

IL-MUSBIEH

MALTA NURSING AND MIDWIFERY JOURNAL

Malta Union of Midwives and Nurses

No.58 - April 2013



MUMN's Success at the CNF Conference in Cyprus



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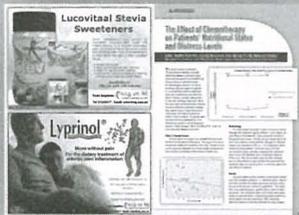
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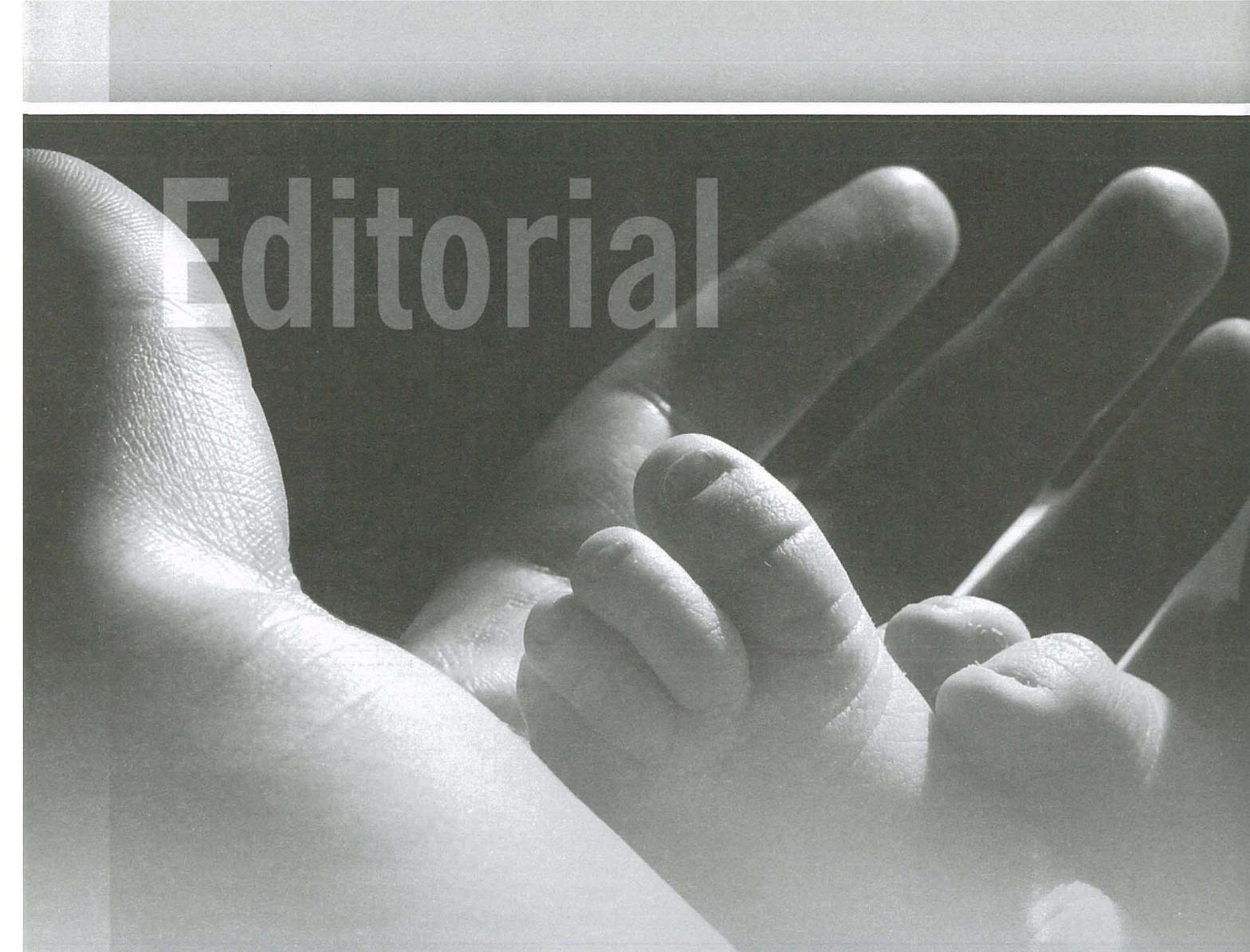
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Editorial

The future of nursing and midwifery...

I believe that we should all start to think about the nursing profession in view that we are living in the year 2013. We should explore how the nurses' roles, responsibilities, and education should change significantly to meet the increased demand for care that will be created by health care reform and to advance improvements in our country's health system.

Nurses and midwives all over the world make up the single largest segment of the health care work force, and Malta is no exception. Nurses and midwives spend the greatest amount of time in delivering patient care as a profession. Therefore one can very easily come to the conclusion, and rightly so, that nurses and midwives have valuable insights and unique abilities to contribute as partners with other health professionals in improving the quality and safety care as envisioned by our health care services.

Nurses and midwives should be fully engaged with other health professionals and assume leadership roles in redesigning care in Malta. Strong leadership is critical if the vision of a redesigned health care system is to be realized.

To play an active role in achieving this vision, the nursing and midwifery professions must produce leaders throughout the system, from the bedside to the board room. These leaders must act as full partners with physicians and other health professionals, and must be accountable for their own contributions to delivering high-quality care while working collaboratively with leaders from other health professions.

Nurses and midwives are already committed to delivering high-quality care under current regulations and organizational conditions. But the power to change those conditions to deliver better care does not rest primarily with nurses, and midwives, regardless of how ably led or educated they are; it also lies with governments, health care institutions, professional organizations and other health professionals.

Together, these groups have the power to transform the health care system to provide seamless, affordable, quality care that is accessible to all, patient centered and evidence based which will eventually lead to improved health outcomes.

President's message

This year from its very beginning started on a very busy note. The sectoral agreement of the nurses/midwives signed on the 6th February was a huge leap forward for both our professions. Such agreement includes incentives and a whole career ladder so that nurses and midwives invest in their career through further training. Unfortunately the "applications" issued by the health department left nurses and midwives bewildered and at times such an agreement was not appreciated as it should be. MUMN was not in a position to start meetings exactly after the signing of the agreement but when the timing was appropriate, MUMN started holding meetings for all nurses and midwives in various hospitals and more meetings are yet to come.

One has to appreciate that such an agreement arrived in the recent economic global crisis which has led to austerity measures in many European countries that have had a severe impact on their healthcare systems, and nurses in particular. The negative effects have been observed for years but concrete solutions at EU level are few and far between. For nurses, the financial crisis has led to cuts after cuts in their salaries and the result is a daily reality marked by uncertainty, increasing work burdens, and low income.

When painting a picture of the current day-to-day realities of nurses across Europe, the gravity of the situation is clear (as illustrated in the EFN's report "Caring in Crisis")

- In Ireland, around 2800 posts were lost in 2011;
- In Moldova, a nurses salary is 100 Euros;
- In Bulgaria, around 1200 nurses leave the country every year looking for better working conditions;
- In some Hungarian hospitals, one nurse has to provide care for around 50 patients during one shift;
- Many countries report no maternity substitution or retirement replacement;
- Cost-cutting has led to a shortage of hospital beds;
- There is an estimated shortage of 8500 nurses in Greece;
- The unemployment rate of newly graduate nurses increased;

The list goes on but the overall trend is the same - there are cuts everywhere as Governments see the crisis as an opportunity to change the healthcare system!

