

IL-MUSBIEH

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MALTA UNION OF MIDWIVES AND NURSES

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- **Fractures & Traumas**
- **Clinical Nutrition 2009**
- **Puttinu Cares**

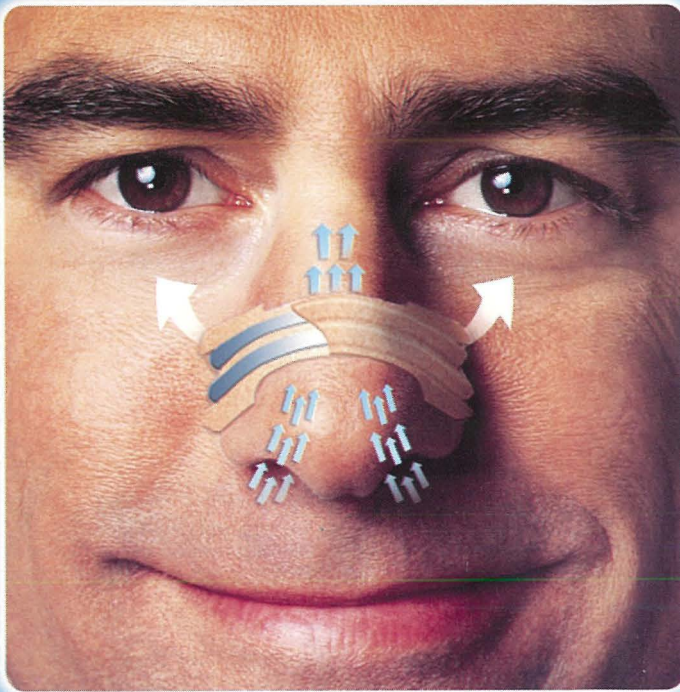


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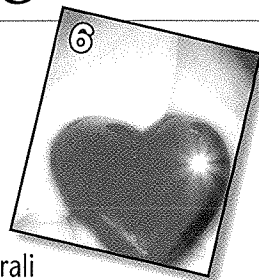
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Il-fehmiet li jidhru f'dan il-ġurnal mhux neċessarjament li jirriflettu l-fehma jew il-policy ta' l-MUMN.

L-MUMN ma tistax tinzamm responsabbli għal xi hsara jew konsegwenzi oħra li jiġu kkawżati meta tintuża nformazzjoni minn dan il-ġurnal.

L-ebda parti mill-ġurnal ma tista' tiġi riprodotta mingħajr il-permess bil-miktub ta' l-MUMN.

Ċirkulazzjoni: 2250 kopja.

Dan il-ġurnal jitqassam b'xejn lill-membri kollha u lill-entitajiet oħra, li l-bord editorjali f'flimkien mad-direzzjoni tal-MUMN jiddeċiedi fuqhom.

Il-bord editorjali jiggarrantixxi d-dritt tar-riservatezza fuq l-indirizzi ta' kull min jirċievi dan il-ġurnal.

Kull bdil fl-indirizzi għandu jiġi kkomunikat mas-Segreterija mill-aktar fis possibli.

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Minhabba kuxjenza ambjentali li thaddan l-MUMN, il-ġurnal jitwassal għand il-membri tiegħu f'boroż tal-karta u mhux tal-plastik.



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Editorial

Li kieku wiehed joġġhod ftit kwiet u jaħseb bis-serjetà dwar dak kollu li jkun għaddej madwarna, jinduna li sirna nparlaw ħafna però meta niġu għall-fatti... ma naslu mkien. Niltaqgħu biex nitkelmu madwar mejda kbira u kulhadd irid iġħid tiegħu... u nerġgħu ma naslu mkien. Nieħdu sehem fil-protesti u manifesti flimkien mall-folla... u nibqgħu ma naslu mkien.

Mela x'qed jiġri? Qed nerġgħu nimxu u nħadnu il-liġi tal-ġungla, min jiflaħ l-iġjed isaltan. Dan jidher ukoll fl-isptarijiet tagħna. Ħafna diskussjonijiet, ittri fil-gazzetti, nisimgħu fl-aħbarijiet dwar is-sistemi ta' tmexxija li qed jintużaw, u xorta ma jinbidel xejn... anzi dawk li jkunu fuq jippuntaw subaġġhom lejn dawk li jinsabu fl-iskalluni ta' taħthom. Meta ser tinbidel din is-sistema? Jew forsi aħjar nistaqsi jekk irridux nibdluha din is-sistema ta' tmexxija?

Però eja aħna bħala nurses u midwives inħarsu lejn l-affarijiet minn lenti ftit iżjed pożittiva. Nibdew billi nitfgħu il-mira tagħna lejn kif nistgħu intejbu is-sitwazzjoni tagħna billi naġġornaw l-lina nfuṣna fuq tekniki u proċeduri aktar innovattivi biex inkunu nistgħu nofru l-aħjar kura lill-klijenti tagħna. Din ta' l-aħħar għandha tkun prijorità, inkella inkunu qed naħlu l-ħin tagħna. Ma jiswa xejn li nżidu l-ittri wara isimha jekk dak li nkunu tagħlimna ma nużawhx biex intejbu is-sitwazzjoni tal-pazzjenti. Fl-aħħar min l-aħħar jekk intejbu is-sitwazzjoni tal-klijenti inkunu qed intejbu is-sitwazzjoni tagħna stess. L-ambjent tax-xogħol tagħna ukoll jitjeb. Wiehed jistaqsi x'qed nistennew? Dawk kolha li komplew l-istudji tagħhom u jistgħu jiktbu xi ittra jew tnejn wara isimhom jistgħu jibdew jużaw iżjed dak li akkwistaw... u mhux biss biex nitilgħu l-iskalluni tal-grad biss. Diġà hemm ħafna li qed jippruvaw jaġmlu xi ħaġa però magħhom iridu jingħaqdu oħrajn.

Ħaġa oħra li bħala nurses u midwives ma nistgħux ninsew hija is-saħħa personali tagħna. Ma nistgħux li ħajjitna ddu biss madwar ix-xogħol... tkun f'liema grad tkun. Għandna bżonn li nsibu l-ħin li nistireħu mhux biss b'mod fiżiku imma wkoll mentalment. Huwa għalhekk li min żmien għal żmien li s-sotto kumitat għal entertainment jipprova jorganizza xi ħaġa fejn aħna n-nurses u l-midwives flimkien mall-familji u l-ħbieb inkunu nistgħu nirrilassaw ftit flimkien u nħallu għall dak il-ħin qasir il-problemi b'mod speċjali tax-xogħol warajna.

Eja nħarsu lejn ix-xogħol tagħna bħala xogħol importanti, anzi xogħol importanti ħafna. L-importanza iġġib magħha responsabilità u din ma nistgħux ninsewha. Jekk naħdmu skond il-kuxjenza ftit li xejn ikollna problemi. Jekk irridu nistgħu nippruvaw.

Nagħlaq billi f'isem il-bord editorjali nawgura lilkom u l-familji tagħkom l-Għid it-Tajjed.

message

from the president



Paul Pace President

 mumn@maltanet.net

This year the MUMN will be involved in two different scenarios, the local setting and the international setting. These challenges which are being addressed by the MUMN have never been dealt before. What I can assure all our members (which continuously are increasing in number) is that all the union structures from the very council to all executive committees are geared up and well prepared to face such challenges.

Let's evaluate first local level which is after all the most important. First and foremost the MUMN has launched a new website which will make us all proud. The reason being is that the new website is offering a quantum leap in quality and a new service to our members. The new website does not only offer the latest information on all the events of the union but will allow each member to have his personal log in password which will allow him / her to access all information on the union, will also allow him / her to message to the union and the most important thing is that all members can receive information to all issues and actions which are being organized by the union.

The union has invested heavily to achieve such a website to its members and I would like to personally thank Vince Saliba for his contribution. The website is the second investment that the MUMN has forwarded to its members after having purchased the new premises for the MUMN offices, the largest and the first investment evoked by the present council in a short period of time. Members now have no excuses of not being aware on the MUMN events since the website will be updated daily by our administrator and can be accessed 24 hours from any computer.

The website will enable the council to be in a better position to face the issues on the local settings. Lack of staff, filling of vacant administrative posts, improving working conditions and other issues which we as council members face on day to day issues. The main issue the MUMN is facing is the lack of initiative the health division is adopting, not just addressing the nurses and midwives shortages but also the lack of implementation on agreed proposals. The few discussions that the MUMN is having with the health minister show clearly that on certain important issues the agenda will have already been set prior discussion with the union. This is not acceptable to the union and such an approach could result in undesirable repercussions. The MUMN will never accept policies which are imposed on the nursing and midwifery profession which can jeopardize patient safety or lower standards in care. As in most occasions the University of Malta has no clue of the poor working conditions of our nurses and midwives working in government hospitals and decided to take its stand against the MUMN and as usual in favour of the government. This will not deter slightly our position and I can assure our members that any necessary action the MUMN will need to take in order to safe guard the profession and the patient safety will be taken.

In the international scenario the MUMN will be involved in the marketing of the International Council of Nurses conference which is going to be held in Malta 2011. This event will be the largest conference Malta has ever hosted. In June the MUMN will host a Maltese night in Durban, South Africa to all nursing associations affiliated in the ICN and will organize various Maltese cultural activities in Durban. In the closing ceremony the MUMN will be handed over the responsibility as the hosting organization to the International Nursing Council. I would like to thank various government departments and a sincere thanks the health ministry and the Malta Tourism Authority for the continuous support in both the organization and the financial support. Lastly as President I appeal to all members to send their email address to our office and to start making good use of our website when launched. One has to remember the MUMN has never been so close to its members.

Paul Pace

People of the heart



On Wednesday 15th October 2008, I was invited to celebrate the Eucharist at the Cardiac Lab of the Outpatient Department. The occasion was that one of the staff members was about to move to another section within the same Department. After the Eucharistic celebration, one of the staff members told me: "Thank you Father for the Eucharist. You managed to unite us more". This thought provoked me to reflect deeper about what really happened during the Eucharist which made that liturgical gathering of the Cardiac Lab feel a powerful spirit of cohesion.

The pivotal reason behind Clinical Pastoral Education is precisely to envisage how theology and the clinical setting meet. While being at the Cardiac Lab the main question I asked myself was: "What is the link between the Eucharist liturgy and the heart"? Drawing from my theological formation, I could find a fascinating idea of how to bridge the two worlds together: using the heart, *Kardia* in Greek, as a symbol. Thus key word was "the heart". As I started to familiarize myself with the environment who warmly welcomed me, I could feel that refreshing springs of insights started welling up within me.

After introducing myself at the beginning of the Mass as well as explaining the reason why we were gathered there, I immediately established the link between the liturgy and the clinical setting by highlighting the necessity of the heart both scientifically and spiritually. As the physiological heart is essential for a human being to live so the Eucharist is the heart of the community of those who believe in Jesus. It is the vehicle through which they are kept together. In his Encyclical on the Eucharist, *Ecclesia de Eucharistia*, the late Pope John Paul II said: "The Church draws her life from the Eucharist." Was not that liturgical assembly at the Cardiac Lab drawing its cohesion and gratitude for what their colleague was and did for them from the Eucharist? Was not the Eucharist a thanksgiving hymn of praise of the staff towards this person and the latter to the former? Did not their cardiac profession serve to make them people of the heart?

Furthermore, their supportive presence for their colleague instructed me to realize that loving hearts enlighten reality's darkness. It proved right what the Irish Poet, Novelist, Dramatist and Critic Oscar Wilde said

about the heart: "Keep love in your heart. A life without it is like a sunless garden when the flowers are dead". How much this was true at Cardiac Lab! The coldness of the clinical setting was warmed by the care the staff showed towards their colleague. And this stream of care became a refreshing rivulet into the big stream of care, which is the Eucharist. In the latter, God's care was outstandingly manifested since we, as Jesus' believers, offered to the Father His beloved Son, as the victim and the priest of his own sacrifice of love in the Holy Spirit. In this sense, the Eucharist for us at the Cardiac Lab was the celebration of the Father's loving heart which is enfleshed in the sacrificial lamb, Jesus. He, who is one with the Father and knows Him thoroughly, as the Father knows His Son, knows the unlimited love of His Father's heart. That is why Jesus told us: "Come to me, all who labor and are heavy laden, and I will give you rest." (Mt 11, 28). Only Jesus could give us a first hand experience of the Father's merciful heart!

During the penitential rite I asked God to forgive us for the moments when we did not harbour for Him a zealous heart so as to love Him above all people and possessions, for our brethren a heart of flesh to serve them in their needs and for ourselves a heart of bronze to control our inordinate desires. In the homily I explained the importance of connecting one's professional practice with one's faith. Therefore, working in the Cardiac Lab already points to the Christian life as being a cardiac lab itself. Christian witness is itself the end result of proved scientific experiments in the science of love. The more one transcends herself/himself the more one can love God, other people and oneself from the heart. Furthermore, the science of love testifies that "the Father of mercies and God of all comfort" (2 Cor 1, 3) is the author of every good work, and that all glory should be given to Him alone (see Matt 5, 16).

People of the heart, like those who work at the Cardiac Lab, are the ones who "dwell in unity!" (Ps 133, 1). Such an experience is "good and pleasant" (Ps 133, 1) since it brings much peace of heart and mind on the work place. Moved by the Spirit of peace, I introduced the Our Father as the prayer of the heart. While praying it together as a family I could sense how much the bonds of peace and concord were being weaved by the One Spirit of God who brought us there that morning as one family.

It was the work of God's Spirit who made this liturgical assembly summoned at the Cardiac Lab a people of the heart. My only task was to humbly surrender to this strong spirit of unity and gently danced to its music. The Eucharistic celebration was simply a thanksgiving as well as a consolidation of the spirituality of the Cardiac Lab staff; that of being a people of the heart, both in their words and deeds. If I were to suggest them a biblical verse to hang on in order that they could maintain this extraordinary spirit of communion, I would strongly suggest them the following one: "But this is the covenant which I will make with the house of Israel after those days, says the LORD: I will put my law within them, and I will write it upon their hearts; and I will be their God, and they shall be my people" (Jer 31, 33). May all the departments and wards in Mater Dei be places where the covenant of the heart is lived and promoted to be lived by our clients, relatives and especially by ourselves, as the care givers!

