaken in nine practice settings across England where nurses prescribed medicines for patients with diabetes. Thematic analysis was conducted on qualitative data from 31 semi-structured interviews undertaken between 2007 and 2008. Participants were qualified nurse prescribers, administrative staff, physicians and non-nurse prescribers.

Nurses prescribed more often following the expansion of nurse-independent prescribing rights in 2006. Initial implementation problems had been resolved and few current problems were reported. As nurses’ roles were well-established, no major alterations to service provision were required to implement nurse prescribing. Access to formal and informal resources for support and training were available. Participants were accepting and supportive of this initiative to improve the efficiency of diabetes services.

The main factors that promoted implementation of nurse prescribing in this setting were the ability to prescribe independently, acceptance of the prescribing role, good working relationships between doctors and nurses, and sound organisational and interpersonal support. The history of established nursing roles in diabetes care, and increasing service demand, meant that these diabetes services were primed to assimilate nurse prescribing.

More than measurement: practice team experiences of screening for type 2 diabetes

The feasibility, cost-effectiveness and best means to implement population screening for type 2 diabetes remain to be established.

The aim of this study from the Institute of Public Health, General Practice and Primary Care Research Unit, University of Cambridge, was to learn from the experiences of practice staff undertaking a diabetes screening programme in order to inform future screening initiatives. Qualitative analysis of interviews with staff in six general practices in the ADDITION-Cambridge trial were studied; three randomly allocated to intensively manage screen-detected patients and three providing usual care.

The authors conducted semi-structured interviews with seven nurses, four doctors, three healthcare assistants and four managers. Four researchers analysed the transcripts practice by practice, preparing vignettes and comparing interpretations. Participants commented on a summary report.

Each practice team implemented the screening and intervention programme differently, depending on numbers at risk and decisions about staff contributions. Several emphasised the importance of administrative support. As they screened, they extended the reach of the programme, testing patients outside the target group if requested, checking other risk factors, providing health information and following up people with impaired glucose tolerance. Staff felt that patients accepted the screening and subsequent management as any other clinical activity.

Although those developing screening programmes attempt to standardise them, primary care teams need to adapt the work to fit local circumstances. Staff members need a sense of ownership, training, well-designed information technology systems and protected time.

Furthermore, screening is more than measurement; at the individual level, it is a complete healthcare interaction, requiring individual explanations, advice on health-related behaviour and appropriate follow-up.
GARDASIL® CAN PREVENT

- Cervical cancer*,
- High-grade cervical intra-epithelial neoplasia,
- High-grade vulvar and vaginal intra-epithelial neoplasia,
- and genital warts,

causally related to HPV 6, 11, 16, 18.

More than 40 million doses distributed worldwide²

* Related to HPV 16, 18
The impact of an intervention for nurse prescribers on consultations to promote patient medicine-taking in diabetes: a mixed methods study

Nurse prescribers are in a key position to promote medicine-taking in diabetes. Although patients’ beliefs about medicines are important predictors of medicine-taking, evidence suggests nurses do not routinely explore these.

The objective of this study from the School of Health Sciences, University of Southampton, was to evaluate a theory-based intervention designed to increase nurse prescribers’ exploration of medicines’ beliefs with people with diabetes.

Nurse prescribers were recruited from seven Trusts in England. A purposive sample of 14 nurse prescribers attended four one-day workshops.

Audio recordings of each nurse prescribers’ consultations with diabetes patients were collected at baseline, one week, three months and six months after the intervention. Nurse prescribers were interviewed at one month and six months post intervention. Changes in medicines’ discussion and participation in consultations were analysed using MEDICODE.

Interview data were analysed using Framework Analysis.

MEDICODE themes of ‘attitudes towards medication’ showed a significant rise at one week (p<0.01) and three months (p<0.05). ‘Asks patient opinion about medication’ significantly increased at one week (p<0.01). Discussion on ‘concerns about medication’ rose significantly at one week (p<0.001) and six months (p<0.01). Discussion on ‘expected effects of medication’, ‘action of medication’ and ‘reasons for medication’ showed no change. There were no significant changes in Dialogue Ratio.