Such cuts on nurses' welfare, working conditions and salaries bring about the detrimental effect that this has on quality of care and patient safety, and the overall health status of the EU citizens!

This has resulted in nurses working even harder than before to maintain quality standards, thus being asked to provide more for less. Nursing is a primarily female dominated profession and women are the hardest hit. Nurses face the dilemma of providing quality care in an environment obsessed with cost with real implications for patient safety.

MUMN have a responsibility to ensure that midwives and nurses are equipped with the necessary skills and have the proper foundation upon which to provide the level of care needed to meet the increasing societal challenges. MUMN has to introduce new innovative ways of thinking and re-engineering of the healthcare system, but even in times of economic struggle when governments are forced to reduce budgets, delivery of healthcare and the working conditions of healthcare providers should not be compromised.

Elections come and go. As MUMN we thank the previous Government for its contribution to nurses and midwives. I would like to take this opportunity to inform our members that MUMN has had already very positive meetings with the new Ministers. Actually with the new Government, nurses now fall under two Ministries due that the Elderly Care is under the Social Solidarity Ministry. Well for MUMN we feel comfortable to work with any Government as to bring the nursing and midwifery professions forward. Therefore MUMN is looking forward to work, collaborate and address long pending issues in the health sector for the good of the professions MUMN represents but also for the welfare of our patients and mothers we are entrusted with their care.

Paul Pace
President

Kelmtejn mis-Segretarju Ġenerali

Fl-aħħar irnexxielna! Wara ħafna laqgħat u taqbid madwar il-mejda tad-diskussjoni l-MUMN irnexxielha tiffirma l-Ftehim Settorali tan-Nurses u l-Midwives. Huwa pass pożittiv għal bosta raġunijiet.

L-ewwel waħda hija l-progression fl-iskali. Wara li konna ffirmajna l-aħħar Ftehim Settorali fis-sena 2007, kien hemm talba ġenerali mill-membri sabiex fil-ftehim li jmiss nieħdu ħsieb il-progression fl-iskali u dan akkwistajnieh. Pass ieħor 'il quddiem kien l-introduzzjoni ta' career progression fl-ispecialists post għaliex huwa importanti li n-Nurses u l-Midwives ikollhom żewġ triqat quddiemhom fejn jidhlu promotions. Barra l-istruttura tal-management issa għandna wkoll dik tal-ispecialisations u b'hekk, Midwife u Nurse tkun tista' tibqa' tagħmel bed side nursing u fl-istess waqt tiegħu promotion.

Punti interessanti oħra huma li l-ammont tas-CPD Allowances issa ġie għal kulhadd l-istess u b'hekk barra li kulhadd ġie ugwali, ser titneħħa l-burokrazija żejda bir-riżultat ikun li nibdew nithallsu fil-ħin wara li nkunu pprezentajna l-irċevuti neċessarji. Akkwist ieħor huwa li l-ammont fin-Nursing Premium li konna intitolati għalih wara li nilhqu t-30 sena servizz issa ser nakkwistaw din is-somma hekk kif nilhqu l-25 sena servizz. Dan l-ammont nirċevuh kull sena u bħala top up tal-ammont li nirċievu

b'mod normali. L-aħħar punt importanti huwa tneħħija tal-EDP's. Dan il-fattur kienu ilu jdejjaq lin-Nurses u l-Midwives għal bosta snin u għalhekk ġie indirizzat ukoll f'dan il-Ftehim. Jista' jkun li għad baqa' xi Midwives u Nurses li għad għandhom xi punti mhux ċara dwar dan il-Ftehim u għalhekk huwa pplanat li jsiru aktar laqgħat sabiex b'hekk kulhadd ikun infurmat sew.

Il-Kunsill tal-MUMN qiegħed issa jħares 'il quddiem sabiex isiru numru ta' laqgħat mal-Ministru tas-Saħħa u s-Segretarju Parlamentari responsabbli mill-Anzjani li ġew appuntati f'tit tal-ġranet ilu sabiex flimkien niddiskutu l-problemi pendenti biex insibu soluzzjonijiet għalihom. Barra minn hekk nieħdu l-opportunità sabiex inressqu l-proposti tagħna dwar temi li l-MUMN tħoss li jkunu ta' benefiċċju kemm għall-membri tagħna kif ukoll għall-pazjenti u ċ-ċittadini Maltin u Għawdxin.

Għal llum ħa nieqaf hawn. Nixtieq nerġa' nfakkar lil dawk il-ftit membri li għadhom ma baġhtulnix l-email address tagħhom sabiex jagħmlu dan mill-aktar fis possibli biex huma wkoll jirċievu l-informazzjoni li l-MUMN tippublika minn żmien għall-ieħor.

Colin Galea
Segretarju Ġenerali

EFN General Secretary meets Commissioner for Health Tonio Borg



Today, 6 March, the EFN General Secretary, together with the President of the Malta Union of Midwives and Nurses (MUMN), Paul Pace, a member of EFN, had a very exciting meeting with the European Commissioner for Health, Tonio Borg. This was a good opportunity to address some key nursing policy challenges linked to his portfolio, such as: Setting up the EU Skills Council; Continuous Professional Development (CPD); best practices for recruitment and retention of nurses (Joint Action); and, last but not least, continuity of care (EIP) and e-health (CIP). The EFN General Secretary encouraged Commissioner Borg to build synergies with DG Employment, DG Internal Market and DG Connect, in order not to reinvent the wheel again and again, and most important, use the nurses' motivation in an effective and efficient way, especially when austerity measures are impacting severely on the nursing profession. Commissioner Borg supports nurses and nursing

EFN BRIEFING NOTE ON

The Implementation of Council Recommendations on Patient Safety and HCAI's

On 15 November, the Commission published a report on patient safety which focuses on the state of implementation of a number of actions aimed at increasing patient safety, based on the Council Recommendation (2009/C151/01) on patient safety, including the prevention and control of healthcare associated infections.

The report provides a summary of the input received from Member States in response to a Commission questionnaire from 2011. It aims to assess the number of Member States that have implemented the specific actions set out in the 2009 Council Recommendations and concludes that no countries have thus far been able to implement all 13 actions. Nevertheless, all Member States have implemented patient safety as a priority in public health policies, 25 countries have designated a competent authority for patient safety, and 24 countries have encouraged training on patient safety in healthcare settings. However, areas which have not been widely implemented include 'embedding patient safety in the education and training of healthcare professionals' (3 Member States), 'providing full information to patients about patient safety' (5 Member States), dissemination of core knowledge on patient safety to healthcare workers (11 Member States), and 'developing core competencies in patient safety for patients' (12 Member States).