Fr Mario Attard OFM Cap

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messagg

mis-segretarju ġenerali



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Mit-twaqqif ta' l-MUMN sa llum esperjenzajna erba' leġislaturi governattivi u fl-ewwel sentejn ta' kull Gvern dejjem ħabbatna wiċċna ma sitwazzjonijiet diffiċli. Kull Ministru tas-Saħħa ġdid jipprova jimplimenta riformi f'xi settur jew ieħor. Dan l-aġir nifmuh. Li ma nistennewx huwa li dawn ir-riformi jsiru b'nuqqas ta' konsultazzjoni u f'ċertu ċirkostanzi anki b'nuqqas ta' qbil. Dan iwassal lill-membri tagħna sabiex jissuspettaw fin-negattiv b'riżultat li tinħoloq ansjetà fl-ambjent fejn jaħdmu li tiġi riflessa f'rabja u ġieġhel in-Nurses u l-Midwives jirribellaw kontra min jipprova jimplimenta affarjiet ġodda. Dawn is-sentimenti huma naturali quddiem sitwazzjonijiet ta' dan it-tip.

Hekk qed jiġri fil-mument kemm fl-*Operating Theaters*, fil-Kura Primarja u fil-Bank tad-Demm fost postijiet oħra. L-MUMN ma tistax taċċetta li d-Divizjoni tas-Saħħa thejji l-pjannijiet kollha, u kif dawn ikunu lesti titlob sabiex tiltaqa' ma l-*Union* biex tipprowa timponi fuqha, u jistennu li jiġi aċċettat dak kollu li jkun ippanat. L-affarjiet ma jsirux hekk. Jekk id-Divizjoni tas-Saħħa tippretendi koperazzjoni mill-MUMN, allura mill-bidu nett irid ikun hemm konsultazzjoni u diskussjonijiet serji. B'hekk biss tista' tintrebaħ il-fiducja tal-membri f'min qed imexxi.

Wasalna biex nibdlu l-*web site* tal-*Union*. Baqa' biss l-aħħar dettalji. Fil-paġni tan-nofs qed nuru din il-*web site* li ser tkun tirrifletti l-ħtiġijiet ta' llum. Kemm din il-*web site* ser tkun suċċess jiddependi minnkom. Il-Kunsill tal-*Union* hejja l-platt ta' l-ikel imma issa trid tkun int li tpoġġi bilqegħda u tibda tiekol minnu. Aktar informazzjoni ser tintbagħat direttament fid-djar tagħkom.

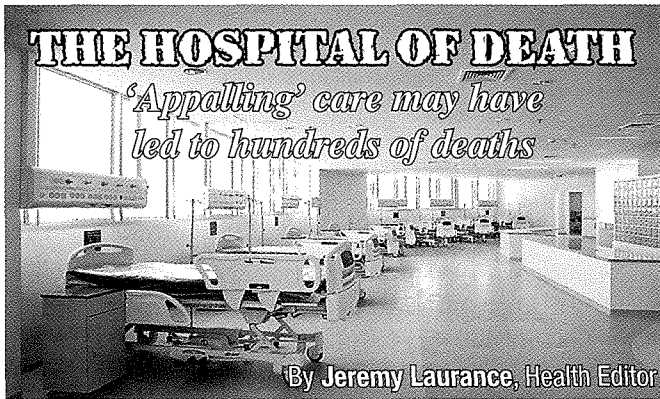
Minn din is-sena l-MUMN bdiet kampanja ta' *marketing* fost iż-żagħżagħ sabiex thajjarhom jaqdbu l-karriera fin-*Nursing* u l-*Midwifery*. Infatti diġa' ħadna sehem f'*Careers' Convention* organizzata mill-Ministeru ta' l-Edukazzjoni fejn għall-erba' t'ijiem shaħ konna preżenti fi *stand* imtella apposta. Iltqagħjna maħafna żagħżagħ li wrew interess u kienu ħerqana jkunu jafu aktar fuq il-professjoni. Dan huwa aspekk ġdid għal din il-*Union* li kif dejjem stqarriet, hija lesta sabiex tgħin u tistinka biex in-nuqqas ta' *Nurses* u *Midwives* jittaffa.

Qed isir ukoll hidma kontinwa sabiex il-Kungress ta' l-*International Council of Nurses* li ser isir f'pajjiżna f' Mejju ta' l-2011 ikun suċċess u opportunità għall-membri tagħna. Din ser tkun esperjenza sabiħa u n-*Nurses* Maltin li ser ikunu preżenti għandhom iħossuhom xxurtjati peress li dan l-avveniment dinji wisq probabli mhux ser nergħu narawh f'pajjiżna għall-għexiren ta' snin oħra.

L-ewwel President tal-*Union*, Rudolph Ċini, kien strumentali sabiex dan il-Kungress isir f'Malta. Rudolph ġie elett fil-Bord tad-Direttori ta' l-ICN erba' snin ilu bħala rappreżentant ta' l-MUMN u ser jerga' jikkontesta dan il-post fl-elezzjoni li ser isir fil-Kungress ta' l-ICN f'Ġunju li ġej ġewwa Durban. Bħal ma tafu Rudolph ser jikkontesta wkoll l-elezzjoni għall-MEP's fis-6 ta' Ġunju ta' din is-sena. Personalment jiena nemmen li jekk ikun hemm *Nurse* fost l-MEP's li ser jiġu eletti, iż-żewġ professjonijiet li l-MUMN tirrapreżenta għandhom x'jigwadanjaw u għalhekk inħeġġigkom sabiex tirriflettu fuq dan il-fattur meta tmorru tivvutaw.

Fil-ġimgħat li ġejjen in-*Nurses* li jaħdmu fl-Isptar Monte Carmeli ser jerga' jkollhom l-opportunità sabiex jeleġġu *Group Committee* ġdid li ser ikun qed jirrapreżentahom. F'dan l-isptar jiena konxju b'numru ta' *Nurses* li huma kapaċi li jirrapreżentaw lill-kollegi tagħom fil-kumitat tal-*Union* sabiex flimkien nħarsu u niddefendu l-interessi tal-professjoni. Aktar informazzjoni fuq din l-elezzjoni ser tintbagħat direttament fid-djar ta' min hu konċernat.

Għallum ser nieqaf hawn. Irid nieħu din l-opportunità sabiex inwassal l-awguri tiegħi lilkom u l-familji tagħkom għal-Ghid il-Kbir.



Warning signs of poor practice in hospitals across the country are to be urgently reviewed after an investigation uncovered “appalling” standards of care at one hospital which may have led to hundreds of deaths.

The scandal was exposed after monitoring of mortality rates showed that Stafford Hospital, in the West Midlands, had between 400 and 1,200 more deaths than the national average in the three years to 2007-08.

The board of Mid-Staffordshire NHS Trust failed to respond to the warning thrown up by its high death rate, saying there was a problem with the data. It spent more time discussing laundry bills than the quality of patient care.

Now experts are to check the early warning systems for identifying problems in every NHS hospital to ensure there is no repeat of the disaster.

The mortality figures at Stafford triggered an investigation by the Healthcare Commission, the NHS inspectorate, which uncovered deficiencies at “virtually every stage” in the care of emergency patients.

One patient who later died was left for three days with a fractured thighbone. Another who died after becoming infected with the hospital bug *C. difficile* was earlier left in a soiled bed for four hours but an internal inquiry found there were “no care issues”.

Sir Ian Kennedy, the commission chairman, said: “This is a story of appalling standards of care and chaotic systems for looking after patients. Those are words I have not previously used in commenting on any report. There is no doubt that patients will have suffered and some of them will have died as a result.” It was impossible to know how many of the excess deaths were due to sub-standard care, he said.

The 382-bed hospital was so short of nurses that receptionists with no medical qualifications were assessing patients as they arrived at A&E and nurses did not know how to operate heart monitors. There were not enough doctors and nurses, vital equipment was unavailable when needed and there was no system to spot when things were going wrong.

Sir Bruce Keogh, the NHS medical director for England, said the management board was guilty of a “gross and terrible breach of trust” and had an “unacceptably casual approach to assessing its own performance”.

The high death rate at the hospital, which ranged between 27 per cent and 45 per cent above average, dates back to at least the year 2000, implying that poor care could have contributed to the deaths of thousands of patients, and raising questions about why the problems were not picked up sooner.

Patient groups in Stafford have been campaigning for

an inquiry into the hospital for years. When the commission announced its investigation, there was an unprecedented public response – 103 patients and relatives contacted the inspectorate, most of whom were highly critical of the hospital.

Neither the West Midlands Strategic Health Authority, formerly run by England’s NHS chief executive, David Nicholson, nor the south Staffordshire Primary Care Trust raised concerns about the hospital. The trust successfully applied for foundation status while the investigation was under way, to the astonishment of the Healthcare Commission. Foundation trusts are the flagships of the NHS, overseen by the regulator, Monitor, which failed to consult the commission.

The hospital board was so focused on hitting financial and performance targets to achieve foundation status that it ignored issues of patient safety.

The chairman, Toni Brisby, and chief executive, Martin Yeates, resigned this month. The trust said yesterday it had suspended Mr Yeates “whilst an inquiry takes place into his leadership”.

The Health Secretary, Alan Johnson, apologised for the failings and announced a review of the A&E service at Stafford Hospital, a second review of the standards of treatment between 2002 and 2007 (before the Healthcare Commission began its investigation) and a third review by the National Quality Board of the “early warning system for clinical underperformance” to ensure it is “working effectively across the whole of the NHS”.

Mr Johnson said: “On behalf of the Government and the NHS I would like to apologise to the patients and families of patients who have suffered because of the poor standards of care at Stafford Hospital. There was a complete failure of management to address serious problems and monitor performance. This led to a totally unacceptable failure to treat emergency patients safely and with dignity.”

A health department spokeswoman said the aim of the National Quality Board review was to “align” the alert systems used by different NHS organisations to ensure information was shared and they had the “most effective way of recognising problems”.

The trust also apologised to patients and said staffing levels had been increased and the mortality rate was now 11 per cent below the national average.

Distraught daughter: ‘We saw patients drinking out of flower vases’

Julie Bailey spent 14 months campaigning for an inquiry into Stafford Hospital following the death of her mother, Bella Bailey, in November 2007. Ms Bailey, 47, from Stafford, was so concerned about the standards of care being given to her 86-year-old mother that she and her relatives slept in a chair at her hospital bedside for eight weeks.

“What we saw in those eight weeks will haunt us for the rest of our lives,” she said. “We saw patients drinking out of flower vases they were so thirsty. There were patients wandering around the hospital and patients fighting. It was continuous through the night. Patients were screaming out in pain because you just could not get pain relief. They would fall out of bed and we would have to go hunting for staff. There was such a lack of staff.

“It was like a Third World country hospital. It was an absolute disgrace.”

Source: <http://www.independent.co.uk/life-style/health-and-wellbeing/health-news/the-hospital-of-death-1647348.html>

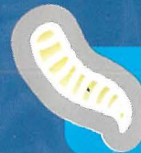
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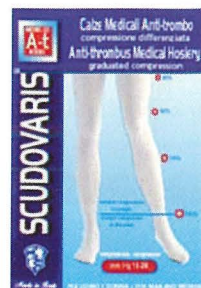
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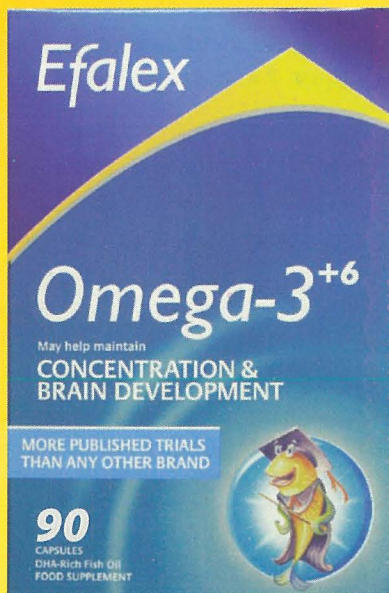
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Dr Lars Lindmark (Sweden) in association with Efamol Ltd. UK, has provided further confirmation that long chain omega 3 and omega 6 fatty acid supplementation improves dyslexia symptoms.

19 children between 9 and 17 years old formally diagnosed with dyslexia were evaluated subjectively by themselves and by their parents at baseline, 6, 12 and 20 weeks after supplementation with 8 capsules per day of Efalex. At each time point the children were asked to complete a word-chain test, to measure the ability to decipher words from a string of letters; it is a measure of the rate of processing which reflects reading speed and word-to-brain-to-hand co-ordination.

13 of the 17 children who completed the study showed significant improvements in the word chain test. Reading speed improved by 60% and word-to-brain-to-hand co-ordination improved by 23%.

Results of this study add to the increasing body of evidence showing that Efalex can provide benefit to dyslexics.

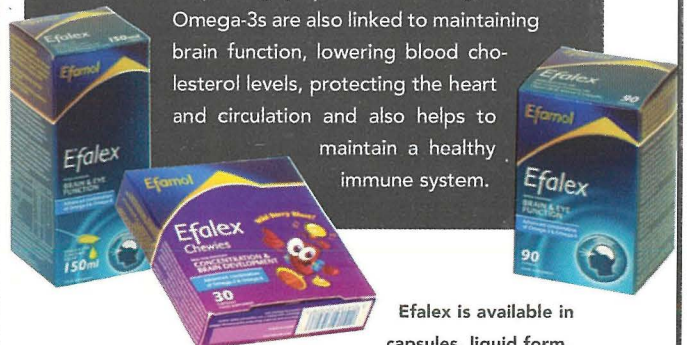
- High DHA tuna oil, actively found in Efalex, measured improvements in dark adaptation and night vision amongst dyslexic children.
- Dyslexics with symptoms of attention deficit hyperactivity disorder (ADHD) achieved reduced anxiety, attention difficulties and behaviour problems following 12 weeks supplementation with Efalex .
- Studies in children with ADHD have reported attention and behaviour improvements and improvements in reading, spelling and behaviour following fatty acid supplementation.

References:

1. Lindmark L, Clough P. A 5- month open study with long-chain polyunsaturated fatty acids in dyslexia. J Med Food 2007 Dec;10(4):662-6.
2. Stordy, B.J. Benefit of docosahexaenoic acid supplements to dark adaptation in dyslexics. Lancet 1995; 346: 385.
3. Richardson, A.J., Calvin, C.M., Clisby, C. et al. Fatty acid deficiency signs predict the severity of reading and related difficulties in dyslexic children. Prog Neuropsychopharmacol Biol Psychiatry 2002;26: 233-239.
4. Stevens, L., Zhang, W., Peck, L., et al. EPA supplementation in children with inattention, hyperactivity, and other disruptive disorders. Lipids 2003; 38: 1007-1021.
5. Richardson, A.J. & Montgomery, P. The Oxford-Durham study, A randomised controlled trial of dietary supplementation with fatty acids in children with developmental coordination disorder. Pediatrics 2005;115 (5): 1360-1366.