However, the Preponderance of Initiative moved towards more patient initiative at one week (p<0.0001), three months (p<0.0001) and six months (p<0.0001).

In interviews, nurses reported increased attention to patients’ medication beliefs and adoption of patient-centred skills. Contextual factors that positively influenced ability to explore medicines beliefs in practice settings were: support of colleagues and practising new skills. Inhibiting factors included: patients’ perceived lack of receptivity, time constraints and concerns about opening a ‘can of worms’.

Six months’ interviews revealed using skills in practice enhanced nurses’ confidence and sustainability of skills requires a nurse-patient relationship. Method triangulation illuminated how the intervention was implemented in practice contexts.

The intervention was effective at changing some key dimensions of prescribing consultations. The use of a self-efficacy framework in the intervention, to promote nurses’ confidence in working in a different way, may have been instrumental in effecting the changes found. Contextual factors influencing beliefs exploration in medicine-taking consultations were identified.

Nursing care of clients treated with atypical antipsychotics who have a risk of developing metabolic instability and/or type 2 diabetes

The aim of this Australian article from the Centre for Nursing Research, Australian Catholic University, Melbourne, was to present a current discussion related to the nursing care of clients treated with atypical antipsychotic medicines and who have a risk of developing metabolic instability and/or type 2 diabetes. The importance of such a discussion was to provide both the novice and the experienced nurse with additional knowledge of this current health issue with which to inform their nursing practice.

The potential for psychosis to be a chronic condition is very high and often people require antipsychotic medicine for lengthy periods throughout their lives. Sometimes, treatment is for life. The second generation of antipsychotic medicines was greeted with much enthusiasm since it was better tolerated than the first generation.

However, each medication has desired and adverse effects and, when taken for lengthy periods, these effects may produce physical illness. Studies show that the prevalence of type 2 diabetes and the metabolic syndrome was significantly higher in clients with a chronic psychiatric disorder, particularly schizophrenia.

Metabolic instability, especially weight gain, is associated with some psychotropic medicines. Nursing interventions need to include care assessment, planning, intervention and evaluation for clients treated with antipsychotic medicines in terms of risk minimisation strategies in routine nursing care.
Introducing NEW FreeStyle Lite test strips... helping insulin patients make a difference.

The benefits start here...

Blood glucose monitoring is a cornerstone of effective diabetes management, particularly for insulin-using patients. NEW FreeStyle Lite test strips have unique ZipWik tabs that make application of blood easier and uptake faster,* and a tiny sample size (0.3µL) means that your patients experience less pain when testing. 9 out of 10 FreeStyle Lite users said they had fewer wasted strips compared with One Touch Ultra strips (P<0.0001).**

Recommend NEW FreeStyle Lite test strips, for use with FreeStyle Freedom Lite and FreeStyle Lite meters, designed to make a difference for your patients.

*Versus original FreeStyle Brand test. Data on file DOC18166.
FreeStyle Lite, FreeStyle Freedom Lite, and ZipWik tabs are trademarks of the Abbott Group of companies in various jurisdictions.
DCMDP100054
Sub-optimal quality of type 2 diabetes care discovered through electronic feedback led to increased nurse-GP cooperation: a qualitative study

The aim of this Danish study from the Department of General Practice, Institute of Public Health, Aarhus University, was to understand the influence of the electronic feedback system (EFS) on providing type 2 diabetes care in general practice using a qualitative approach embedded in a randomised, controlled trial.

All 160 GPs randomised to receive EFS were invited. Thirteen GPs from two solo and two partnership practices were interviewed about their experience with EFS which provided data on the quality of diabetes care in their practices. Data were analysed using a qualitative descriptive approach.

All participants found the insight into the overall quality of their diabetes care beneficial. While the two solo practices reported no changes, EFS catalysed organisational changes in the two partnership practices by allocating a number of diabetes controls to nurses. Limited time and a lack of real-time data were main barriers towards using the system.

EFS used at an overall level provided an overview of the diabetes population which made GPs aware of the need to improve the quality of diabetes care. The EFS influenced partnership practices, but not solo practices, to hire nurses and allocate parts of diabetes care to them. The findings are important in the interpretation of the effect of EFS.