The report therefore concludes that more effort is needed towards actions targeting patients, e.g. patient empowerment, and health professionals, e.g. more education and training. Specifically, more efforts are needed to ensure adequate numbers of specialised infection control staff, receiving regular training, and with dedicated time for this task in hospitals and other healthcare settings. Tailored basic infection prevention and control structures and practices in nursing homes and other long term care facilities should be reinforced. Finally, information on healthcare associated infections to patients should be improved and their involvement in the compliance with infection prevention and control measures should be strengthened.

The report also shows that the economic crisis slowed down the implementation because of changing public health priorities. The Commission stresses that the crisis should not undermine patient safety: for the sake of the patient and because unsafe care has a cost: research shows that between 13 and 16% of hospital costs are due to healthcare related injuries and ill health. In the current financial context, it is crucial to reduce the costs of unsafe care and to develop cost-effective patient safety programmes. On the prevention and control of Healthcare associated infections, 26 out of 28 responding countries have implemented

a combination of actions to prevent and control such infections, in most cases (77 %) in the context of a national/ regional strategy and/or an action plan.

The report is accompanied by a Commission Staff Working Document on the 'Detailed analysis of countries' reports on the implementation of the Council Recommendation (2009/C 151/01) on patient safety, including the prevention and control of healthcare associated infections', which provides a more detailed technical analysis of the replies received both at the national and regional level.

The Commission has called on Member States to implement further actions for patient safety and HCAs and proposes that the Commission continue the development of guidance on the prevention and control of HCAs, including tailored guidance for nursing homes and other long-term care facilities. At EU level, the focus will also be on supporting research on the prevention and control of HCAs, including studies on the cost-effectiveness of prevention and control programmes. An assessment will most likely take place again in two years' time, taking the current report as a comparative reference. In June 2014, the Commission will also prepare a second progress report taking into account the mid-term results of the Joint Action on Patient Safety and Quality of Care (April 1st 2012 – March 31st 2015).

The EFN will continue to monitor the state of implementation in Member States, particularly through its engagement in the Joint Action on Patient Safety and Quality of Care. Patient safety means that patients are not exposed to unnecessary harm or potential harm associated with healthcare, including the prevention and control of healthcare associated infections, and the Joint Action should do its part to ensure that Member States are supported in the implementation of the 2009 Council Recommendations. This includes analysing the extent to which the proposed measures are working effectively and putting in place the necessary framework to allow Member States to improve certain areas for the effective implementation of the recommendations and priorities set out by the Commission. As always, EFN members are encouraged to link up with their national contact points to see how they can get involved in the process, from a nursing perspective.

EFN Briefing Note – November 2012

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The role of the midwife in Malta across

“A midwife is a person who has successfully completed a midwifery education programme that is duly recognized in the country where it is located and that is based on the ICM Essential Competencies for Basic Midwifery Practice and the framework of the ICM Global Standards for Midwifery Education; who has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery and use the title ‘midwife’; and who demonstrates competency in the practice of midwifery” (International Confederation of Midwives Council, 2011).

INTRODUCTION

Midwifery embarks itself way back in time. Across the years, the role of the midwife in Malta changed both in practice and theory as I am going to discuss below. Due to the word limit I am going to focus on some points such as technological advancements, politics and advance in health care although there are others which one can mention. These points, outlined in the next section in one way or another altered the skills of the midwife and thus the role in itself which in turn has been affected by the history of the midwife and her education.

MIDWIFERY EDUCATION

Maternity care has been present since antiquity. In fact, it is stated that:

“Throughout the ages, women have depended upon a skilled person, usually another woman, to be with them during childbirth” (Cooper & Fraser, 2009, p.3)

Evidence of this is seen in pre-historic times with archaeological findings such as the pregnant mother figurine (Savona-Ventura). Although being a small island, in the middle of the Mediterranean, Malta served as a refugee care point for other countries even during war times. Care has always been present including maternity care.

Back in centuries, home births were very popular, the norm, the only possible method of birth. The trend back in the days, in case of an emergency, was to call for a midwife and not any other health care professional. Sometimes, not even a midwife was present but only the mother of the expectant mother provided that she had some experience because of the fact that those days’ people used to have many children. The mother used to assist the childbearing mother during her labour, helping her as much as she could because one must not forget to mention that those days no devices were present to aid in delivery (Savona-Ventura, 2009, pg.7).

In towns and villages, one would usually find one of what those days a midwife was referred to as ‘qabla or ‘majjistra’. She would be called from every part of the town or village to assist the birth and thus practice her skills at

a full potential. This situation resulted in continuity of care because when an advice was needed due to the presence of one midwife people used to recall back to that same midwife. Over the years this continuity of care was lost.

However due to lack of resources, no aseptic procedures and other factors maternal and neonatal deaths were on the increase. This was also due to poor education and thus poor advice regarding proper health practices. People used to believe in oldwives tales, a common one being that if a childbearing woman desires something and she is not granted, the new-born will be born with a birthmark resembling what the mother has been longing for (Savona-Ventura, 2003, p.21) These were based on no evidence because ancient midwives did not follow any midwifery education, courses, and apprenticeship. This contributed a major shift and urgency in developing further the education and role of the midwife.

Thus the first formal carers in the eleventh century where the Order of St. John when Dr. Giuseppe Antonio Cren proposed to start a midwifery course. This start gave birth to other opportunities and throughout the years, the education of the midwife continued taking the form of different aspects (Cassar, 1978, p.5) Midwifery training improved as years progressed and reached its enlightenment period as Cassar stated:

“At the beginning of the 20th century, Dr. S Grech, Professor of Midwifery and Gynaecology, pressed for a reform of the School but it was not until 1915 that it was placed on a sound footing when the course of midwifery was instituted under the auspices of the University and led to the Diploma of Midwife” (Cassar, 1978, p.9).

Furthermore in the 21st century more importance and recognition was given to the midwife. The University of Malta holds a Bachelor of Science (Honours) Degree, Master of Science and also Doctor of Philosophy with evidence-based practice in which students have the opportunity to further their studies. The profession of midwifery flourished, received its gained merit and the midwife being more than ever appreciated. This shift resulted with competent, professional and skilled midwives which can deal effectively with current and upcoming challenges.

PROFESSIONAL SCOPE

As discussed earlier on, in ancient times a narrow crude interpretation of the midwife was present in which midwifery was associated only with the mother but however in due time a broad interpretation became enforced and although still being women centred it is more than ever associated with the holistic approach of the well-being of the mother and her baby including the father/partner, other children and close relatives. This is seen to be manifested as the

the years

newspaper article implies where midwife Louise Bugeja, in an information session, is seen to teach grandparents everything they need to know about breastfeeding. She emphasized on its advantages such as breast cancer reduction and benefits to the baby (Carabott, 2011).

In fact, The International Confederation of Midwives also felt the need to review the scope of practice of midwifery which points out that:

“The midwife is recognised as a responsible and accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period, to conduct births on the midwife’s own responsibility and to provide care for the newborn and the infant. This care includes preventative measures, the promotion of normal birth, the detection of complications in mother and child, the accessing of medical care or other appropriate assistance and the carrying out of emergency measures”.