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Pathology of Fractures & Trauma

Reggie Aquilina

Practice Development Nurse -Orthopaedics
Chairperson AMON
(Association of Maltese Orthopaedic Nurses)
Aquilina Reginald @MDH

A fracture is present when there is loss of continuity in the substance of a bone. The term covers all bony disruptions, ranging from the highly comminuted fracture at one end to the hairline and even microscopic fractures at the other.

When a fracture occurs there may be severed nerves, crushed muscles and ruptured blood vessels or torn ligaments. The severity of an injury is influenced by the violence of impact. A leg broken by a car travelling at 60mph will be more seriously injured than one broken by tripping over your cat. In the high-speed injury there will be damage to all the soft tissues and the bone ends will be crushed. Although bone may unite well and in good position so that it is even stronger than before the injury, damaged muscles cannot be restored and severed nerves will never be the same even if repaired.

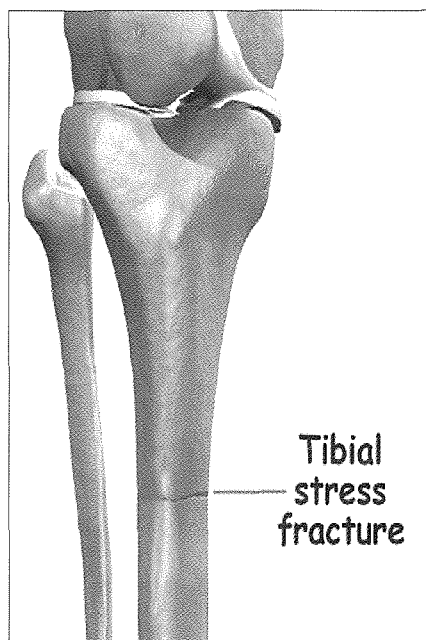
Musculoskeletal trauma may result in fractures, joint dislocation, soft tissue oedema, haemorrhage into muscle and joints, nerve, tendon, and vascular damage, and injuries to body organs.

- **Fracture:** As previously mentioned, a **fracture** is any disruption, complete or incomplete, in the continuity of bone.
- **Dislocation:** occurs when there is complete displacement of the bone from its normal position at the surface to the joint and the articular surfaces are no longer in contact.
- **Subluxation:** refers to the partial dislocation of the joint from its normal position. The term is often used to describe the early stages in a condition which may proceed to complete dislocation (e.g. in a joint infection or in rheumatoid arthritis)

CLASSIFICATION OF FRACTURES

Fractures may be subdivided, according to their aetiology, into three groups:

1. **Fractures** caused solely by **sudden injury** (the most commonly seen as occurring in accidents). It may be due to *Direct violence* as in bumper car injuries or forcible strike on a bone after a fall; or else by *Indirect violence* such as that occurring in twisting or bending stress applied to a bone that results in a fracture at some distance from the application of the causal force. (e.g a rotational stress



applied to the foot may cause a spiral fracture of the tibia). Indirect violence is also the commonest cause of dislocation.

2. **Fatigue or stress fractures** (caused by cumulative exposure to repeated stresses) occurs commonly in athletes or new military recruits. The mechanism is often compared with fatigue in metals which break after repeated bending beyond their elastic limit. Muscles become fatigued and their stress shielding ability decreases leading to more stress on the bone and fractures. The commonest of these fractures involves the second metatarsal (the *march fracture* - Fig.1), so called

because of its frequency in army recruits.

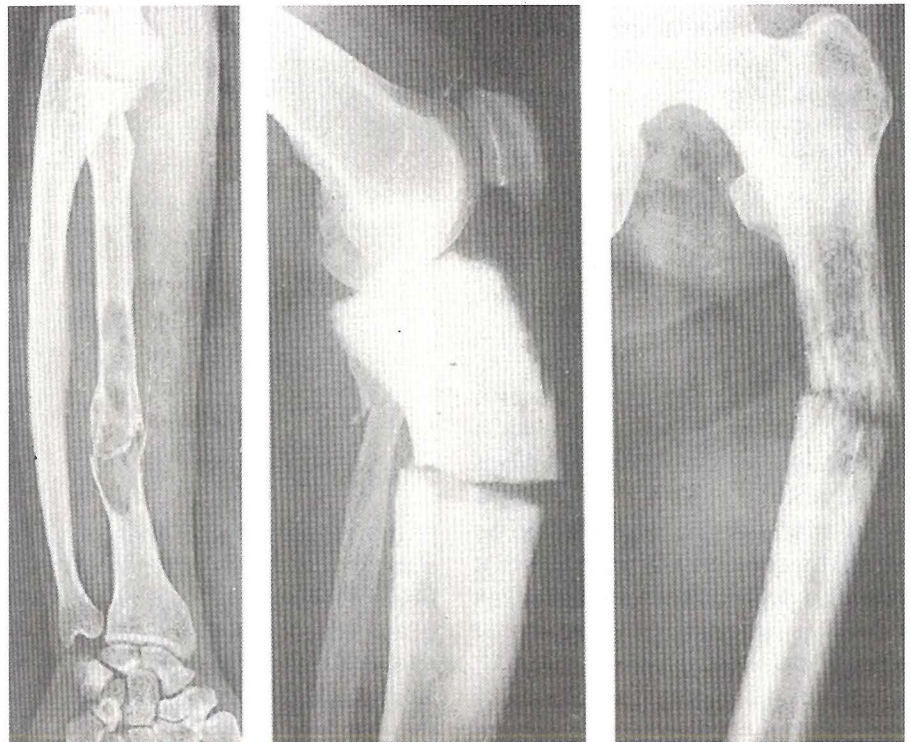
3. Pathological Fractures:

A pathological fracture (Fig.2) is one which occurs through a bone already weakened by disease. If the osseous abnormality reduces the strength of the bone a fracture may occur from trivial violence, or even spontaneously. The patient may admit to having suffered pain or discomfort in the region of the affected bone for some time before the fracture or may state that he felt the bone 'giving' just before he fell down (the fracture would have led to the fall and not vice-versa). Whether or not a pathological fracture will unite depends largely upon the nature of the underlying disorder of the bone. When this is a generalised condition such as Paget's disease or osteoporosis, the fracture may be expected to unite, often in about the usual time but sometimes more slowly than usual. A fracture at the site of a bone cyst or benign tumour will also generally unite, but there may be some delay. On the other hand, in fractures through a bone weakened by infection, union is often seriously delayed or may fail altogether unless the infection is eradicated. Fractures through the site of a malignant tumour may remain ununited, but union can sometimes occur, especially after appropriate treatment by irradiation or hormones (Adams & Hamblen 1998). Examples of bone conditions leading to weakened bones are: osteoporosis, tumours, bone cysts, Paget's disease, infections etc.

CLOSED AND OPEN FRACTURES

The type of fracture will affect the management of each individual case and thus an accurate description of fractures is essential to ensure optimal care.

Fractures may be classified in different ways: as open or closed,



Examples of Pathological Fractures:

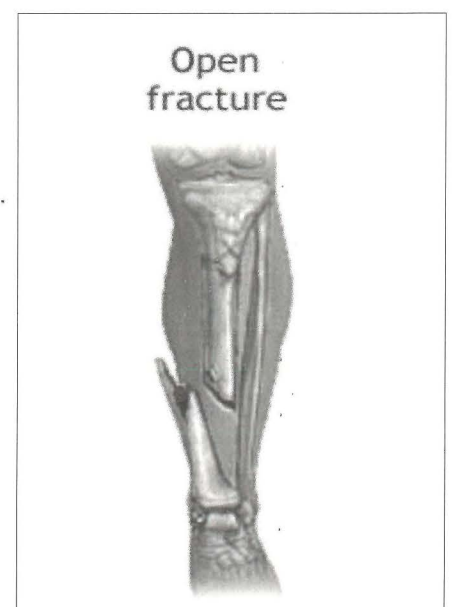
- Fracture through a bone cyst in the radius
- Fracture through a tibia affected by Paget's disease (osteitis deformans)
- Fracture at the site of carcinomatous metastasis in the upper half of the femoral shaft

the type of fracture line, the anatomic location of the fracture, the appearance, or by classic names (e.g., Colles' fracture).

Closed fractures are those in which there is loss of bone continuity internally, but there is *no break in the skin* and thus, no communication between the site of fracture and the exterior of the body. In the past, closed fractures were sometimes referred to as simple fractures. This term can be misleading because closed fractures may be as complicated as open ones.

In an **open fracture** (Fig.3) there is loss of continuity of the bone internally and there is an external wound *communicating directly to the fracture site*, or there is a fracture fragment protruding through the skin. Open fractures may be referred to as compound or complex fractures. Compound fractures are of two types: Those which are compound from **within**

out, where the bone penetrates or punctures the skin and may then promptly reduce so that only a wound at the level of the fracture is seen. Otherwise, compound fractures can be from **without in**. In direct violence the causal force breaks the skin and fractures the underlying bone. *The risks of infection are greater in the 'without*



in' type of compound fracture as dirt and fragments of clothing may be driven into the wound. The skin is often badly damaged, oedematous and there may be vascular and neurological complications. This is usually complicated with the fracture being comminuted with consequent difficulty in reduction and fixation.

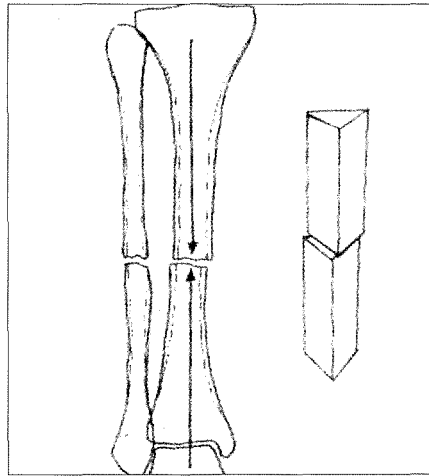
It must be stressed that the presence of a wound of the skin in association with a fracture does not necessarily mean that the fracture is an open fracture: it is classed as open or compound only when a *direct communication exists between the body surface and the fractured bone ends*.

The distinction between closed and open fractures is important, because an open fracture is liable to be contaminated by organisms introduced from without and may therefore become infected, whereas a closed fracture is free from that risk.

PATTERNS OF FRACTURE

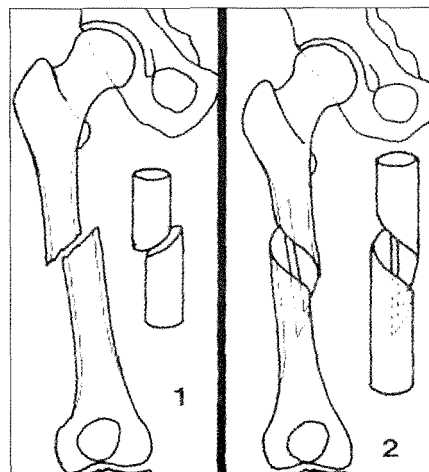
Fractures are often designated by descriptive terms denoting the shape or pattern of the fracture surfaces as seen on radiographs. The pattern of fracture is important as it may indicate the nature of violence that caused the fracture. For instance, a fracture occurring transversely through a long bone has almost certainly been caused by an angulation force rather than a twisting force, whereas a spiral fracture is usually caused by a twisting force. The pattern of fractures can also indicate certain outcomes in stability of the fragments. Thus a transverse fracture is unlikely to become redisplaced after reduction, whereas an oblique or spiral fracture is prone to redisplacement.

A **transverse fracture** (Fig. 4) is usually caused by a direct blow and an angular force being applied to the bone. It is also commonly



found in pathological fractures. The fracture line crosses the shaft of the bone involved at approximately 90° angle. Transverse fractures are generally stable after reduction and have a reduced risk of shortening. In the tibia, weight bearing may be permitted at a comparatively early stage. On the other hand, the area of bony contact in transverse fractures is small, requiring very strong union before any external support can be discarded.

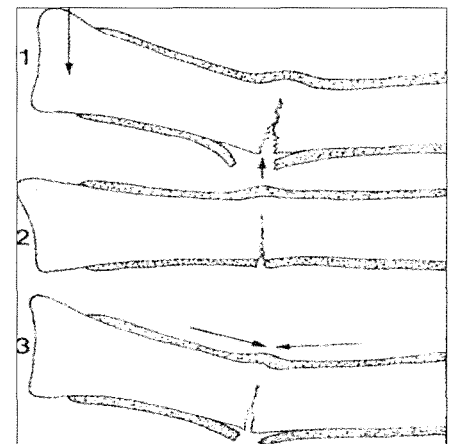
Oblique and spiral fractures (Fig. 5) In an oblique fracture (1), the fracture line occurs diagonally across the bone. In spiral fractures, the line of the fracture curves in a spiral fashion round the bone. Both these fractures may result from indirect violence. Spiral fractures (2) in particular are usually caused by the foot being held trapped whilst the leg twists about it (eg. Trapping your leg in a hole and twisting it). Spiral fractures may also be associated with soft tissue damage due to bone spikes.



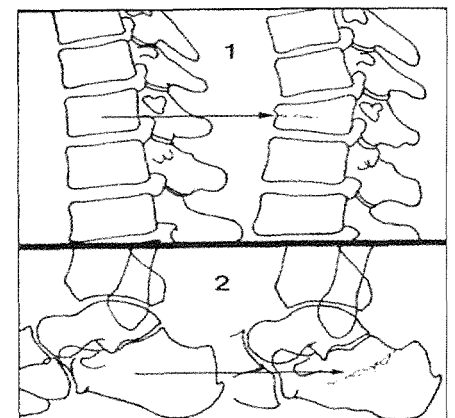
Oblique and spiral fractures may slip following reduction and are difficult to maintain without traction or internal fixation. Spiral fractures are also a major cause of malrotation in fractures however union may be achieved rapidly due to the often large area of bone in contact.

CLASSIFICATION BY TYPES OF FRACTURES

Greenstick fractures (Fig.6) are incomplete fractures that occur particularly in children, whose bones, especially before the age of 10 years, are springy and resilient like the branches of a young tree. The bone may bend at one cortex and buckle or break at the other thus producing an incomplete fracture.