The meaning of a consultation with the diabetes nurse specialist

The aim of this Swedish study from the Sahlgrenska Academy, University of Gothenburg, Institute of Health and Care Sciences, Göteborg, was to elucidate the essential meaning of a consultation between diabetes nurse specialists and patients to gain a deeper understanding of the patients’ experiences.

Twenty patients with type 2 diabetes were interviewed about their experience of a consultation at an annual check-up with the diabetes nurse specialist. A phenomenological hermeneutic method was used in the analysis and interpretation of the text.

The patient’s experience of a consultation was interpreted as a ‘manifestation of hold on the disease control’; this means a safeguard to continue daily life shown in the four themes: being controlled, feeling exposed, feeling comfortable and feeling prepared.

The patients’ experiences of a consultation with the diabetes nurse specialist became the basis for a health maintenance process in dealing with critical health-disease aspects.

In a consultation, professionals have to take into account the potential emotional turbulence that disease progression can mean to a patient. Diabetes care implies patient dependence on support to avoid a potential self-management insufficiency and calls attention to professionals’ time for listening to patients’ perceptions.

Weight management using a meal replacement strategy in type 2 diabetes

The growing prevalence of diabetes parallels the increased prevalence of obesity. Overweight and obese individuals with diabetes who attempt weight reduction face considerable challenges. However, several recent studies have shown that weight reduction in patients with diabetes is feasible using a multidisciplinary approach that incorporates structured dietary intervention and meal replacements (MRs).

Nutritionally-complete MRs are shown to be useful at the start of weight reduction programmes and for weight maintenance because of their nutrition adequacy. However, this study from the Joslin Diabetes Center, Boston, showed that patients using this approach need to monitor their blood glucose levels closely and may need to adjust their diabetes medications.

Most commercial MRs are currently fortified with vitamins and minerals to prevent long-term deficiency in essential micronutrients that are commonly seen in low-calorie diet plans. They also come in different flavours and formats that improve their general acceptability. To successfully initiate weight loss, MRs are generally used as an absolute replacement of an agreed-upon number of meals and snacks.

This article covers the use of MRs for patients with diabetes for short-term and long-term weight reduction in clinical trials and real-world clinical practice.
Victoza® (liraglutide), in combination with metformin, impacts on multiple factors associated with type 2 diabetes providing, from baseline.1,2

- Reductions in HbA1c: up to 1.30%1,2
- Reductions in weight: up to 2.8kg1,2
- Reductions in systolic blood pressure1,2
- Improvements in beta-cell function1,2

**Abbreviated Prescribing Information**

Victoza® 6 mg/ml solution for injection in pre-filled pen (liraglutide). Please refer to the Summary of Product Characteristics for full information. Victoza® 2 x 3 ml pre-filled pens, Victoza® 3 x 3 ml pre-filled pens. 1 ml of solution contains 6 mg of liraglutide. **Indications:** treatment of adults with type 2 diabetes mellitus in combination with metformin or a sulphonylurea, in patients with insufficient glycaemic control despite maximal tolerated dose of metformin or sulphonylurea monotherapy or in combination with metformin and a sulphonylurea, or metformin and a thiazolidinedione in patients with insufficient glycaemic control despite dual therapy. **Dosage:** Victoza® is administered once daily by subcutaneous injection and can be administered at any time independent of meals however, it is preferable that Victoza® is injected around the same time of the day. Victoza® should not be administered intravenously or intramuscularly. Recommended starting dose is 0.6 mg daily. After at least one week, the dose should be increased to a maintenance dose of 1.2 mg. Based on clinical response, after at least one week the dose can be increased to 1.8 mg further improve glycaemic control in some patients. Daily doses higher than 1.8 mg are not recommended. When used with existing metformin therapy or in combination with metformin and thiazolidinedione therapy, the current dose of metformin and thiazolidinedione can continue unchanged. When added to existing sulphonylurea therapy or in combination with metformin and sulphonylurea, a reduction in the dose of sulphonylurea may be necessary to reduce the risk of hypoglycaemia. Victoza® can be used in the elderly (>65 years old) without dose adjustment but therapeutic experience in patients ≥75 years of age is limited. No dose adjustment is required for patients with mild renal impairment (creatinine clearance ≥60 - 90 ml/min). Due to lack of therapeutic experience Victoza® is not recommended for use in patients with moderate (creatinine clearance of 30-59 ml/min) and severe renal impairment (creatinine clearance below 30 ml/min). Patients with end stage renal disease, patients with hepatic impairment and children below 18 years of age. **Contraindications:**