“The midwife has an important task in health counselling and education, not only for the woman, but also within the family and the community. This work should involve antenatal education and preparation for parenthood and may extend to women’s health, sexual or reproductive health and child care. A midwife may practice in any setting including the home, community, hospitals, clinics or health units.” (International Confederation of Midwives Council, 2011)

Nowadays one hardly ever hears about a home birth. Before, caring for pregnant women was community based however a major shift occurred in which nowadays pregnant women are looked after in a hospital environment either public or private and thus care is now in the hands of a multidisciplinary team and not only in the hands of the midwife which brought its own advantages and disadvantages. Continuity of care is thus lessened. In Malta, women are restricted whereas in other countries women can choose either to deliver at home, at a birthing centre or within a hospital.

The midwife used to practice autonomy; she had her professional role and knew when to refer: Professional demarcation line. But, nowadays the autonomous midwife unfortunately is under the care of another health care professional under a hierarchal relationship with a secondary role.

Also, unlike before, one sees more obstetricians and gynaecologists coming into play which are slowly taking over the midwives’ role. Thus, the role of the midwife is being fragmented because the work that is supposed to be done by her is taken from other professions were in fact she should be the one dealing with as she is professionally trained and qualified to practice her profession.



TRENDS IN MIDWIFERY

The world also experienced changes from time to time, technological advancements being one of them. The changes in technology impacted severely the role of the midwife through the years. Whereas beforehand the midwife used to for example to listen the fetal heart using a pinard stethoscope, nowadays it is generally heard with a cardiotocography machine. This electrical device took over and replaced the manual skill of the midwife.

One must not also forget to mention that couples are delaying time at which they decide to have a baby and increased number of teenage pregnancies which also impacted the midwives' role. Obesity, diabetes and other health related disorders are on the increase especially locally. In fact:

"Clearly, one of the main lifestyle challenges that the Maltese population faces is that of obesity with a total of 56% of the Maltese adult population being reported as overweight or obese. Indeed Malta ranks as the country with the highest percentage of obese men and the third highest among females within the EU" (The Department of Health Information and Research, 2008, pg.5).

These factors pose a threat to the mother and fetus and therefore considered as a high risk pregnancy (Miller, 2009, pg.1062). Due to this, the mother may experience different problems and complications relating to her pregnancy resulting in a high risk pregnancy which the obstetrician needs to take care of and intervene and not the midwife which further fragmented the role of the midwife. The perspective of pregnancy is considered from a different view. Midwives see pregnancy as a normal life process while physicians see pregnancy as a disease which can lead to something so they intervene. As a result to this medical interventions and the numbers of caesarean sections increased as this document states:

"According to the official National Obstetric Information System (NOIS), the induction rate for 2009 was 30.8 percent and the caesarean section rate was 29 percent (14.2 percent elective; 14.8 percent emergency). (Borg Xuereb & Zammit, 2011)

This removes the right for mothers to choose and the right for midwives to promote natural labour. It is evident that modern labour has become medicalised. This shift brought the autonomy disrupted. On paper the obstetrician should deal with high risk births and the midwife with low risk births. However, this is not the scenario in Malta. Although it is important that health care professionals work in an interprofessional team aiming for the proper care of the patient, the way the maternity services are provided interfer with most of midwifery care leaving the profession of midwifery fragmented.

The influence of politics also affected the role of midwives. During the forming of Malta Union of Midwives and Nurses (MUMN) full potential and merit of the midwifery profession was gained. However, Maltese midwives in 2010 felt that they are playing a secondary role, working under a

hierarchical relationship rather than a collective professional one.

"In fact, most of the midwives practicing in Malta pleaded on the MUMN to intervene so that something will be done to halt the misuse and waste of midwifery skills and expertise. Maltese midwives envisage seeing progress towards being autonomous practitioners and further their status as midwives" (MUMN, 2011).

This scenario instigated MUMN to develop a report titled 'Strategic Direction for strengthening Maltese midwifery services' which was then presented to the Health Minister in October 2011. Maltese midwives were so let down that they wanted a change with one aim that the implementation of some of the suggested practices will be implemented in the future so as for the midwifery profession to move forward and gain back its status symbol in the community (MUMN, 2011).

Antenatal care is mostly delivered in the antenatal clinic, private clinics or health centres. Literature advocate that this care should be given at the patient's home so that the midwife will have a better picture of the environment which the mother lives in, her support and other factors. In few words the midwife will gain a better holistic picture of the mother. This results in a proper holistic approach and an ingrained community midwifery practice. Moreover, false-positive and false-negative results resulting from the white coat syndrome will decrease.

The presence of midwives in school which our grandparents talk about today has completely vanished. What happened nowadays? Evidently this is not practiced by midwives anymore but this role was taken by Personal and Social Development (PSD) teachers. The role of midwives in educational institutions needs to be re-introduced. This can be done in collaboration with teachers. In my opinion this is very much needy nowadays as sexually transmitted diseases increased as well as teenage pregnancies.

Through the years, the needs of the patient changed as well which further effected the role of the midwife, such as the discovery of post-natal depression, change in the structure of the family, fertility problems, assisted reproductive technologies, breastfeeding practices, the inclusion of a birth partner during labour and other factors.

CONCLUSION

As pointed out in the introduction, maternity care and the role of the midwife changed through the years to meet the patients' needs and expectations. Having said all this, midwives have a vital role in advancing the primary health care agenda. This is not meant to replace any other health care professional but being part of a team, complementing another profession. Some roles are nowadays unfortunately lost and we as future midwives should fight for our rights and to ingrain lost roles back in society and build back the profession of midwifery.

Annabelle Mamo
B.Sc (Hons) Midwifery Student

Conference 2014

Commonwealth Nurses Federation

NURSES AND MIDWIVES: Agents of Change

2nd Commonwealth Nurses Conference

Saturday 8 and Sunday 9 March 2014

London United Kingdom

CALL FOR ABSTRACTS

The abstracts should demonstrate a contribution to improving the health and wellbeing of citizens of the Commonwealth in the following areas:

- maternal and child health care
- mental health care
- acute and chronic health care
- public health and primary health care

Abstract submission

Email your abstracts (of no more than 300 words) to the Commonwealth Nurses Federation at cnf@commonwealthnurses.org by 31 October 2013.



Bioness NESS L300 Foot Drop System

What is it?

The NESS L300 Foot Drop System is a functional electrical stimulation (FES) device used by physiotherapists to help patients who have foot drop following a lesion to the brain or the spinal cord. FES is the use of low-level electrical stimulation to improve function following a neurological condition or injury. Conditions that can cause foot drop are stroke, multiple sclerosis, brain injury, cerebral palsy and incomplete spinal cord injury.

How does it work?

The L300 Foot Drop System consists of three main components that use a wireless system to communicate to each other. The system uses a technology that 'senses' when the foot is off or on the ground and is able to adapt to changes in walking speed and terrain.

1. The main component is the leg cuff, that is worn below the knee and delivers electrical stimulation to muscles and nerves that actively lift the foot up during the swing phase of gait.

2. A gait sensor attaches to the shoe and lets the main component 'know' if the heel is on the ground or in the air.

3. A wireless portable component that can be hand-held and lets the user adjust the level of stimulation and turns the unit off/on. This can be carried in a pocket or handbag.