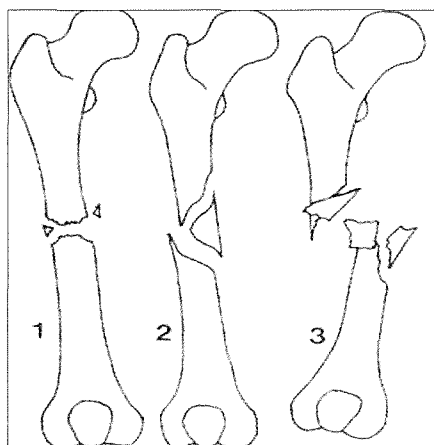


Compression fractures (Fig. 7) Crush fractures occur in cancellous bone which is compressed beyond the limits of tolerance. Common sites are (1) the vertebral bodies (as a result of flexion injuries) and (2) the heels (following falls from a height). Compression fractures

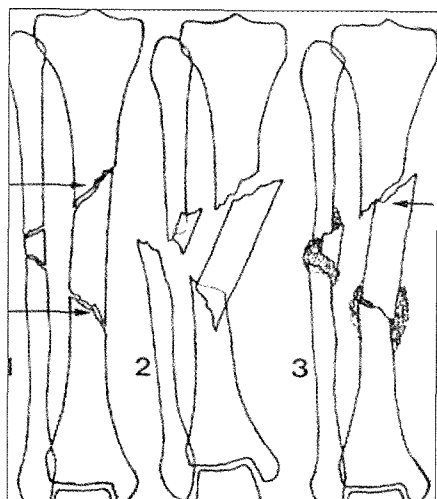


are not always easy to reduce anatomically, because the spongy bone substance may be crushed and compressed and cannot be restored fully to its original trabecular form.

Comminuted fractures (Fig. 8) occur when there is splintering of the bone ends usually due to a direct trauma. Comminuted fractures are frequently associated with *severe soft tissue damage* and are unstable. It is generally difficult to achieve and maintain reduction in these fractures. Comminution ranges from (1) slight comminution at the fracture site through (2) comminution at the fracture site with a large *butterfly fragment* (so called from its shape) to (3) a highly comminuted fracture'

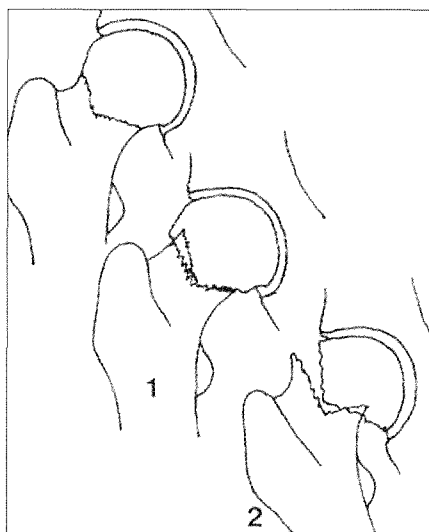


Double fracture: (segmental fracture – Fig.9) In double fracture (1) the affected bone is fractured at two distinct levels. Double fracture must be distinguished from comminution. In the case illustrated, there is also a double



fracture of the fibula. Instability (2) and difficulty in reduction and fixation are common. Internal fixation may further impair a dubious blood supply to the central segment, and non-union (3) may occur at one level.

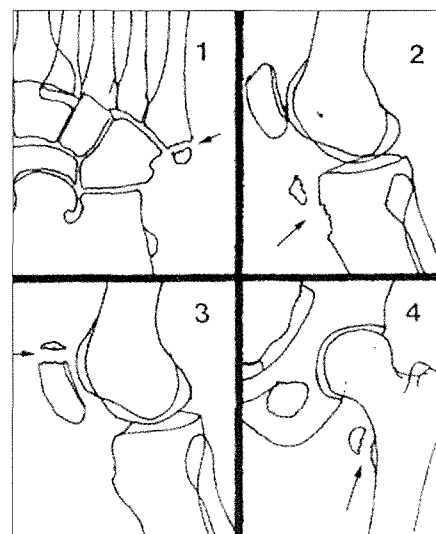
Impacted fractures : (Fig. 10) (1) occur when direct force causes a fracture and telescopes the fragment with the smaller diameter into the fragment with the larger diameter at the fracture line (one fragment is driven into the other). Cancellous bone is usually involved and union is often rapid. The stability of these fractures varies and is more implied than real. Displacement will occur if the fracture is subjected to deforming forces; eg. Without fixation, impacted femoral neck fractures frequently come adrift especially if weight bearing is permitted (2). Most common sites of impacted fractures are the neck of the humerus, lower end of radius, and neck of femur.



Avulsion fractures (Fig. 11) are those in which bone fragments and tissue are *pulled away from bone* at the insertion site by a sudden muscle contraction. These fractures often occur in skeletally immature children. Common examples include:

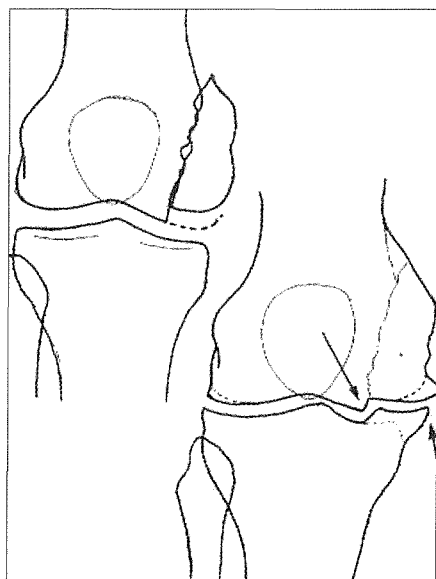
1. Base of 5th metatarsal (due to peroneus brevis muscle contraction)
2. Tibial tuberosity (quadriceps contraction)

3. Upper pole of patella (quadriceps contraction)
4. Lesser trochanter (iliopsoas contraction)



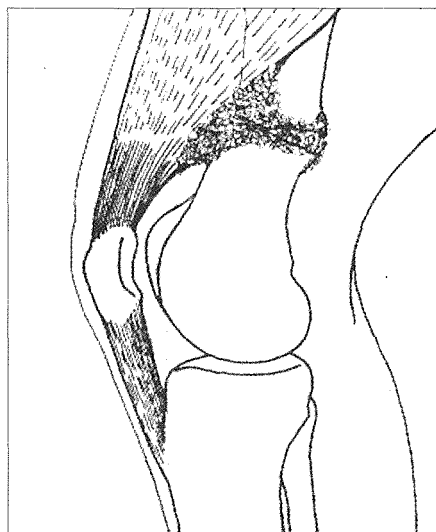
Depressed fracture: Depressed fractures occur when a sharply localised blow depresses a segment of cortical bone below the level of the surrounding bone. Although common in skull fractures, this pattern is only rarely found in the limbs.

Intra-articular fractures: (Fig. 12) When a fracture involves a joint, *any residual articular irregularity may lead to secondary osteoarthritis*. In all cases, there is a risk of stiffness from intra-articular adhesions. Sometimes complications may be minimised by accurate open reduction and internal fixation, but thereafter early mobilisation is essential if increased adhesions

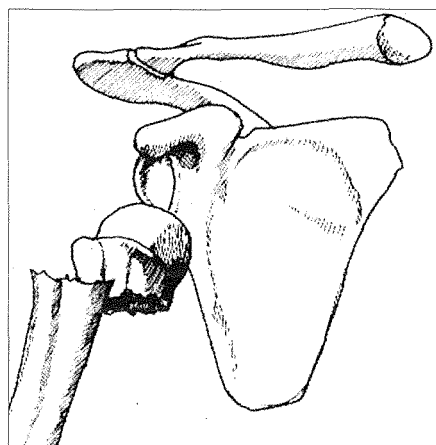


and stiffness are to be avoided. Prolonged physiotherapy is required as a rule in all these cases.

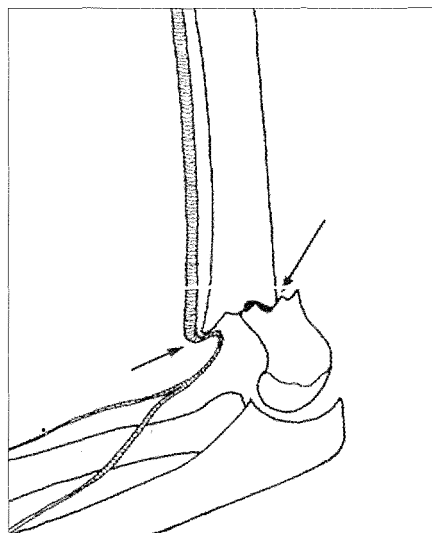
Fracture close to a joint: (Fig. 13) When a fracture lies close to a joint, stiffness may also be a problem due to tethering of neighbouring muscles and tendons by spread of callus from the healing fracture; e.g. in fractures of the femur close to the knee, the quadriceps may become bound down by the callus, resulting in difficulty with knee flexion.



Fracture-dislocation: A fracture-dislocation is present when a joint has dislocated and there is in addition a fracture of one of the bony components of the joint. Illustrated is a fracture-dislocation of the shoulder, where there is an anterior dislocation with a fracture of the neck of the humerus. Injuries of this kind may be difficult to reduce and may be unstable. Stiffness and avascular necrosis are two common complications.

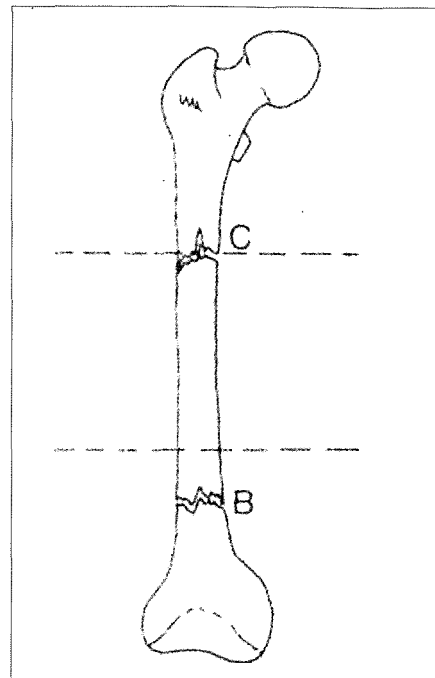
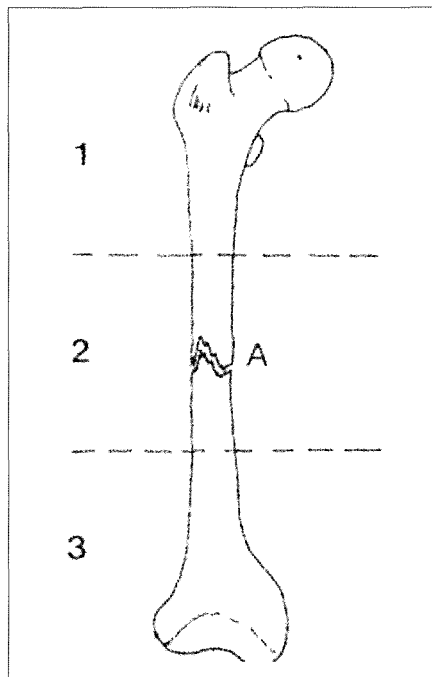


Complex or complicated fractures: a fracture is described as complicated if there is accompanying damage to major neighbouring structures. The diagram (Fig.15) is a *complicated supracondylar fracture of the humerus*. (Such an injury might also be described as a supracondylar fracture complicated by damage to the brachial artery.)



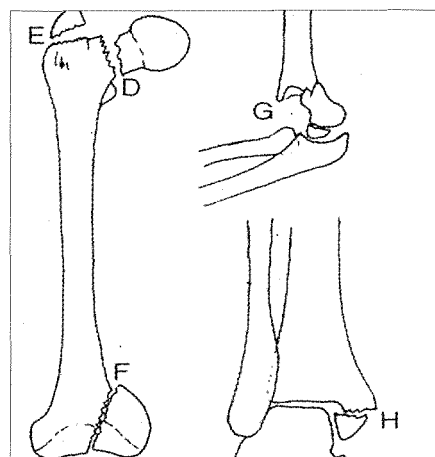
Classification by Point of Reference or Appearance

Terms to classify fractures by point of reference on the bone include midshaft, proximal third, middle third, and distal third. More specific anatomic locations include intra-articular, epiphyseal, or apophyseal.



In the case of the long bones, the shaft is divided into thirds for descriptive purposes. A fracture to A (Fig. 16) would be described as middle third fracture of the femur (or a midshaft fracture of the femur)

In the same way, a fracture as at B (Fig.17) would be described as a fracture in the distal third and C would be described as a fracture at the junction of the proximal and middle thirds.

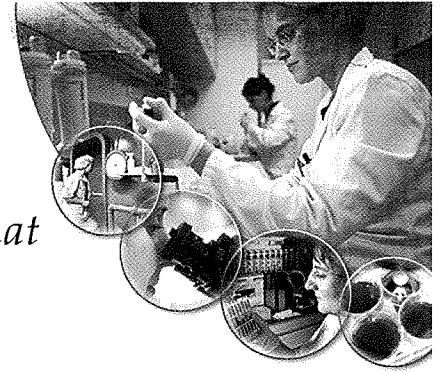


At the ends of the bones the nomenclature is either anatomical or refers to a personality whose name is associated with the fracture: In Fig. 18:
 D # neck of femur;
 E # of the greater trochanter;
 F intercondylar #;
 G supracondylar #of the humerus;
 H # of the medial malleolus.

HUNTINGTON'S DISEASE

Dr Rob Hicks
Dr Trisha Macnair

Huntington's disease is a hereditary disorder that damages the nerve cells of certain areas of the brain



What is Huntington's disease

Huntington's disease (also referred to in more formal medical research as Huntington Disease) is an hereditary neurological disorder of the central nervous system that causes progressive degeneration of cells in the brain, slowly impairing a person's ability to walk, think, talk and reason.

It was first described in 1872 by an American doctor, George Huntington, who studied an extended family in Long Island affected by the condition.

Symptoms

Symptoms develop gradually over months or years. The age at which they first appear is usually between about 30 and 50.

However, in about 5% of cases Huntington's disease becomes apparent before the age of 20 (in this situation, referred to as juvenile-onset Huntington's Disease, it is usually inherited from the father). The onset and rate of progression of the disease tends to follow a pattern within each family.

Symptoms begin with memory loss (especially of recent events) or confusion, changes in personality and mood that may include aggressive and antisocial behaviour, as well as clumsiness or uncontrolled muscle movements (these movements are known as chorea) and rigidity.

As the condition progresses, other symptoms of dementia appear, such as loss of rational thought and poor concentration. Involuntary movements; difficulties with speaking and swallowing, weight loss, seizures, depression and anxiety may also occur.

The disease often progresses slowly, and the affected

person may live for 15 to 20 years after the initial diagnosis.