Hypersensitivity to the active substance or any of the excipients. **Warnings and Precautions for use:** Victoza® should not be used in patients with type 2 diabetes mellitus or for the treatment of diabetic ketoacidosis. Limited experience in patients with congestive heart failure New York Heart Association (NYHA) class 1-4 and no experience in patients with NYHA class III-IV. Due to limited experience Victoza® is not recommended for patients with inflammatory bowel disease and diabetic gastroparesis. Victoza® is associated with transient gastrointestinal adverse reactions, including nausea, vomiting and diarrhoea. Other GLP-1 analogues have been associated with pancreatitis; patients should be informed of symptoms of acute pancreatitis: persistent, severe abdominal pain. If pancreatitis suspected, Victoza® and other suspect medicinal products should be discontinued. Thyroid adverse events, including increased blood calcitonin, goitre and thyroid neoplasms reported in clinical trials particularly in patients with pre-existing thyroid disease. Risk of hypoglycaemia in combination with sulphonylureas; lowered by dose reduction of sulphonylurea. No studies on the effects on the ability to drive and use machines performed. Patients should be advised to take precautions to avoid hypoglycaemia while driving and using machines, in particular when Victoza® is used in combination with a sulphonylurea. Substances added to Victoza® may cause dehydration; in the absence of compatibility studies Victoza® must not be mixed with other medicinal products. **Pregnancy and lactation:** Victoza® should not be used during pregnancy or during breast feeding. If a patient wishes to become pregnant, or pregnancy occurs, treatment with Victoza® should be discontinued; use of insulin is recommended instead. **Undesirable effects:** During clinical trials with Victoza® the most frequently observed adverse reactions which varied according to the combination used (sulphonylurea, metformin or a thiazolidinedione) were: Very common: nausea, diarrhoea, hypoglycaemia when used in combination with metformin and a sulphonylurea and headache when used in combination with metformin; Common: hypoglycaemia when used in combination with a thiazolidinedione, vomiting, constipation, abdominal pain, discomfort and distension, dyspepsia, gastritis, flatulence, gastroesophageal reflux disease, gastrointestinal viral, toothache, headache, dizziness, nasal congestion, bronchitis, anorexia, appetite decreased, fatigue and pyrexia. Gastrointestinal adverse reactions are more frequent at start of therapy but are usually transient. Very few hypoglycaemic episodes observed other than with sulphonylureas. Patients >70 years or with mild renal impairment (creatinine clearance ≥ 40 - 90 ml/min) may experience more gastrointestinal effects. Consistent with medicinal products containing proteins/peptides, patients may develop anti-liraglutide antibodies following treatment but this has not been associated with reduced efficacy of Victoza®. Few cases reported of angioedema (0.05%), acute pancreatitis (<0.3%) and injection site reactions (approx. 2%). Injection site reactions usually mild. Causal relationship between Victoza® and pancreatitis can neither be established nor excluded. Thyroid neoplasms, increased blood calcitonin and goitres are the most frequent thyroid adverse events and were reported in 0.3%, 1% and 0.8% of patients respectively. The Summary of Product Characteristics should be consulted for a full list of side effects. **Overdose:** In the event of overdose, appropriate supportive treatment should be initiated according to the patient’s clinical signs and symptoms. **MA numbers:** Victoza® 2 x 3 ml pre-filled pens EU/1/09/529/002, Victoza® 3 x 3 ml pre-filled pens EU/1/09/529/003. **Legal Category:** POM. For complete prescribing information please refer to the Summary of Product Characteristics which is available on www.medicines.ie or by email from info@novonordisk.ie or from Medical department, Novo Nordisk Limited, 3-4 Upper Pembroke Street, Dublin 2, Ireland; www.novonordisk.ie. **Date created:** July 2009


Victoza® is a trademark owned by Novo Nordisk A/S. **Date of preparation:** July 2009. IRU/0709/0268

Information about adverse event reporting is available at www.medsafe.govt.nz. Adverse events should be reported to the Novo Nordisk Medical Department: Tel: 1850 665 665.
Efient (prasugrel) is now available

Daiichi Sankyo and Eli Lilly have announced the launch of Efient (prasugrel) in Ireland. Efient offers a new treatment option to acute coronary syndrome (ACS) patients, undergoing percutaneous coronary intervention (PCI). Data show that, when taken with aspirin, Efient may help prevent recurrent cardiovascular events in these patients.