Why is it used?

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Christ by the sick person's bedside

Fr Mario Attard OFM Cap

In his letter to priests on the occasion for the Year for Priests, sent on October 1 2009, Archbishop Zygmunt Zimowski, the president of the Pontifical Council for Health Care Ministry, wrote "A priest at the bedside of a sick person represents Christ himself, the Divine Physician, who is not indifferent to the fate of those who suffer." This beautiful reflection, fully charged with meaning, set me thinking.

Various Church documents attest to the fact that the priest represents Christ. Since their list is practically endless I shall be limiting myself by quoting few of them. The 2002 instruction issued by the Congregation for the Clergy entitled *The Priest, Pastor and Leader of the Parish Community*, openly asserts that the priest "represents the presence of Jesus Christ as head of his Mystical Body, the Good Shepherd who tends every single member of the flock" (§ 30). On the other hand, Pope Paul VI's encyclical regarding the celibacy of the priest, *Sacerdotalis Caelibatus*, went even further by stating that "in the community of the faithful committed to his charge, the priest represents Christ. Thus, it is most fitting that in all things he should reproduce the image of Christ and in particular follow His example, both in his personal and in his apostolic life. To his children in Christ, the priest is a sign and a pledge of that sublime and new reality which is the kingdom of God; he dispenses it and he possesses it to a more perfect degree" (§ 31). Finally, the Catechism of the Catholic Church in number 1548 explicitly states: "It is the same priest, Christ Jesus,

whose sacred person his minister truly represents. Now the minister, by reason of the sacerdotal consecration which he has received, is truly made like to the high priest and possesses the authority to act in the power and place of the person of Christ himself (*virtute ac persona ipsius Christi*). Christ is the source of all priesthood: the priest of the old law was a figure of Christ and the priest of the new law acts in the person of Christ".

Popular piety has a simpler and more heartfelt rendition of how a priest represents Christ. A catchy prayer which powerfully depicts Christ's sacramental character in the person of the priest is *The Lorica or Saint Patrick's Breastplate*. Taken from its Latin origin, body armour, the prayer amazingly details how the priest is to be filled with Christ. "Christ with me. Christ before me. Christ behind me. Christ in me. Christ beneath me. Christ above me. Christ on my right. Christ on my left. Christ when I lie down, Christ when I sit down. Christ when I arise. Christ in the heart of every man who thinks of me. Christ in the mouth of everyone who speaks of me. Christ in the eye of everyone who sees me. Christ in every ear that hears me".

As we said earlier, the priest "tends every single member of the flock", thus including patients at the hospital. Presently our hospital benefits from the pastoral ministry of six chaplains. With our strengths and weakness we chaplains try to let the Spirit of Jesus touch the hearts, minds and bodies of our patients. Different Gospel accounts

show that Jesus reacted with compassion when the people he met were suffering from any kinds of disease. Moreover, as the paralytic episode suggests, Jesus was sent by the Father to heal, first and foremost, the human person's spirit. Seeing the pitiful state of the paralytic Jesus recognized that the outer miserable condition of the man called for an urgent inner intervention of his soul. The interior spiritual decay of the paralytic was too obvious for Jesus to bypass it. Totally enforced by those who brought the man before him, Jesus said to the paralytic: "Take heart, my son; your sins are forgiven" (Matt 9:2).

The same thing occurs on a daily basis in our wards at Mater Dei Hospital. Jesus, in the person of our chaplains, stops at the bedside of each patient and gently liberates him/her with the same compassionate verdict with which he freed the thousands of people he came across when he lived amongst us: "Your sins are forgiven!" How comely and appropriate is the comment made by the Catechism of the Catholic Church when it says that "the whole power of the sacrament of Penance consists in restoring us to God's grace, and joining with him in an intimate friendship" (§1468). Our patients direly need the sweet comfort which emanates from a reconciled heart with God, others and itself. As Pope Benedict XVI explains, sickness is "a time of suffering, in which one could be tempted to abandon oneself to discouragement and hopelessness." Contrarily, it "can thus be transformed into a time of grace so as to return to oneself, and like the prodigal son of the parable, to think a new about one's life, recognizing its errors and failures, longing for the embrace of the Father, and following the pathway to his home".

The second sacrament which Christ himself, through the human agency of his priest, imparts on our patients at Mater Dei is that of the Anointing of the Sick. In the primitive Church this sacrament was a common practice among the baptized who were sick. James 5:14-16 bears witness to this fact. In his homily on Chrism Mass on 1 April 2010, the Holy Father demonstrates that in the Anointing of the Sick the sacramental oil is presented to us "as God's medicine ... which now assures us of his goodness, offering us strength and consolation, yet at the same time points beyond the moment of the illness towards the definitive healing, the resurrection (cf. Jas 5:14)."

The last sacrament to which every sacrament points to and finds its ultimate expression is the Eucharist. Jesus says: "He who eats my flesh and drinks my blood has eternal life, and I will raise him up at the last day" (John 6:54). The Eucharist is, according to Saint Ignatius of Antioch's magnificent description, "the medicine of immortality, the antidote for death." It is a Viaticum in that it is essentially the sacrament of the passage from death to life, from this fallen world to the eternal bliss which the Father has prepared for us from eternity, the heavenly Jerusalem. Each patient who appropriately disposes himself/herself to receive this extraordinary sacrament can rightly say: "Heaven is in my heart!" Jesus' sacramental presence within the sick communicant brings immense deep-seated joy.

Christ by the bedside of our patients lovingly reveals himself through his forgiveness, anointing and self-communication. What better medicine a patient believer can ever get other than this?

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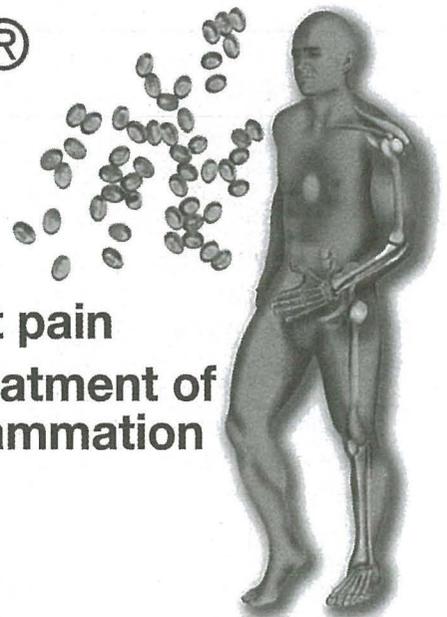
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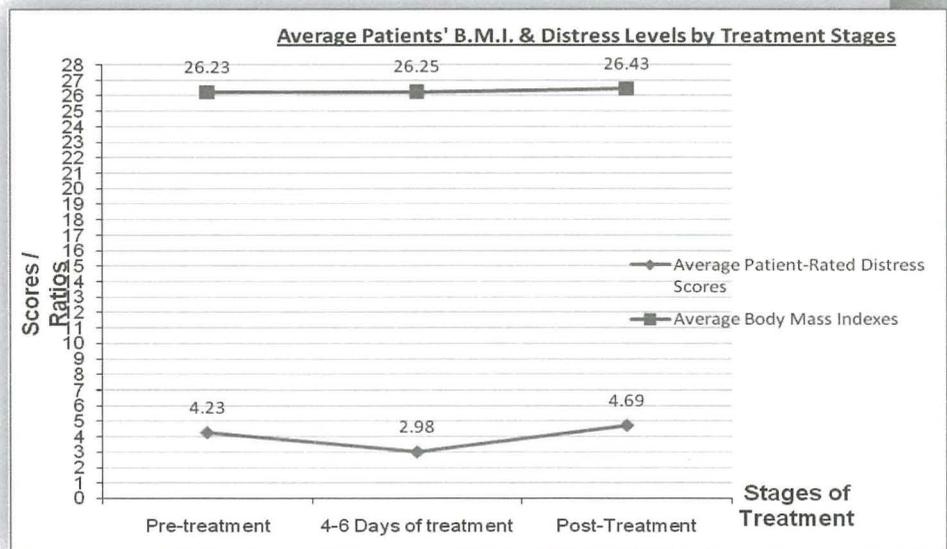
The Effect of Chemotherapy on Patients' Nutritional Status and Distress Levels