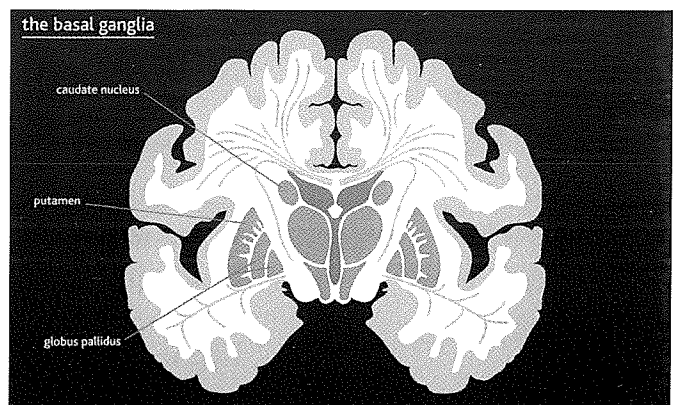
Causes and risk factors

Huntington's disease is caused by a single defective gene on chromosome 4. This leads to damage of the nerve cells in areas of the brain including the basal ganglia and cerebral cortex, and to the gradual onset of physical, mental and emotional changes.

The Huntington's Disease Association estimates between 6,500 and 8,000 people in the UK have the disease.

The tragedy is that by the time symptoms appear, the person has often had a family and may have passed on the gene to their children. Each person whose parent has Huntington's disease has a 50 per cent chance of inheriting the gene, and everyone who inherits the gene will at some stage develop the disease.

In three per cent of cases, there's no family history of Huntington's disease and the genetic fault may be a new mutation.



The disease can't be prevented from developing if someone has the faulty gene. To inherit the illness, the gene only has to come from one parent, making it autosomal dominant.

The gene for Huntington's disease can be detected with a blood test, which is available to those aged over 18, before symptoms begin. This can determine whether someone has the faulty gene and help them in their family planning.

With no cure, many of those at risk decide not to take the test rather than live their life in the shadow of the disease. Genetic testing has also led to fears that those with a family history of the condition will have financial problems, such as getting insurance and mortgages.

Treatment and recovery

There's no cure, but supportive care can ease many symptoms and help a person with Huntington's disease, and their family, lead as normal a life as possible.

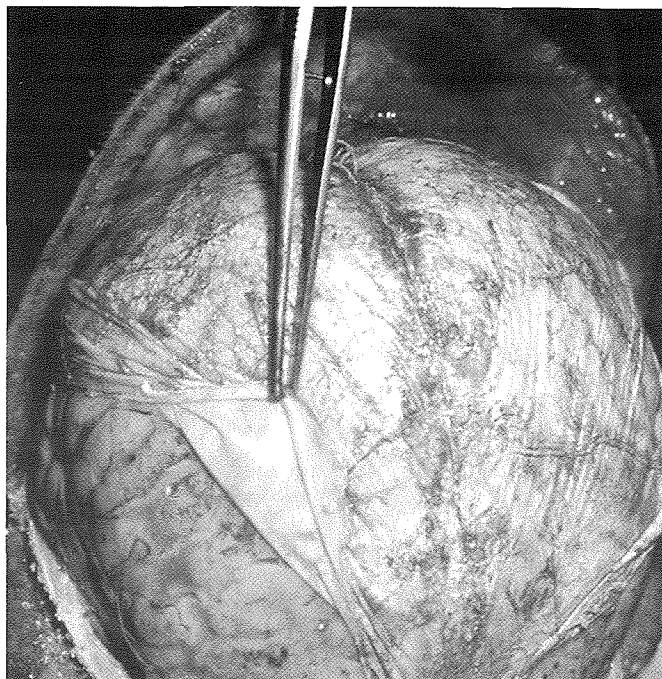
Drugs can relieve symptoms of involuntary movements, depression and mood swings. Speech therapy can help improve speech and swallowing problems. A high-calorie diet can help maintain weight and improve symptoms such as involuntary movement and behavioural problems.

Cognitive changes often result in loss of enthusiasm, initiative and organisational skills, which can make multi-tasking difficult. Constant nursing care is needed in the later stages of the disease and support for carers is important, too.

Secondary illnesses, such as pneumonia, are often the cause of death.

There's extensive research into possible treatments for Huntington's disease. One technique is the use of transplants of foetal brain cells, which appear in some cases to repair and rejuvenate the damaged area.

Meanwhile, researchers at the University of Leeds have found that one of the body's naturally occurring



proteins is causing some of the disruption that occurs in the brains of those with Huntington's, and its effects may be modified by using drugs that are already being used to help cancer patients. But it is likely to be years, if at all, before these developments result in an effective treatment.

This article was last medically reviewed by Dr Trisha Macnair in March 2009.

Source: <http://www.bbc.co.uk/health/conditions/huntingtons1.shtml>

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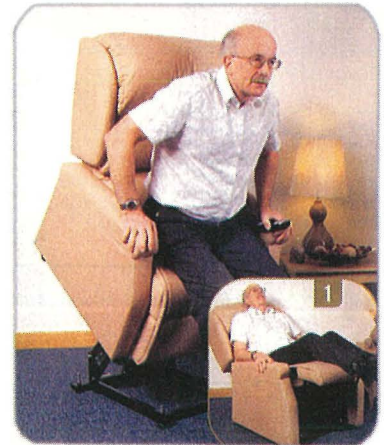
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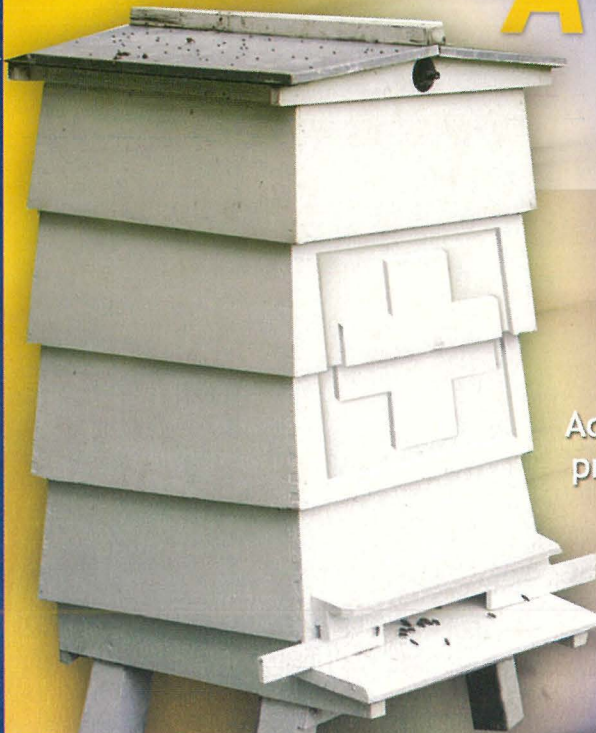


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News

Pharmaceutical plant to conduct original research in Malta

Joanna Ripard

Pharmacare Premium Malta, the Palestinian-German-Maltese joint venture which is to open a €10 million plant in Hal Far next year, will be the first pharmaceutical facility in Malta to have a dedicated unit for original research, managing director Bassim Khoury told *The Times Business* in an interview.

"We are proud of the fact that we will be the first and only pharmaceutical company involving Maltese with headquarters in Malta to carry out original research. Research and development in the classical sense is six per cent of our sales, but we have earmarked another three per cent to original research, focusing on new molecules and new issues.

"It is a small percentage compared to larger companies, but most small pharmaceuticals have zero budget for original research. There is good potential for research in Malta. Biotechnology is the field of the future. One of the early developments in this area for our German partners Grünenthal took place in co-operation with the University of Malta about 15 years ago," he said.

Pharmacare Premium is a joint venture between Palestinian-German Pharmacare Europe and Maltese-registered Pharma Group. The 12,500-square metre Malta plant, on which construction begins in April, will kickstart operations on two lines manufacturing conventional generic pharmaceuticals and high potency generics in tablet and capsule form in mid-2010.

It will have a staff complement of over 100 by its third year of operation. The venture constitutes Malta's first ever foreign direct investment from Palestine.

Pharmacare Europe is a subsidiary of Palestinian-registered Pharmacare plc which exports to the CIS (former Soviet republics) and some Middle Eastern countries. Set up 24 years ago, its main operation is in Beutunia, a twin city of Ramallah, 15 km north of Jerusalem; 24 per cent of its production is exported to Europe.

It has 600 shareholders: the largest shareholding belongs to the Wirtz family who also owns Grünenthal and Mr Khoury's family. Pharmacare has been manufacturing products under licence for Grünenthal and other companies for over 10 years; Mr Khoury said the company, which was the first in its country to export in 1994, has 12 per cent market share in Palestine.

"Our turnover is around \$10 million," Mr Khoury, an industrial pharmacist, explained. "In 10 years, we have more than doubled our assets, more than tripled our balance sheet, increased our profits threefold, and return on investment is a healthy 13 per cent."

These are remarkable strides for a manufacturer operating in a war zone, amid yet another *intifada*. Pharmacare plc - which according to two of Mr Khoury's Maltese



Pharmacare Premium Malta managing director Bassim Khoury: "In 10 years, we have more than doubled our assets, more than tripled our balance sheet, and increased our profits threefold. And we operate in a war zone." Photo: Matthew Mirabelli

partners Peter Seychell and Lawrence Hill, operates a state-of-the-art plant among the best in the country - is the image of Palestinian industry in every sense.

Mr Khoury, a school friend of Palestine's Ambassador to Malta Jubran Taweel, and his sister Suha, Palestinian leader Yasser Arafat's widow, is president of the Palestinian Federation of Industries, the largest private sector comprising 14,000 industrialists. He also heads the Private Sector Coordinating Council which incorporates ten private sector groups governing industries such as banking and insurance and IT.

The father of three explains how contingency is a top priority at Pharmacare plc: "Next to our facility we rent apartments for staff, so when there is a curfew they are able to sleep there. We gave bonuses to staff to relocate within 500 metres from the factory and we pay 80 per cent of their rent. There were times when it was really tough and people who could not relocate had to sleep in their offices. My research and development manager and I have slept in our offices when we had business to finish. We have our own power generation and water treatment system for emergencies and we can be independent for about a week.

"As a German partnership, we are registered with the Israeli Ministry of Defence as a German interest and we fly the German and Palestinian flags. I hold Israeli identification, so whenever the Israeli soldiers turn up during a

curfew I show them a letter in Hebrew explaining that this company is owned by a Jerusalemite and a German company. We have been shelled only once and there was only minor damage."

Despite its challenging operational environment, Pharmacare's business profile is remarkable. Over the past few years, it has invested close to \$5 million to maintain quality standards. It develops many technologies and software in-house and trains most of its staff, 72 per cent of whom are university graduates and 52 per cent are women. Most are Palestinian.

"We would like to see the creation of a Maltese generic association which would also push for legislation governing them."

Of its female staff, 28 are pharmacists who work in the plant or travel through the territories as medical representatives. Pharmacare was the first company to employ female marketing staff in Palestine: Mr Khoury says it was unheard of for a Palestinian woman to visit a doctor's practice alone in a country where most pharmacists are female but with limited job opportunities. Its

research and development unit is headed by two women who were originally working in the US and who should come to Malta to carry out research with Maltese personnel.

By the time the Maltese operation gets off the ground, Pharmacare should have obtained the EU's Good Manufacturing Practice (GMP) certification which will allow it sell its products across the bloc.

Mr Khoury says Pharmacare also intends to widen its outreach in the Middle East and North Africa region as far as the United Arab Emirates. As Malta, historically, always maintained a balanced foreign policy, it makes for a very good gateway, Mr Khoury pointed out: "Take Libya, for example. The fact that Malta maintained balance in international relations allows Malta now to be a good player in that region where it could have a much bigger role than its size.

"Besides, the alliance behind Pharmacare Premium Malta embodies the true spirit of the Euro-Med."

Significantly, despite being primarily export-oriented, Pharmacare will turn its attention to Malta. "There are companies here who manufacture to the tune of millions and ignore the Maltese market. As a result the cost of pharmaceuticals in Malta is still high," Mr Khoury pointed out. "Pharmacare has a different approach. We will target the Maltese market. It is a small market but we can nourish it.

"We would like to see the creation of a Maltese generic association which would also push for legislation governing them. We have to strike a very delicate balance. We want to maintain a spirit of innovation. There has to be a balance between innovators and generic manufacturers. What is happening in Malta is that the island is not benefitting from the generic manufacturers enough. Very few products that are manufactured in Malta are sold in Malta."

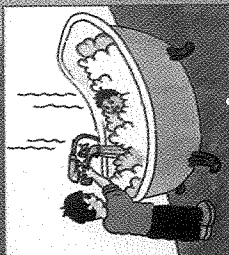
Mr Khoury, who describes himself as a proud Palestinian, says the funding for Pharmacare plc's first-ever investment overseas was earmarked last year, and although the international crisis is a factor, the current climate is a time to grasp opportunity.

He points out that the pharmaceutical industry has a crisis of its own to worry about: the lack of innovation. The number of drugs patented between 2002 and 2007 is less than 50 per cent of those patented in the previous five years. Patents since 2007 and what is expected by 2012 will be less than half the number of the previous five years. Mr Khoury says pipelines of major pharmaceuticals are drying up as they struggle to identify new molecules, despite spending billions in research.

Grünenthal, which has excelled in its niche targeting palliative and acute pain relief, is fortunate to be one of the few international companies to have a launch this year.

SCALDS ARE PREVENTABLE

THE BATHROOM



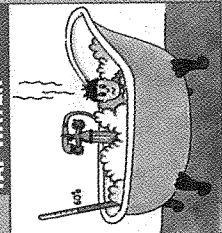
Scalds from hot tap water can result in very severe injuries to young children. Hot tap water at 65°C can severely burn a child in less than half a second. At 50°C it will take five minutes.

Scalds from hot tap water can happen when young children turn on the hot water tap and they are under it, or when they are placed into a bath that is too hot.