The launch of Efient follows the European Commission’s Decision granting marketing authorization for Efient on February 25, 2009, based on data from several trials including TRITON-TIMI 38, a global trial involving 13,608 patients worldwide. TRITON-TIMI 38 found that, Efient reduced the relative risk of the combined endpoint of cardiovascular death, non-fatal heart attack or non-fatal stroke in patients with ACS undergoing PCI by 19 percent. Efient also reduced the relative risk heart attack or stroke.

Despite continued advances in treatment, 8-12 per cent of ACS patients still experience a major cardiovascular event, including stent thrombosis, within a year following PCI5-7, making protective drug treatments such as Efient necessary. Efient works by reducing the tendency of platelets, the blood particles responsible for clotting, from sticking or clumping together. By blocking a specific receptor (P2Y12 adenosine diphosphate) on the platelet surface, Efient prevents platelets from clumping, which can result in clogged arteries and may lead to heart attack or stroke.

Data published in The Lancet showed a significant reduction in cardiovascular events (combined endpoint of cardiovascular death, non-fatal heart attack or non-fatal stroke) in patients with acute ST elevation myocardial infarction (STEMI, or high-risk heart attack) treated with Efient as early as 30 days and continued for up to 15 months.

ConvaTec change of packaging

ConvaTec have announced packaging improvements that will be taking place during 2010.

Following the transition to a stand-alone organisation, ConvaTec’s stated objective is to deliver improved user-friendly and intuitive packaging while minimizing the administrative impact of the change.

They are implementing a new standardised packaging design across the Wound Therapeutics range comprising; logo placement on sides of the box for easy onshelf identification, distinct colour bands on all sides of the box for quick product differentiation, and recyclable materials. In addition they are refreshing their AQUACEL and Versiva XC dressing packets with easy-to-read product size printed directly onto the packet, graphics to demonstrate easy product application, and improved adhesive for easier packet opening. The improvements will be rolling out across the range from April 2010.

For more information please contact: Karen Hand 01895 628378, karen.hand@convatec.com

Launch of Dovobet Gel – new treatment option in psoriasis

LEO Pharma has announced a new treatment for psoriasis, Dovobet Gel (calcipotriol 50 microgram/g and betamethasone dipropionate 0.5mg/g).

Dovobet Gel is a convenient once-daily, gel formulation with an indication for the ‘topical treatment of mild to moderate ‘non-scalp’ plaque psoriasis vulgaris’ and also for the ‘topical treatment of scalp psoriasis’.

Dovobet Gel is designed to improve compliance and clinical outcomes in patients with psoriasis. The new treatment combines the same effective mode of action as Dovobet Ointment in a non-alcohol gel formulation. Dovobet Gel will be available in a 60g pack and is fully reimbursable under the GMS. The GMS code for the 60g pack is 13689.

Full prescribing information and references are available from Paul Kirwan, Dermatology Marketing Manager, LEO Pharma, telephone 01 490 8924 or email paul.kirwan@LEO-Pharma.com

www.medical
Novartis announce the launch of EXFORGE HCT—first combination of an angiotensin receptor blocker, calcium channel blocker and diuretic.

Exforge HCT combines the efficacy of three widely prescribed blood pressure treatments, valsartan, amlodipine and hydrochlorothiazide, in a single pill.

Up to 80% of patients may need multiple medications to help control their blood pressure, highlighting the need for more effective combination treatments.

Single-pill combinations reduce daily pill burden and simplify treatment schedules.