Author: Geoffrey Axiak M.Sc. Nursing (Manchester), B.Sc. Nursing, P.G. Dip. Nutrition & Dietetics
 (This study was carried out in part fulfilment of his Masters Degree in Nursing with the University of Manchester)

This study involves a correlation study aimed to identify a possible relationship between nutritional status (actual and perceived) and chemotherapy-induced distress in patients treated for haematological cancers. As well as providing a physical support to patients, it is surmised that nutrition might have some sort of relationship also with their levels of distress, perhaps helping them to cope with challenges they meet. Whilst this study might not demonstrate a definite causative relationship between correlates, there seemed value in exploring possible relationships that might be examined further in future research. All patients were recruited from those admitted for a first treatment at a specific unit at the general hospital in Malta (between March and May 2009), under the care of the same Medical Consultant.

Ethics & Consent Issues

The participants were given pre-validated tools that could be filled in by the patients themselves. The scope of this was to increase the validity and reliability of the study. Consent to carry out the study was obtained from all the hospital authorities and from the Ethics Committee of the Institute of Health Care.

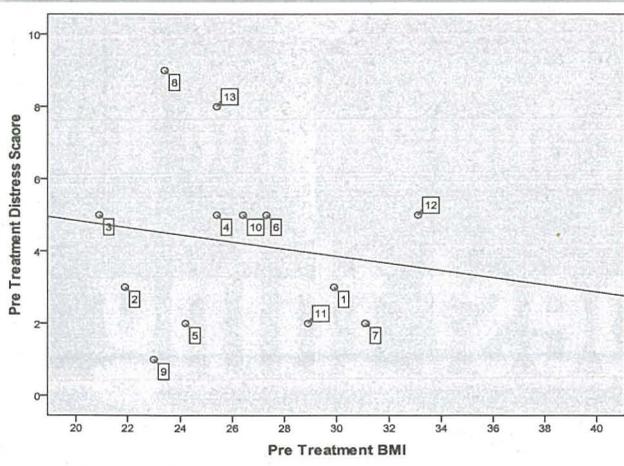


Methodology

The study sample consisted of seven men and six women. Although their treatment regimes differed in small degree, the side-effects of the treatment, those causing the distress to the patients were similar. Sample size was limited due to the short data collection period available, although the obtained sample size amounted to 50% (n= 13) of population above, comparing actual patients' nutritional status with their own perceived status, and also comparing their nutritional status across the treatment cycle. A subsidiary objective of the study, after all correlation data had been collected, was to invite patients to report whether they perceived their nutritional status as insulating them in some way against the side effects of treatment.

Results

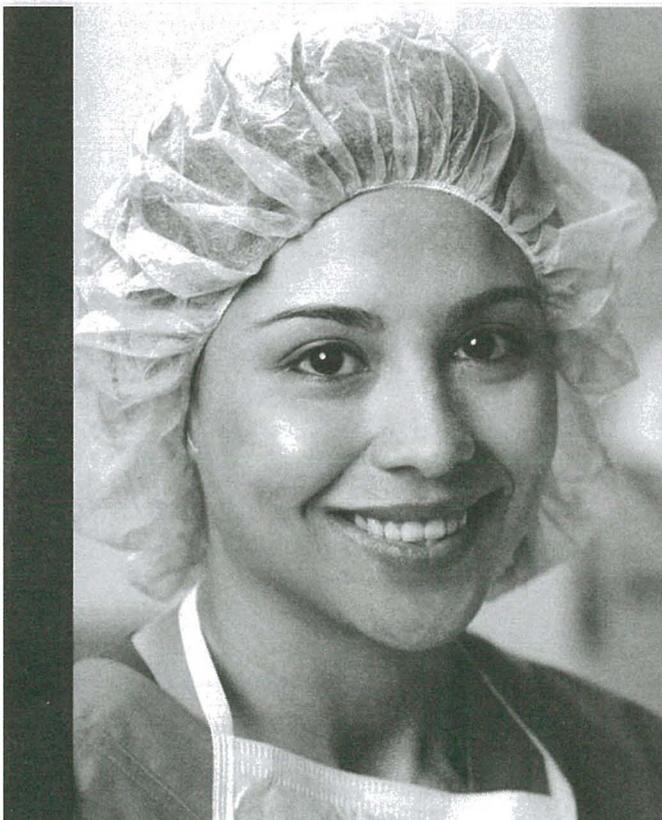
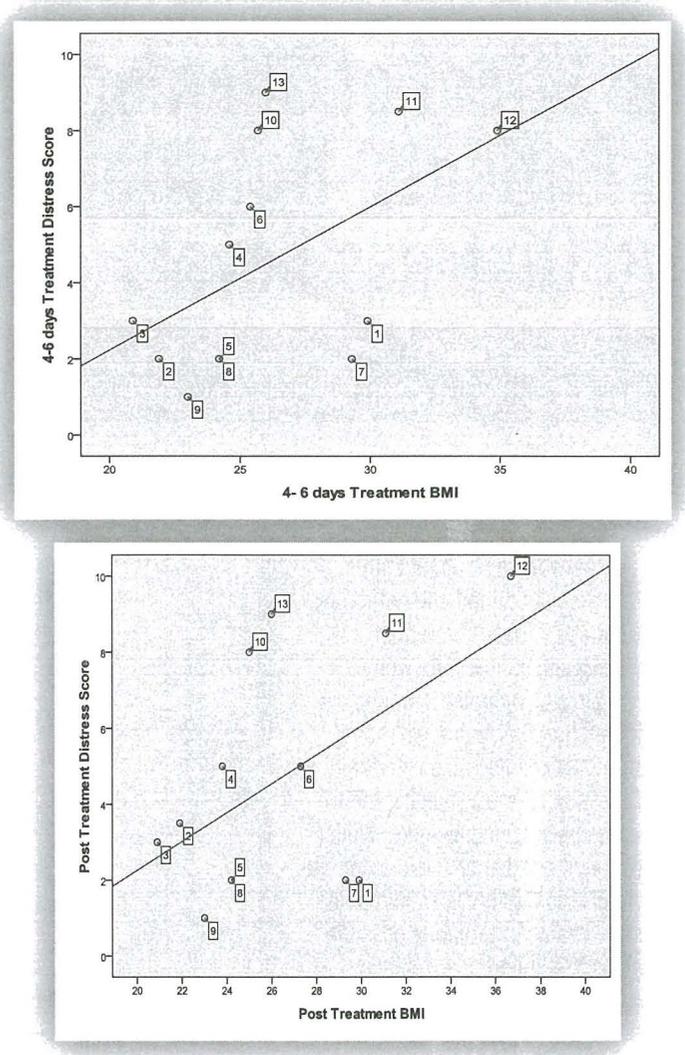
Individual patient profiles showed no relationship between any of the variables compared, i.e. nutritional status, distress and other variables like patient-perceived nutritional status, the use of steroids and nutritional supplements. That means that, on an individual basis, patients did not seem to follow any trends. Their nutritional status and distress were based mostly on personal factors influenced by patient preferences, family support and past experiences. After conducting statistical analysis on the data obtained, the study showed