ALWAYS

- ▶ Stay with children whenever they are in the bathroom. (A good idea would be to take the phone off the hook) or Take the child out of the bathroom if you need to answer the phone or the door
- ▶ Test the temperature of the water with your elbow before placing your child in the bath
- ▶ Make sure that the hot water tap is turned off tightly

TIPS TO PREVENT SCALDS FROM HOT TAP WATER



NEVER

- ▶ Leave a toddler in the care of another child as the older child may be able to turn on the hot water tap

FIRST AID TIPS

As recommended by the Plastic Surgery & Burns Unit at Mater Dei Hospital

1. Remove Clothing (remove all wet clothing quickly, as this retains the heat).
2. Apply Cold Water for 5 to 10 minutes (immediately shower the scalded area with cold water for 5 to 10 minutes, to reduce heat in the skin, thus preventing deeper burns). Never use butter, oils or ointments to cover the burn as they may retain the heat. Never use ice as children can be dangerously chilled in iced water.
3. Cover the injured area with a sheet of cling film as this does not stick to the body. Also always maintain a clear airway.
4. Seek Medical Advice immediately i.e. take the child to Hospital or the nearest Health Centre.

Preventing Scalds in Young Children

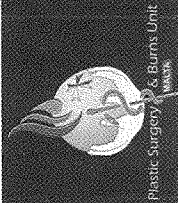
How to make your home safer

Pierre Scerri, Staff Nurse at the PSBU. Scerri Pierre at MDH

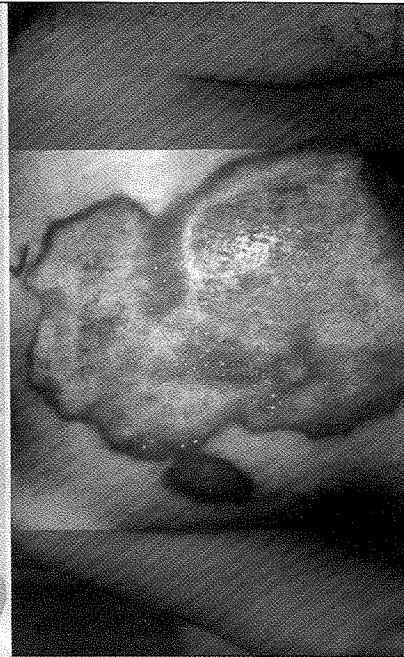
The need of an informative leaflet in the prevention of burns in young children has long been felt by all the nurses and doctors working at the Burns Unit in St. Luke's Hospital. Scalds and Burns in children are mainly due to lack of knowledge by the parents or through carelessness. As partial fulfillment for the S.E.N. to S.R.N. conversion course the In-Dept Study was deemed necessary. The author opted to choose scald burns as these are the most common injuries sustained by young children while they are being cared for in the home of their parents or carers. An informative leaflet with the necessary preventive information was formulated in order to make parents aware of all the dangerous situations that are found in the home. The first addition of this leaflet was published in 2003 and distributed from different outlets that the Health Division has. Before this leaflet was published at the Burns Out-Patients Clinic the number of young children in the 0-5 year age group was 104 cases every year. This was established in a study made by the author in 2001/02. After the leaflet was published and five years passed since this date, in another study it was established that the number of young children in the 0-5 year age group has decreased to 31 cases every year. This was in 2007. In 2008 the cases decreased to 20 yearly. Another leaflet was published again in 2008 and again will be distributed from different outlets that the Health Division has. Thanks to this leaflet the objective of the author to educate parents and carers deemed futile and this will eventually continue to help in preventing scalds in young children.

Health Promotion & Disease Prevention Department

Produced by Pierre Scerri, Registered Nurse in collaboration with the team of the Plastic Surgery & Burns Unit, the Health Promotion & Disease Prevention Department.



If you take the necessary safety precautions
SCALDS ARE PREVENTABLE



SCALDS ARE PREVENTABLE • SCALDS ARE PREVENTABLE • SCALDS ARE PREVENTABLE • SCALDS ARE PREVENTABLE • SCALDS ARE PREVENTABLE

PREVENTION IS BETTER THAN CURE

Young children see things differently from you. To a small child the home is an exciting place, like a playing field, as children love to explore, touch, climb and grab.

Children grow fast and can reach new things daily. The challenge is to stay one step ahead of them particularly when it comes to safety.

Young children do not distinguish between a dangerous situation and a safe one. They do not know that hot water and hot drinks can burn them and leave their mark on them for life.

Scalds are commonly caused by cups of tea or coffee, hot tap water and hot liquids in kettles and saucepans.

But if one takes the necessary safety precautions

SCALDS ARE PREVENTABLE

Over 85% of scalds happen in the home.



Tea & Coffee

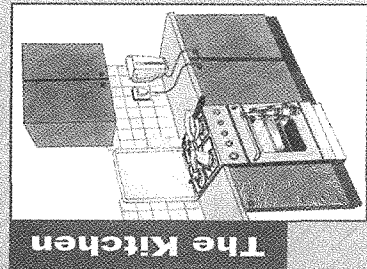
Tea and coffee should be treated like fire. Most scalds from tea and coffee result from children pulling a cup down onto themselves.

ALWAYS

- Place all hot drinks in the centre of the table
- Use non-slip placemats instead of table cloths
- Have your tea break when your toddler is resting or sleeping
- Always drink from a broad base mug
- Keep mugs and cups well back from the edge of the bench when making tea or coffee
- Ask relatives and friends to follow the same steps

NEVER

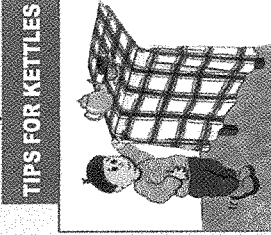
- Hold a baby or toddler while drinking hot drinks
- Use low coffee tables which a toddler can easily reach
- Prepare hot drinks in a mug which the child normally uses
- Encourage toddlers to take sips from your mug



The Kitchen

The kitchen is full of dangerous objects that young children want to touch.

Severe scalding commonly occurs when a child pulls the cord of the electric kettle, grabs a saucepan handle or knocks these objects over.



TIPS FOR KETTLES

ALWAYS

- Keep kettles, jugs and teapots away from the edge of the kitchen top
- Use a cordless kettle, or Use a 'curly cord' (this will recoil to prevent hanging)
- Install an 'appliance stop' (this is a steel bar that can be attached to the counter to prevent appliances from falling)

NEVER

- Leave cords hanging over the edge of the kitchen top

TIPS FOR POTS AND PANS

ALWAYS

- Turn pot handles away from the edge of the stove
- Use the back burners or hot plates instead of the front
- Install a stove guard to prevent children from pulling objects off the stove

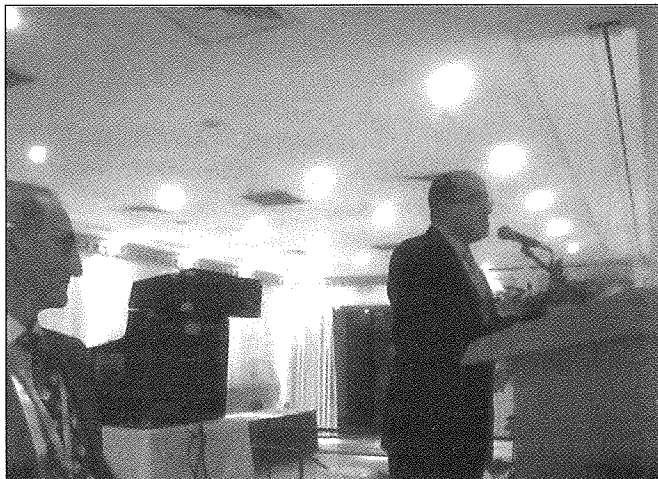
NEVER

- Carry pots or saucepans with hot liquids across the kitchen (carry plates to pots or sauce pans, and not the other way round)



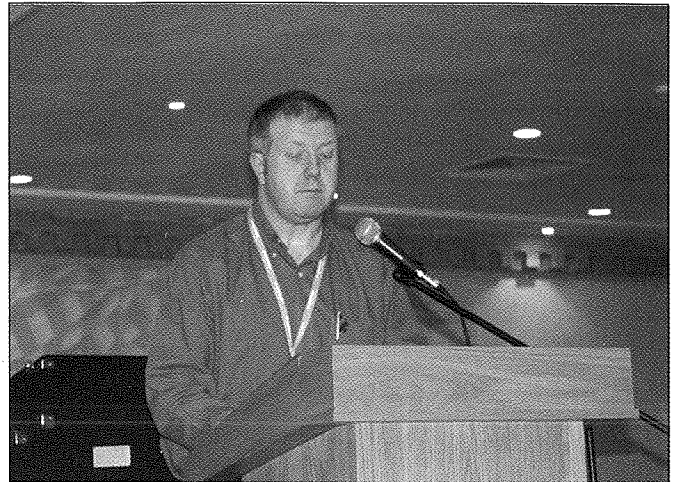
Clinical Nutrition Conference 2009

The Clinical Nutrition Unit of Mater Dei Hospital, as part of its aim to upgrade Nursing practice and healthcare, organised a Clinical Nutrition Conference on the 6th and 7th February 2009. The programme consisted of various papers covering various health topics in relation to nutrition and Clinical Nutrition (i.e. enteral and parenteral nutrition). The topics discussed during the conference covered areas ranging from breastfeeding, obesity, nutritional assessment in hospital and in the community, infection control on central venous catheters, enteral nutrition, parenteral nutrition, food consistencies, providing adequate nutrition for patients in surgical wards, with multiple injuries or having wounds, maintaining good bowel habits, music therapy and its benefits and nutrition in relation to different diseases such as arthritis and diabetes. Some papers discussed the roles of specific professionals in relation to Clinical Nutrition and the



Mr Geoffrey Axiak and Mr Jesmond Seychell - Clinical Nutrition Nurses - at the opening of the Clinical Nutrition Conference 2009

Clinical Nutrition team. Some papers even discussed the need for more education with regards to obesity in children and their parents and related to enteral nutrition for nursing staff. A special guest speaker, Mr Glyn Scott, Clinical Nurse Specialist in Nutrition from Medway Maritime Hospital, U.K., talked about the input that Nutrition Support Teams can give in hospital and the need for teamwork and outlined certain measures that he brought about within the hospital where he works, together with the Nutrition team, to improve patient care and comfort. The conference speakers included Consultants and Consultant Geriatricians, Specialist Nurses and Practice Development Nurses from various specialities, ward



Mr Clyn Scott- Clinical Nurse Specialist (Nutrition) at Medway Maritime Hospital, U.K.

nurses with special interests and other professionals, including Speech Language Pathologists and Dietitians. The variety of the speakers also gave the conference a multidisciplinary attitude and hence promoted an environment of learning and information-sharing.

Various themes emerged from the conference presentations. One of the main themes that emerged was the need for an adequate assessment of patients' nutritional and calorific needs before starting a feeding regime, preoperatively and even postoperatively. Mr Carmel Grima and Mr Reggie Aquilina discussed the need to undertake a proper nutritional assessment for surgical patients and those with multiple injuries and thereby be able to provide these patients with a nutritional intake which would provide them with a calorific intake which would permit them to heal and recover quicker. Ms Corinne Ward even highlighted the need for a nutritional assessment of patients with wounds and pointed out various minerals and vitamins which, when combined with an adequate calorific intake, would enhance wound healing.

Breastfeeding was also a major point of discussion. Two papers discussed the topic. Ms Helen Borg focussed on the benefits of breastfeeding to the child and his/her development especially when compared to formula milkfeeding. Professor Simon Attard Montalto presented the results of a study carried out in Malta on a large number of mothers, which highlighted that out of more than 3000 mothers who delivered, 53% chose to breastfeed. Out of the 25% who chose

to participate (405), 2 withdrew. Out of 403 Maltese women who opted to breastfeed between June 2004 and March 2005, 152 (38%) were still breastfeeding at 6 months, 200 (50%) stopped breastfeeding by 6 months due to poor advice given, above all, by healthcare professionals.

Dr Edgar Pullicino gave an overview of the affects of starvation, hyperalimentation and of providing excess metabolites. He also described the contents of total parenteral nutrition and outlined the main complications of parenteral nutrition, such as mineral and vitamin deficiencies and liver dysfunction. Mr Noel Abela continued to focus on the importance of maintaining asepsis when handling central lines and stressed on the importance of preventing line infections through proper hand washing, disinfection and aseptic technique.



De Edgar Pullicino
Consultant Gastroenterologist

A number of presentations were focussed on the role of particular healthcare professionals within the Clinical Nutrition speciality. These included the role of the Dietitian (Mr Mario Caruana) and that of the Speech Language Pathologist (Ms Helen Fiorini). Other presentations focussed on the role of nutrition



Ms Helen Fiorino - Speech Language
Pathologist (ZCH & KGH)

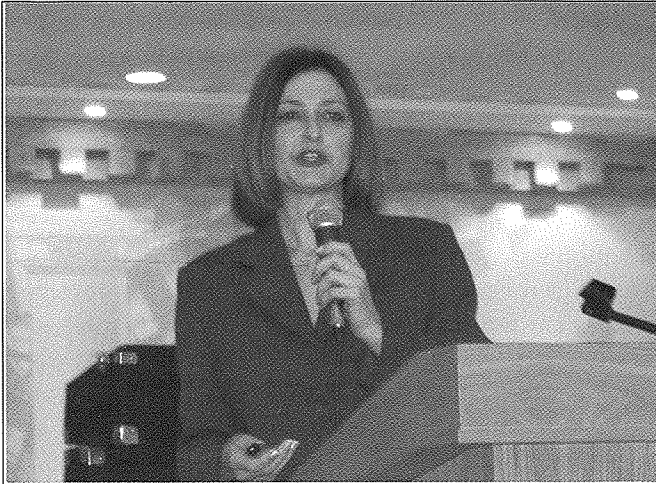
in arthritis (Ms Doris Aquilina) and diabetes (Mr Joseph Sammut). Mr Reuben Cassar gave a very interesting presentation on music therapy and its affect on nutrition particularly in infants and neonates where studies showed that music therapy induced neonates to increase their sucking reflex and their nutritional intake. The affect was also evident in adults where nutritional intake increased when soothing music was played at mealtimes. Ms Helen Fiorini also presented a study carried out by a number of Speech Language Pathologists where they compared various thickeners and produced a sheet whereby ward nurses could make up uniform consistencies regardless of the thickeners used.

Various presentations focussed on elderly care. Ms Mary Anne Bugeja focussed on "Myths and Facts about enteral nutrition in Elderly Care", where she gave a lot of food for thought about certain myths that nurses have regarding enteral feeding. Ms Antoinette Zahra gave a very capturing presentation on how to maintain good bowel habits in the elderly. Mr Mario Scicluna presented yet another perspective of elderly care. He focussed on maintaining a healthy lifestyle in elderly people in the community setting. His main emphasis was on elderly people staying active and involved in everyday activities, preventing disease and identifying disease as early as possible.