Exforge HCT, a new, first-of-its-kind, 3-in-1 treatment for hypertension combines in a once-daily single pill the efficacy of three widely prescribed blood pressure medications: the angiotensin receptor blocker valsartan (Diovan), the calcium channel blocker amlodipine, and the diuretic hydrochlorothiazide (HCT). All three have been used extensively for many years in patients with hypertension.

“Novartis is committed to helping patients improve their treatment compliance and blood pressure control. Simplified treatment regimens and reduced pill burdens have been shown to help achieve this,” said Dr Greg Hays, Medical Director, Novartis Ireland Limited.

Exforge HCT is indicated for substitution therapy in adult patients whose blood pressure is adequately controlled on the combination of valsartan, amlodipine and HCT, taken either as three single-component formulations or as a dual-component and a single-component formulation.

Hypertension is one of the most important but treatable risk factors for cardiovascular disease—the number one cause of death worldwide. Nearly half of Europeans suffer from high blood pressure and up to 80% of these patients may need multiple medications to help reach treatment goals. Here about half of Irish adults over 50 years of age have high blood pressure. The primary patient-related factor for hypertension treatment failure is non-compliance with the prescribed antihypertensive medication. Patients therefore may find treatment more convenient with one single pill rather than multiple separate pills. One recent, large-scale study showed that approximately 75% of patients achieved their blood pressure treatment goal after switching to a single-pill combination therapy.

Novartis Consumer Health introduces new Pantoloc Control (pantoprazole) over-the-counter for effective treatment of heartburn

Novartis Consumer Health has announced that it is introducing Pantoloc Control (pantoprazole 20mg) as an over-the-counter (OTC) remedy for heartburn.

Just one tablet a day of Pantoloc Control suppresses acid secretion for up to 24 hours, so frequent heartburn sufferers can start to achieve day and night relief from their symptoms which may start from as early as day one. However the tablets, for short term treatment of reflux symptoms, are not intended to provide immediate relief and may need to be taken for 2 to 3 days to achieve improvement of symptoms.

Richard Palmer, Northwest Europe Operating Unit Head for Novartis Consumer Health, explains the company’s position: “Pantoloc Control is the first PPI to be authorised as an over-the-counter medicine across 27 EU countries. Novartis Consumer Health has developed an extensive pharmacy training programme and consumer awareness drive to support pharmacists, so they in turn can deliver enhanced service to those suffering from frequent heartburn.”

The Pantoloc Control brand manager at Novartis Consumer Health UK commented: “Heartburn and other symptoms of reflux are not trivial and are the cause of significant pain and discomfort that can really disrupt normal, daily life. The avoidance of certain everyday foods or drinks can be a real bother and troublesome night-time symptoms can be particularly difficult to cope with, leaving the sufferer very tired the next day. The availability of this new treatment gives pharmacists a great opportunity to recommend an effective treatment that offers relief and satisfaction to their customers suffering from frequent symptoms.”
COPD Assessment Test (CAT) helps uncover disease burden

Allen & Hanburys has announced the availability of the COPD Assessment Test (CAT), a new patient-completed assessment test which provides a simple and reliable measure of health status in COPD.

Tests currently used in clinical practice to assess COPD are aimed at measuring disease control or disease severity but do not provide an overall picture of the impact of the disease on a patient’s life.

The CAT is a validated, short and simple-to-use, eight-item questionnaire which can be completed quickly and used in clinical practice, alongside lung function tests to provide an overall picture of the impact that COPD is having on an individual patient. The CAT has been shown to correlate well with the more complex St George’s respiratory questionnaire (SGRQ).

The tool was developed by a multidisciplinary group of international experts including pulmonary specialists, primary care physicians and representatives from patient organisations. Patients with COPD were also integral to the development and validation of the test.

Dr Terry O’Connor, President of the Irish Thoracic Society, commented: “The CAT will help to optimise COPD management by facilitating a fact-based dialogue between physician and patient to ensure they gain an understanding of the disease impact and help reduce the burden of the disease as much as possible.”

Used in conjunction with spirometry, the CAT will provide additional information on the disease burden, highlighting the impact of the disease on the patient’s life. Ms Ruth Marrow, Advanced Nurse Practitioner, commented: “The CAT may help detect changes with disease progression and treatment, thus facilitating better patient care”.