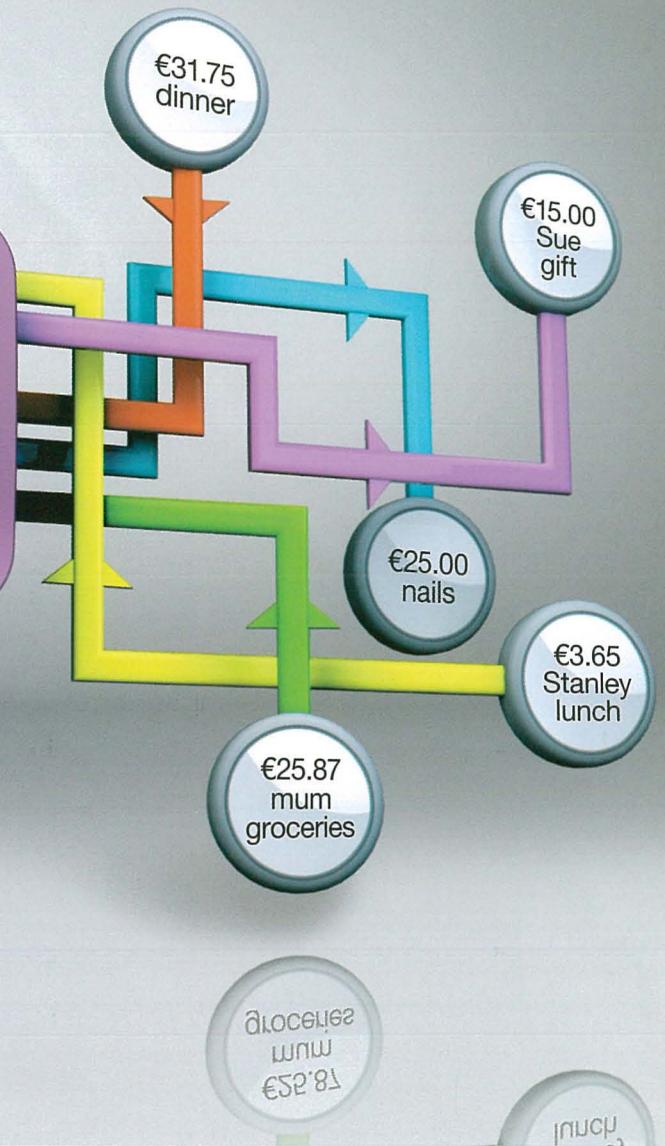
no correlation between actual nutritional status and patient distress before chemotherapy started (P-value 0.309), although significant correlations were then found once the side-effects of treatment started to be experienced by the patients, up to the end of the treatment (P-values 0.508, 0.528 respectively). Secondary relationships were also found between B.M.I. (actual nutritional status) and patient-perceived nutritional status (P-value of 0.027 at data collection point 1 and 0.041 at data collection point 3).

Conclusion

Although statistically some correlations and relationships were found between nutritional status and patient distress, individual patient profiles did not show the same trends. The results of this study are therefore not conclusive although they start to shed light on the role of nutritional support in haematological cancer patients, an area of medicine which is rather scarcely researched and provides a basis for future research. It prompts for further studies going deeper into topic area, studying the various variables that might influence the patients' distress and nutritional status, treatment, different side-effects and other factors that are ingrained and form part of the daily treatment of these patients.



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from our diary...



MUMN signs another Sectoral Agreement for all the Nurses and Midwives working in the Public Service and Public Sector.



During a thanks giving dinner FORUM Unions expressed their appreciation for the excellent contribution John Bencini performed during the period he was President of FORUM.



The FNBF Group Committee organised its Annual Ceremony for those Nurses and Midwives who retired from work the preceding year. The Ceremony started with a Mass followed by the presentation of Memorable Mementos and a reception afterwards.



A group of 67 Nurses and Midwives attended the Commonwealth Nurses Federation Conference in Cyprus. A group of nurses also presented a paper and Chaired sessions during this conference.



MUMN's Entertainment Group Committee organises the Annual Christmas Dinner. Well done it was great fun.



MUMN's Administrative Committee thanks Chantelle Muscat for her sterling work during the five year period she worked in MUMN's Central Office as an Officer Administrator.



During the CNF Conference in Cyprus MUMN President addressed the delegates present where he highlighted the milestones attributed to the nursing and midwifery professions in the last few years in our country.



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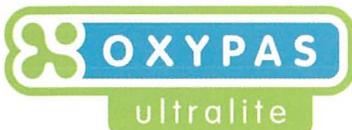
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- 400g sea bass
- 500g of rock salt
- 2 cloves of garlic
- 2 spoons of chopped parsley
- Mix of fresh herbs (mint, dill , rosemary etc)
- pepper
- 1 whole egg
- Olive oil
- Parchment sheet paper



Preparation

Cut open the belly of the sea bass, clean the fish and wash well under running water. Wash and dry the garlic, dice and place it in a cup, add the parsley, herbs and a pinch of pepper and mix the ingredients well. Season the abdominal cavities of the fish with the aromatic mixture.

Take a dish, add 1 egg with the rock salt then lay on the bottom, lay the fish mean time add olive oil to the fish , then top and cover with the rest of the salt.

Place in the oven preheated to 180° and bake for approximately 15 minutes. To test whether the sea bass is cooked, it will turn to a golden brown colour .