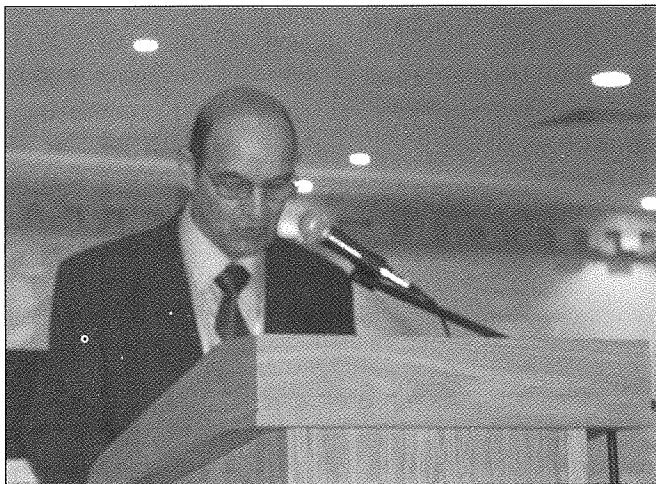
Ms Antoinette Zahra
Continance Nurse Advisor

With regards to paediatrics, Mr Chris Fearné outlined the choices of nutrition in disabled children, highlighting the benefits of using various kinds of enteral nutrition such as P.E.G.s, buttons, jejunostomies, the pillcam and other techniques to diagnose feeding problems and facilitate feeding. Ms Michele Bezzina presented a project that she is planning whereby she would be coordinating a team of experts whose aim would be to educate obese children and their parents to ultimately reduce the children's obesity problem through activity and education in an environment of play and physical activity.



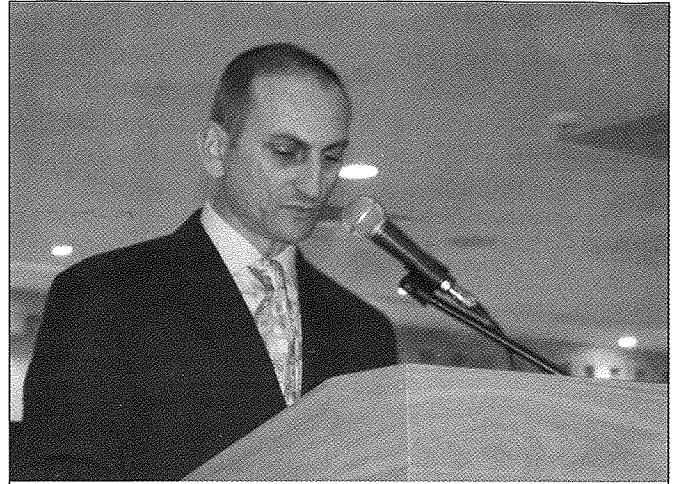
Ms Michele Bezzina
Nurse on Wonderland Ward

A highlight on each day of the conference was a patient experience whereby a relative recounted the experience s/he had while their relative was receiving home enteral and/or parenteral nutrition. These experiences, which were personal and very touching, gave a different taste to the conference, the patients' and relatives' perspective and therefore showed the other side of the coin, one that is often overlooked. These provided insight as to the psychological care and support needed by the patients and relatives and hence gave a holistic approach to patient care. One the first day of the conference the patient was a child and on the second day the patient was an elderly gentleman and therefore the experiences had their similarities as well as their differences, and that made the experiences even richer.



Mr Carmel Abela
Relative of an ex-home TPN patient

As a follow-up of the conference, Mr Seychell and I have thought of organising workshops on the most important issues that emerged from this conference, so that the information and knowledge offered would be disseminated to as many healthcare professionals as possible with the aim of improving practices and patient care. We are also offering a CD containing all the presentations presented at the conference.

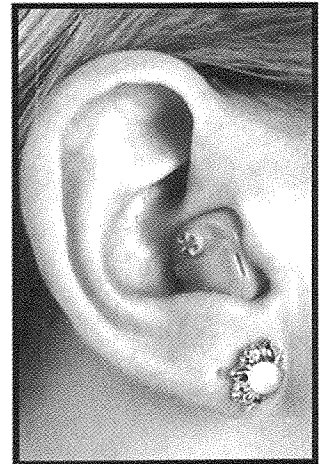
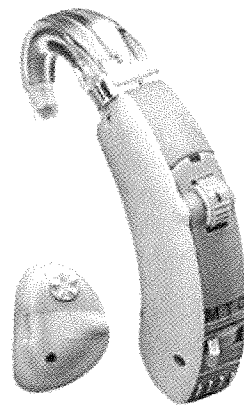


Mr Jesmond Seychell
Clinical Nutrition Nurse

As a conclusion, I would like to thank the Nursing Management and all the speakers for their support and cooperation with the organisers of this conference, the persons who directly helped with the organisation, the sponsors without whom this event would never have been possible, the Management of the hotel for their professional services and also the participants, who flooded us in large numbers, thus making this conference so worthwhile and such a huge success.

Geoffrey Axiak D.N.O., B.Sc.(Nursing), P.G.Dip.
(Nutrition & Dietetics), MDH.

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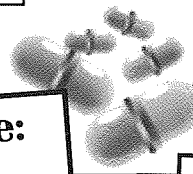
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- 6) Interesting aromas.
- 7) Courteous and infallible doctors who always leave clear orders in perfectly legible handwriting.
- 8) Do enough charting to navigate around the world.
- 9) Celebrate all the holidays with your friends- at work.
- 10) Take comfort that most of your patients survive no matter what you do to them.

HERO IN A MENTAL HOSPITAL

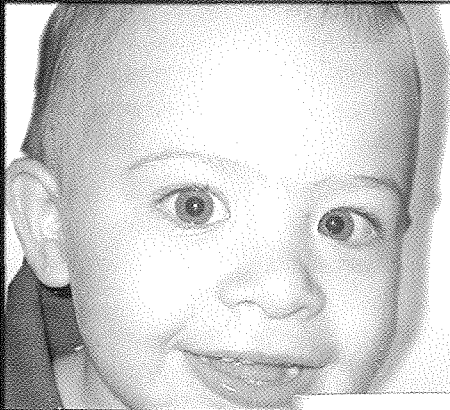
Jim and Mary were both patients in a Mental Hospital. One day while they were walking past the hospital swimming pool, Jim suddenly jumped into the deep end. He sunk to the bottom & stayed there.

Mary promptly jumped in to save him. She swam to the bottom and pulled Jim out. When the medical director became aware of Mary's heroic act he immediately ordered her to be discharged from the hospital, as he now considered her to be mentally stable.

When he went to tell Mary the news he said, "Mary, I have good news & bad news. The good news is you're being discharged because since you were able to jump in and save the life of another patient, I think you've regained your senses." The bad news is, Jim, the patient you saved, hung himself with his bathrobe belt in the bathroom. I am so sorry, but he's dead."

Mary replied "He didn't hang himself, I put him there to dry."

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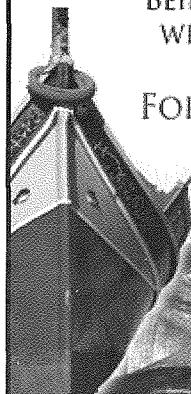
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- Septicaemia
- Pneumonia

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VACCINATE HELP STOP IT



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Pneumococcal Saccharide Conjugate Vaccine, Adsorbed

Wyeth

Pneumococcal saccharide conjugated vaccine, adsorbed. Presentation: Each 0.5ml dose of Prevenar contains 2 micrograms of each of the following saccharide serotypes: 4, 9V, 14, 18C, 19F, 23F and 4 micrograms of saccharide serotype 6B. Each saccharide is conjugated to the CRM197 carrier protein and adsorbed on aluminium phosphate. Indications: Immunisation against disease (including sepsis, meningitis, pneumonia, bacteraemia and acute otitis media) caused by Streptococcus pneumoniae serotypes 4, 6B, 9V, 14, 18C, 19F and 23F in infants and children from 2 months up to 5 years of age. Dosage and Administration: The immunisation schedules for Prevenar should be based on official recommendations. For intramuscular injection. Infants 2-6 months: Three doses with at least a 1 month interval between doses. A fourth dose is recommended in the second year of life. Infants 7-11 months: Two doses with at least a 1 month interval between doses. A third dose is recommended in the second year of life. Children 12-23 months: Two doses with at least a 2 month interval between doses. Children 24 months-5 years: one single dose. Contra-indications: Hypersensitivity to any component of the vaccine or to diphtheria toxoid. Warnings and Precautions: Do not administer intravenously. Appropriate treatment must be available in case of anaphylaxis. The potential risk of apnoea and the need for respiratory monitoring for 48-72 hours should be considered when administering the primary immunisation series to very premature infants (born 28 weeks of gestation) and particularly for those with a previous history of respiratory immaturity. Impaired immune responsiveness may affect antibody levels. Prevenar does not replace 23-valent polysaccharide vaccine in at risk children ≥ 24 months of age. Children ≥ 24 months of age at high risk, previously immunised with Prevenar should receive 23-valent pneumococcal polysaccharide vaccine whenever recommended. Prophylactic antipyretics recommended when vaccinating children with history of seizure disorders, or when vaccinating simultaneously with whole cell pertussis vaccines. Delay vaccination in acute moderate or severe febrile illness. The immunogenicity of Prevenar has been demonstrated in infants with sickle cell disease. Safety and immunogenicity data are not yet available for children in other specific high-risk groups for invasive pneumococcal disease. Side Effects: Very common: Decreased appetite, vomiting, diarrhoea, injection site reactions (e.g. erythema, induration/swelling, pain/tenderness), fever equal to or over 38°C, irritability, crying, drowsiness, restless sleep. Common: Injection site swelling/induration and erythema larger than 2.4cm, tenderness interfering with movement, fever over 39°C. Uncommon: rash/urticaria. Rare: Seizures including febrile seizures, hypotonic hypersensitive episode, injection site hypersensitivity reactions (e.g. dermatitis, pruritus, urticaria), hypersensitivity reactions including face oedema, angioneurotic oedema, dyspnoea, bronchospasm, anaphylactic/anaphylactoid reaction including shock. Very rare: Lymphadenopathy localised to the region of the injection site, erythema multiforme. Legal Category: POM Package Quantities: Pack of 1 single-dose pre-filled syringe (with separate needle) Marketing Authorisation Numbers: Single-dose pre-filled syringe (with separate needle) pack of 1: EU/1/00/167/006 Marketing Authorisation Holder: Wyeth-Lederle Vaccines S.A., Rue du Bosquet 15, B-1348 Louvain-la-Neuve, Belgium For full prescribing information and details of other side effects see Summary of Product Characteristics. Full prescribing information is available on request from: Wyeth (Mahar) Sanitas Building, Tower Street, Mslba MSD, 1824. Telephone: 21347095 Date of Prescribing Information: 20Jun08 Code no. PRV 012

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Midwifery

Real life stories - Midwife

Name: Sue Jones

Job title: Midwife, Bloomsbury Birthing Centre, University College London Hospitals NHS Foundation Trust

Entry route: Following a three year degree course in midwifery

After studying for her degree in midwifery, Sue qualified in September 2004. She says that midwifery is hard work and the role can be brutal and beautiful in equal measures.

The midwives who have inspired me in my career are all excellent communicators and decision makers. To be a midwife, you cannot be a shrinking violet. A mother needs to know that you will take control of a situation.

I have been working at UCLH for the past five and a half years. I did the last half of my training here and then joined as a community midwife. For the last year I have been working at the birthing centre. As well as caring for mothers during labour, I am also there to help them during the birth and the early postnatal period, for example supporting them in establishing breastfeeding.

There have been some fantastic experiences in my time as a midwife. It's an incredibly intimate time and sometimes it amazes me just how quick and easy it is to build up a rapport with a woman in labour. One that

always sticks in the mind was when a mother who had given birth at home came into the birthing centre with a thank you card. It brought back lovely memories of a wonderful and emotional birth.

Midwifery is hard work and not all experiences are as wonderful as this. On these occasions, it is important for colleagues to be supportive and then any situation is workable. The women we look after are very important to us but they also pass quite quickly through our working lives. A work colleague and friend recently said to me that a working day can be very different depending on whom you're working with. My colleagues are caring and understanding which makes such a difference.

Source: http://www.nhs Careers.nhs.uk/midwife_stories07.shtml

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Position Statement

Protection of the title “Nurse”

ICN Position:

The title of “Nurse” should be protected by law and applied to and used only by those legally authorised to practice the full scope of nursing.

Background

Persons receiving health care and those employing nurses have a right to know whether they are dealing with a legally qualified nurse. Reserving the title “Nurse” for those who meet the legal standard allows the public to distinguish legally qualified nurses from other nursing care providers.

Persons who legitimately use the title “Nurse” are individually responsible and accountable for their actions, and are required to adhere to professional codes of practice and ethics. Nurses need to be educated about their legal rights to the exclusive use of this title, and the ensuing accountability and responsibilities related to the scope of practice assigned to those who are entitled by law to bear this title.

The unlawful use of the title “Nurse” should result in criminal, civil, and/or administrative actions against the person and anyone who assists them in using the title “Nurse”.

References:

The Regulation of Nursing: A Report on the Present, a Position for the Future,
Madden-Styles, M., Affara, F. A., ICN, 1986, p48
ICN on Regulation: Towards 21st Century Models, ICN, Geneva, 1996, p20

Adopted in 1998

(Replaced previous ICN Position: “The Title of Nurse”, 1995)

Reviewed and revised in 2004

Related ICN Positions:

- Nursing regulation
- Scope of nursing practice

The International Council of Nurses is a federation of more than 130 national nurses associations representing the millions of nurses worldwide. Operated by nurses and leading nursing internationally, ICN works to ensure quality nursing care for all and sound health policies globally.