The CAT is available as a paper-based questionnaire that patients fill in or an electronic version of the CAT is freely available on the following website, along with a copy of the accompanying user guide: www.catestonline.org. Copies of the test can also be requested directly from Allen & Hanburys on (01) 495 5000.

TRUEresult and TRUEresult twist Blood Glucose Meters

Clonmel Healthcare are delighted to announce the launch of our new TRUEresult and TRUEresult twist Blood Glucose Meters which will be replacing the TrueTrack Meter from 1st June 2010. The new TRUEresult and TRUEresult twist systems offer advanced technology, state of the art design and on-the-go convenience to better fit your patients’ active lifestyles.

TRUEresult twist is the world’s smallest blood glucose meter! You simply twist the TRUEresult twist on to top of a new vial of test strips and you are ready to test!

Features and benefits of TRUEresult and TRUEresult twist:

- No Coding
- Results as fast as 4 seconds
- Strip release button
- Extra features and benefits of TRUEresult
- Testing Reminder Alarm
- Audible fill detection

TRUEresult and TRUEresult twist systems use TRUEresult Blood Glucose Test Strips featuring patent-pending, state-of-the-art GoldSensor™ laser accuracy and TRUEfill™ beveled tip. These advanced features ensure highly accurate test results and first test success by allowing for greater sampling precision and consistency.

GMS Code 10117 will be switched from TrueTrack Blood Glucose Test Strips to TRUEresult Blood Glucose Test Strips on 1st June 2010.

If you require any additional information on TRUEresult please contact Clonmel Healthcare on 01 620-4000.

New Lactase Infant Drops from ClonMedica

Clonmel Healthcare has announced the launch of its new lactase enzyme product – Lactase Infant Drops. Clonmel Healthcare has 20 years experience in the use of lactase enzyme, a deficiency of which can be an important factor in colic.

Lactase Infant Drops are available in two sizes – 7ml and 15.5ml. Both products are extremely competitively priced as well as giving your consumer a choice to purchase the 7ml (starter pack) or the larger 15.5ml pack.

There is a launch offer available with a compact display unit. There is also, for the first time in Ireland, a national radio campaign for a lactase enzyme product.

Contains lactase enzyme and glycerine.

Code: 2010/ADV/LAC/034

www.yourmedicines.ie
Congratulations to the winner of last month’s crossword, Kathleen Renehan, Johnstown Health Centre, Co Kilkenny.

Please send your answers to the Editor, Nursing in General Practice, GreenCross Publishing, Lower Ground Floor, 5 Harrington Street, Dublin 8.

Closing date for entries: 1st July 2010.

Winner will receive €50.

Please note: the winners’ cheques will be sent out within 45 days.

ACROSS
1. Ointment gambolling as lamb (6)
4. On the flip side of the coin it’s an instrument! (4)
8. Jim, we hear, for a keep-fit establishment (3)
9. No particular officer? (7)
10. Hard growth encountered in war-time (4)
11. In rhyme, he simply met a pie man (5)
14. Painful kind of media aunt? (5)
16. City in a bottleneck? (4)
18. Cruet is shattered causing jaundice (7)
20. Flying saucer, initially! (3)
21. Centres of wheels in thorny bush (4)
22. Regard tern as backward at sea (6)

DOWN
1. Insects causing computer problems! (4)
2. Lob a mug awkwardly to produce back pain (7)
3. Anything in old English confuses a thug! (5)
5. Ventilate an affected manner? (3)
6. Supporters of electricity? (6)
7. Burden placed upon ourselves? (4)
12. Queer Ma demolished large tent (7)
13. Like Hamlet or his pastry! (6)
15. Tale that is spun? (4)
16. Abnormal sacs discovered in aristocracy’s Tsar heritage (5)
17. Satellite reputedly made of cheese! (4)
19. But coming back, it’s a bath! (3)

Answers to last month’s crossword

Caltrate is a trademark. PA 172/38/1.
Full prescribing information available from Wyeth Consumer Healthcare, Plaza 254, Ballycoolin, Dublin 15 or from www.medicines.ie
Calcium and/or vitamin D deficiency in the elderly can lead to loss of muscle tone and an increase in falls and osteoporotic fractures. 1-5 Calcichew-D 3 Forte is indicated for the treatment and prevention of calcium and vitamin D deficiency.6

**CALCICHEW-D 3 FORTE CHEWABLE TABLETS PRESCRIBING INFORMATION**

(Please refer to full Summary of Product Characteristics when prescribing)

**Presentation:** Chewable tablet containing 1250mg calcium carbonate (equivalent to 500mg of elemental calcium) plus 400IU colecalciferol (equivalent to 10 micrograms vitamin D 3).