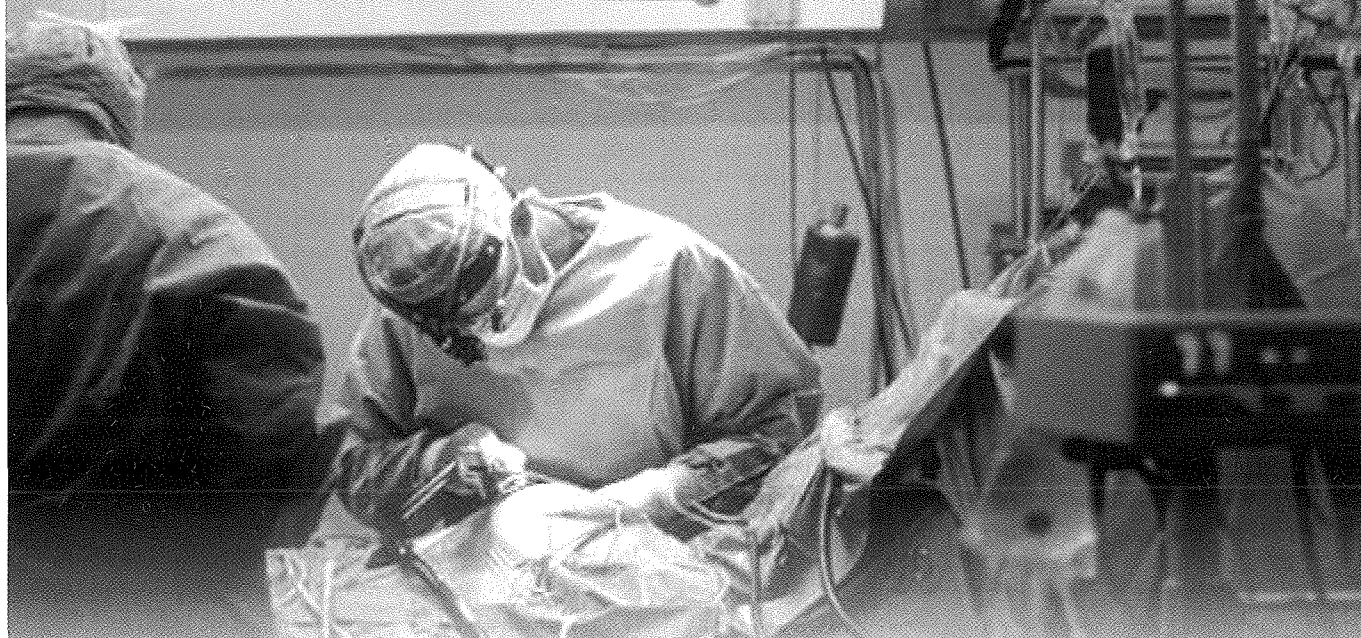
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Telephone +41 (22) 908 0100
Fax +41 (22) 908 0101
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Right patient? Right limb?

Two questions that have almost halved death rate at one hospital

By **Jeremy Laurance**, Health Editor



Surgeons in England and Wales will be ordered today to carry out a safety checklist before every operation they perform, after a study showed it cut surgical deaths and complications by a third.

Described as the biggest clinical innovation in 30 years, the checklist is based on a set of seemingly banal questions but is set to become as essential to daily medicine as the stethoscope. In Britain alone, the new procedure could save hundreds of lives a year and 80,000 complications.

A pilot study run in a London hospital, St Mary's in Paddington, and seven others around the world, has shown that using the checklist cut the death rate following surgery from 1.5 per cent to 0.8 per cent (47 per cent) and the complication rate from 11 per cent to 7 per cent (36 per cent). There was no distinction between hospitals in richer and poorer countries on complications, but richer countries saw a smaller decline in deaths of about a third (though this was not statistically significant).

With an estimated 234 million operations performed yearly around the world, and eight million in Britain – one for every eight people in the population – that translates to millions of lives saved.

The results of the study, organised by the World Health Organisation (WHO), are published in the *New England Journal of Medicine*. Surgeons and nurses run through a series of basic safety checks before each operation, similar to those made by pilots before

take-off. The checks include asking: Is this the right patient? Is this the right limb? Has the patient had the right drugs?

Britain's National Patient Safety Agency (NPSA) issued an alert today to all hospitals and clinics where surgery is performed, setting a deadline for implementation of the checklist by February 2010. Kevin Cleary, the medical director of the NPSA, said: "It is very difficult for the general public to believe that these checks are not being made already. It is about making them every time, and not assuming that someone else is making them."

The latest figures for Britain show that there were 129,419 surgical incidents in 2007 when patients were put at risk, more than 1,000 of which resulted in severe harm and 271 in death. One patient a day was listed for the wrong operation. Sir Liam Donaldson, the Government's chief medical officer, highlighted in his annual report last year 14 cases in which patients undergoing brain surgery had had burr holes drilled on the wrong side of the head. More than one operation a month was carried out on the wrong site in 2007.

Lord Darzi, a Health minister and surgeon at St Mary's who chaired the WHO group that devised the 19-item checklist, said that its implementation across the country was "a dream come true". He added: "It was in front of us – we all travel and it is in every [aircraft] cockpit. Surgery has become vastly more complex and susceptible to errors. Having a system that reminds the whole team of the 19 items is essential. No single

individual, however bright, could ensure it happens every time."

About 20,000 patients die each year following surgery, but it is not known how many are preventable. An estimated 2,000 patients die as a result of errors following all forms of treatment and an inquiry by the National Audit Office in 2005 concluded that half could have been avoided if staff had learnt the lessons of previous incidents.

Atul Gawande, an American surgeon and associate professor at the Harvard School of Public Health, who led the study, said work was under way on further checklists for maternity and childbirth (to be published this year), heart disease, pneumonia, HIV and mental health. "It is one of those simple, unbelievably powerful ideas that will have an impact across medicine. Surgeons had assumed that doing well for patients was mostly about their skill. But there is now too much technology and too many patients for one person to deal with."

He added: "When I talk to clinicians, they say: 'we already do this stuff.' The answer is: we are good at doing it most of the time, but we are not good at

doing it all the time. We found some members of the team felt they were such low agents, they only felt responsible for their corner. Being allowed to say who they were [one item on the checklist] and hear the surgeon say what he expected made them feel part of the team. When you are not given a voice you turn your brain off."

Peter Walsh, chief executive of the charity Action against Medical Accidents, said there was concern about how surgeons would react to the checklist. "People are on tenterhooks. Some surgeons say that checklists de-professionalise them, turning them into automatons who don't think. But it is only a tool. It has to be used with professional judgement," he argued.

Donald Berwick, the president of the US Institute for Healthcare Improvement, said of the innovation: "I cannot recall a clinical care innovation in the past 30 years that has shown results of the magnitude demonstrated by the surgical checklist."

Source: <http://www.independent.co.uk/life-style/health-and-wellbeing/health-news/right-patient-right-limb-two-questions-that-have-almost-halved-death-rate-at-one-hospital-1366705.html>

NURSE/MIDWIFE OF THE YEAR AWARD ~ MAY 2009

NOMINATION FORM

A Nurse/Midwife can be nominated on one or more of these three aspects down listed by two of her/his nursing/midwifery colleagues: -

1. Demonstrates professional dedication that exceeds regular duty requirements, which resulted in significant contributions to the health and well being of patients/clients while delivering Nursing/Midwifery care.
2. Exemplary leadership and skill resulting in noteworthy accomplishments, productivity, creative resource utilisation and enhancement of patient/client relationships.
3. Noteworthy accomplishments in professional education/research which stimulates development of new knowledge and practice in Nursing/Midwifery.

We are nominating Ms / Mr _____, ID No _____
Grade _____, on aspect/s number (1, 2, 3) _____ and are attaching all relevant documents to prove and explain in detail our nomination with this form. We understand that this form has to be sent to the MUMN's Offices in Les Lapins Court B, No. 3, Independence Avenue, Mosta MST 9022 by not later than Thursday 30th April 2009.

Nominee's Signature (1)

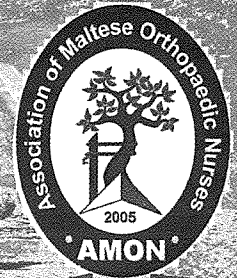
Nominee's Signature (2)

ID No _____

ID No _____

First Announcement & Call for Abstracts

Association of Maltese Orthopaedic Nurses



2nd International Conference & Exhibition

Temples of Inspiration

'Passion and commitment towards professional and holistic practice.'

Thursday 15th - Friday 16th October, 2009
Le Meridien, St.Julians Hotel & Spa *****

Closing date for abstracts submission:
Friday 1st May, 2009

The Association of Maltese Orthopaedic Nurses (AMON) is organizing its 2nd International Orthopaedic Nursing Conference in Malta. Speakers from different countries including USA, Canada and UK, as well as representatives from International Orthopaedic Nursing Associations will be participating in this event.

The scientific committee invites abstract submissions from all professionals who are interested in sharing their skills and knowledge with an international audience. Abstracts will be accepted for concurrent, workshop and poster presentations related to the following themes:

- Innovative Practice development & Nurse led clinics*
- Orthopaedic and trauma conditions*
- Fracture femurs and Prevention of Falls in elderly*
- Theatre and Paediatric Orthopaedics*
- Orthopaedic research*
- Inter-Disciplinary Initiatives*
- Rehabilitation Initiatives*

Assistance to submit an abstract can be provided by the Scientific committee. Please send an email to: reginald.aquilina@gov.mt

An electronic Abstract Submission Form will then be sent to you by email with instructions on how to fill it in.

The Registration fee for the two days is € 95 including coffee breaks and buffet lunch on both days at the Le Meridien St.Julians Hotel and Spa. More details about different options of registration will be provided later on.

Important notice

All selected presenters must register for the conference to be eligible to present. The Association regrets that it cannot fund any speakers.

More information can be found on the AMON website: <http://www.amon-nurse.com>

Invited Speakers include:

Professor Dame Betty Kershaw - UK

Ms.Elaine Collins - Director NHS Direct - UK

Julie Santy - Senior Lecturer, University of Hull - UK

Dr. James A Rankin -Professor & Acute Care Nurse Practitioner - University of Calgary, Canada

Dr. Ricky Autar - Principal Lecturer/Research Fellow - De Montfort University – Leicester, UK

Anita Meehan- Clinical Nurse Specialist – Geriatrics, Akron General Medical Center- USA

Sonya Clarke – Teaching Fellow- Queen's University, Belfast- Northern Ireland

Mr. Brian Lucas – Advanced Nurse Practitioner - Whipps Cross Hospital, London

Margaret Flanagan – Primary Care Clinician- Western Avenue Medical Centre, Chester

Rangsiya Narin- Lecturer- Faculty of Nursing, ChiangMai University- Thailand

Sonali Banerjee- Lecturer- Apollo College of Nursing , Hyderabad- India



Do not miss this opportunity !!

5th Football 2009 Marathon



The Puttinu Cares Children's Cancer Support Group is organizing another football marathon which is going to be held at the Marsa Sports Complex between 10am Friday 24th and 10pm Sunday 26th April. This year's main theme will concentrate on "Treating Each Patient with Dignity."

I was inspired to adopt this theme because my experience have clearly shown me that by enabling the patients to keep their dignity in the face of such a cruel disease they will also have the courage and moral strength to fight it. This will result in less suffering for the patient and his family.

As nurses we have a professional duty to respect the dignity of patients and this year's marathon aims to concentrate on what the patient and his family feel when treated with respect. The marathon will therefore focus on how important the behaviour and attitude of the caring profession towards the patient and his family is in helping them keep their dignity in the face of a devastating disease. Of course it is not an easy task, nevertheless I am proud to say, and at the same time very fortunate, to work with a team of professionals that truly believe that kindness, humanity and respect are the core values of patient care. Together we make an effort to work hard to cure every patient without ever losing sight of the patient's dignity. This is immediately appreciated by the patient and his or her family and as a consequence they face their disease with courage and determination for a brighter future.

Restoring dignity to the patient involves much more work than just giving medical treatment. At Rainbow Ward, the consultant and the team of doctors dedicate a lot of time to discussing the disease and treatment options and effects with the patient and his family. They work hard to allay their fears, doubts and anxieties about the disease and its treatment. The doctors deliver the best conventional treatment available for that type of cancer and also make sure that the patient's discomfort is minimized. They are also very aware of the various problems that can crop up during the patient's treatment; e.g. infection, nausea and vomiting, change in bowel habits, pain, and complaints of a psychological nature. These problems can have a negative effect on the patient's dignity and therefore they are dealt with quickly and in good time by the medical team.

I am also fortunate to be part of Puttinu Cares that selflessly works hard to improve the quality of life of patients with cancer. Our constant aim is to find ways how to make each day a better day for the children and their families. We have therefore altered the environment on Rainbow Ward so that the patients and their families can truly say that the ward looks and feels more like a second home than a hospital ward. Puttinu Cares works hard to improve the quality of life for patients by organizing a BBQ in summer and a Xmas Party where each child is given a beautiful gift. These events as well as the annual football marathon help to bring the new and old patients and their families together. These activities give the children and their families the opportunity to relax and feel that they are part of a big loving family. Puttinu

Cares with the help of various generous organizations sponsor weekend breaks, holidays to Euro Disney and other holiday resorts for the family in Europe and a pilgrimage to Lourdes. These events all help to minimize the hardships of these families and at the same time help to draw public attention and increase the general public's awareness of the problems these families go through because of cancer. In my role as the main event organizer for Puttinu Cares I have been fortunate to meet many generous volunteers and sponsors whose main aim was to find ways to make a difference in the lives of these children. None of the above would be possible without the generous help of these people and I would like to thank them not only in the name of Puttinu Cares but also in the name of the families that they help to bring so much joy to.

However our biggest ambition so far has been the purchase of three apartments in Sutton that serve as free accommodation to patients who need special treatment abroad. Living in a foreign country away from the support of the whole family and the Maltese community brings a lot of hardships to the family that can easily result in loss of dignity. The financial and emotional burdens on the families are tremendous. Puttinu Cares has therefore embarked on ways to reduce most of the financial burden that these families face when away from home and this was the main reason for buying the apartments. Puttinu Cares through the generous support of the Maltese people is paying for the expenses related to these apartments. This show of solidarity by the Maltese community is helping to save the dignity of these patients and their families.

This year's football marathon is therefore geared to help generate more funds that will be used by Puttinu Cares to pay for these apartments and for the other initiatives. We are working hard so that the marathon will be an activity full of fun and excitement for all the family. From the 24th to the 26th we are turning this sixty hour football marathon into a stop spectacle of entertainment for the whole family. The team coordinating the football matches will be handling five hundred football teams, a record for Malta. During the day (10am – 6pm) the animation team has prepared a three day programme which is jam-packed with excitement for the children. The entertainment team is working hard to put together a programme which will fill the evening with singing and dancing. During this time there will be many well-known personalities who with their vast experience will contribute to the success of this year's marathon. Arrangements are also being made for a live transmission on all the television stations so that the viewing public will still be able to watch a donation to Puttinu Cares and will also see for themselves the realities of childhood cancer.

I praise the Lord for blessing us with so much love and also with so many extraordinary families whose experiences continue to teach us what real love for children is. In spite of the pain and suffering they have shown, what real courage, love and providence is.

5th Edition

60hr Football Marathon



24th - 26th April 2009

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in aid of Puttinu Cares Children's Cancer Foundation

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