**Uses:**
Treatment and prevention of vitamin D/calcium deficiency.
Supplementation of vitamin D and calcium as an adjunct to specific therapy for osteoporosis, in pregnancy, in established vitamin D dependent osteomalacia and in other situations requiring therapeutic supplementation of malnutrition.

**Dosage and administration:**
Oral (suck or chew).

- Adults and elderly: Two tablets daily.

- Hepatic impairment: No dose adjustment required.
- Renal impairment: Should not be used in patients with severe renal impairment.

**Contraindications:**
Diseases and/or conditions resulting in hypercalcaemia and/or hypercalciuria, renal stones, hypervitaminosis D, hypersensitivity to ingredient(s) especially soybean oil and peanut.

**Precautions:**
Monitor serum calcium and creatinine levels, particularly in elderly patients on cardiac glycosides or diuretics and in patients with high tendency to calculus formation. Use with caution in patients with impaired renal function. Take into account risk of soft tissue calcification. Avoid in patients with phenylketonuria or sugar intolerance. Prescribe with caution in patients with sarcoidosis. Use with caution in immobilised patients.

Additional doses of calcium or vitamin D should only be taken under close medical supervision. **Interactions:** Tetracyclines (take 2 hours before, or 4 to 6 hours after Calcichew-D 3 Forte), bisphosphonates or sodium fluoride (take 3 hours before Calcichew-D 3 Forte), thiazide diuretics, corticosteroids, cardiac glycosides, ion exchange resins (cholestyramine), laxatives (paraffin oil). Calcichew-D 3 Forte should not be taken within 5 hours of eating foods high in oxalic acid (e.g. spinach and rhubarb) or phytic acid (e.g. whole cereals). Side effects: Hypercalcaemia, hypercalciuria, constipation, flatulence, nausea, abdominal pain, diarrhoea, pruritus, rash, urticaria. Use in pregnancy and lactation: Can be used in case of calcium and vitamin D deficiency. Daily intake in pregnancy should not exceed 1500mg calcium and 600IU colecalciferol (15 micrograms vitamin D 3). Avoid overdose as permanent hypercalcaemia affects developing foetuses. Calcium and vitamin D 3 pass into breast milk so consider this when giving additional vitamin D to the child.

**Adverse events should be reported to the Pharmacovigilance Unit at the Irish Medicines Board (IMB) (imbpharmacovigilance@imb.ie). Information about adverse event reporting can be found on the IMB website (www.imb.ie). Adverse events may also be reported to Shire Pharmaceuticals Ltd on +44 1256 894000.**

**Date of revision:** July 2007.

**CALCICHEW is a registered trademark of Shire Pharmaceuticals Ltd in the Republic of Ireland.**

**Pharmaceutical precautions:**
Do not store above 30°C. Keep container tightly closed.

**Legal category:** Pharmacy product.

**Product Authorisation holder:** Shire Pharmaceuticals Ltd., Hampshire International Business Park, Chineham, Basingstoke, Hampshire RG24 8EP UK. Distributed in Republic of Ireland by: Cahill May Roberts, P.O. Box 1090, Chapelizod, Dublin 20, Republic of Ireland. Further information is available on request.

**Date of preparation:** April 2010.
**Item Code:** RE/CDF/10/0008

**Now 24% less expensive than our nearest competitor.**

CALCICHEW-D 3 FORTE CHEWABLE TABLETS

HELP PROTECT THE FRAGILE ELDERLY

**Calcium and/or vitamin D deficiency in the elderly can lead to loss of muscle tone and an increase in falls and osteoporotic fractures.** 1-5 Calcichew-D 3 Forte is indicated for the treatment and prevention of calcium and vitamin D deficiency. 6