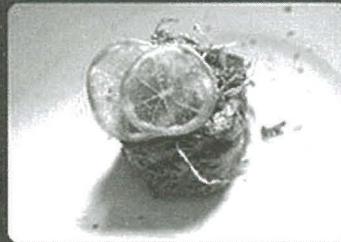
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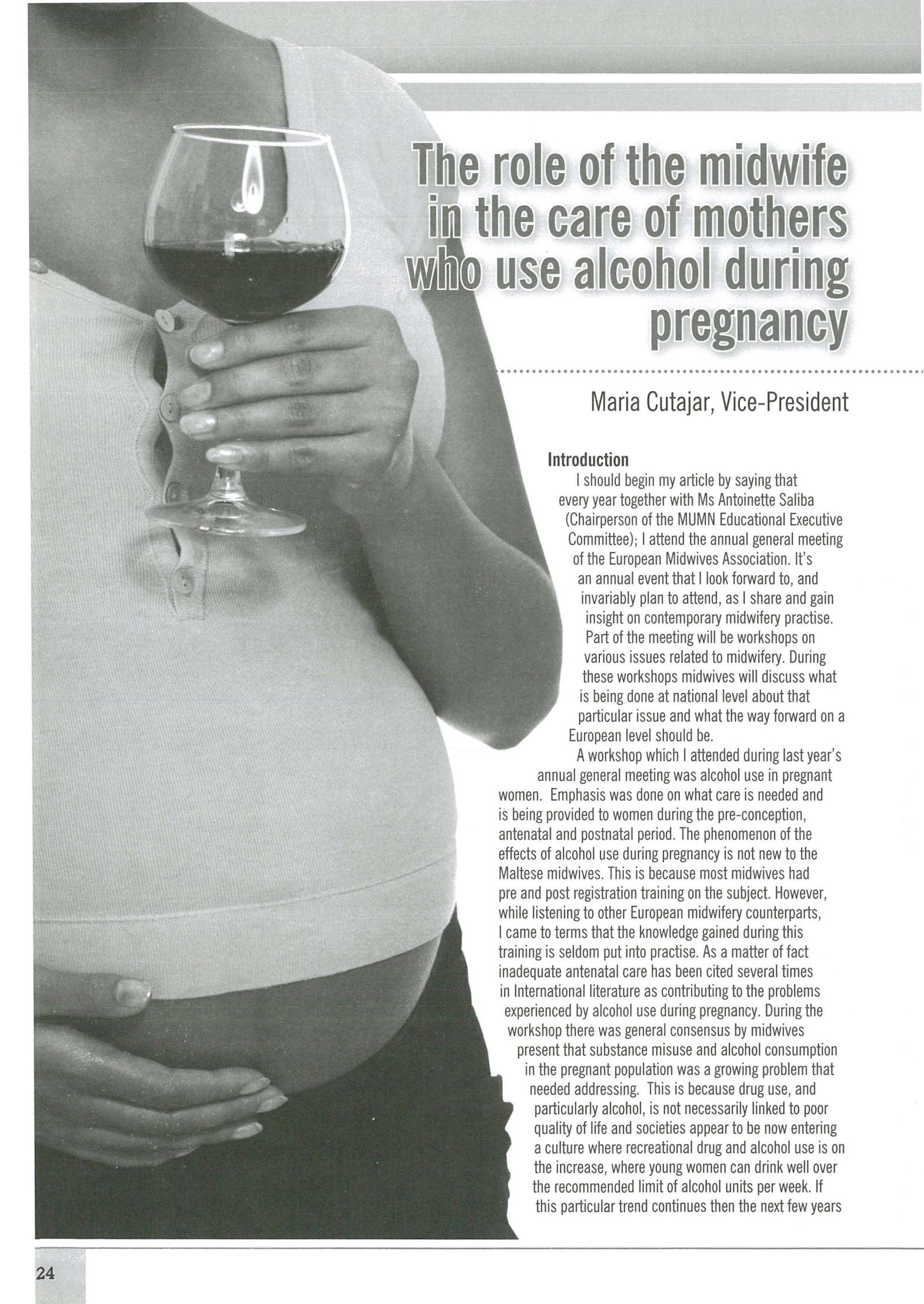
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The role of the midwife in the care of mothers who use alcohol during pregnancy

Maria Cutajar, Vice-President

Introduction

I should begin my article by saying that every year together with Ms Antoinette Saliba (Chairperson of the MUMN Educational Executive Committee); I attend the annual general meeting of the European Midwives Association. It's an annual event that I look forward to, and invariably plan to attend, as I share and gain insight on contemporary midwifery practise. Part of the meeting will be workshops on various issues related to midwifery. During these workshops midwives will discuss what is being done at national level about that particular issue and what the way forward on a European level should be.

A workshop which I attended during last year's annual general meeting was alcohol use in pregnant women. Emphasis was done on what care is needed and is being provided to women during the pre-conception, antenatal and postnatal period. The phenomenon of the effects of alcohol use during pregnancy is not new to the Maltese midwives. This is because most midwives had pre and post registration training on the subject. However, while listening to other European midwifery counterparts, I came to terms that the knowledge gained during this training is seldom put into practise. As a matter of fact inadequate antenatal care has been cited several times in International literature as contributing to the problems experienced by alcohol use during pregnancy. During the workshop there was general consensus by midwives present that substance misuse and alcohol consumption in the pregnant population was a growing problem that needed addressing. This is because drug use, and particularly alcohol, is not necessarily linked to poor quality of life and societies appear to be now entering a culture where recreational drug and alcohol use is on the increase, where young women can drink well over the recommended limit of alcohol units per week. If this particular trend continues then the next few years

may show an increased number of relatively heavy drinkers presenting for antenatal care. Hence, the importance of sustainable antenatal programs (and hence midwifery) care in reducing or minimising the problem experienced by these women and their babies.

The effects of alcohol

During this workshop participants agreed that alcohol is one of the most commonly used psychoactive drugs in the world. There are times and situations when even small amounts of alcohol can cause problems. Alcohol is a drug that after indigestion passes rapidly into the blood stream. Over 90% of it is broken down by the liver, hence the connection of heavy drinking and liver disease. Long term problems can be divided in 3 groups:

Social; Physical; Legal.

The chairperson of this workshop emphasised that such a scenario is problematic and affirmed the importance of setting up services to provide a holistic care to these women. This is because alcohol use during pregnancy put women and their babies at higher obstetric risk than non-alcoholic pregnant women. Research findings on alcohol consumption during pregnancy indicate that high alcohol consumption or regular binge drinking during pregnancy increases the risk of miscarriage, premature birth and a low birth weight (Gray and Henderson, 2006; Royal College of Obstetricians and Gynaecologists, 2006). Alcohol consumption during pregnancy can also cause foetal alcohol spectrum disorder (FASD), a range of physical and mental disabilities that persist throughout life (Mattson et al., 2011). Although evidence reviews have concluded that there is no consistent evidence of harm caused by low to moderate alcohol consumption during pregnancy, new evidence continues to emerge of the potential risks (e.g. for low birth weight and foetal death) (Royal College of Obstetricians and Gynaecologists, 2006; Henderson et al., 2007; Meyer-Leu et al., 2011; Andersen et al., 2012).

The chairperson of this workshop attested that through her professional career, it has become apparent to her that many women who use alcohol during pregnancy don't just come with one problem; their complicated lives can have multi-faceted problems from domestic abuse, sexual abuse, mental health issues, poor nutrition, poor housing/homelessness, and poor access to primary health, including dentistry. So when planning care all of these aspects need to be taken into consideration, most importantly though and central to all of this is the woman herself.

Practices implemented by other European Counterparts

Amongst participants present for this workshop were midwives coming from the United Kingdom (UK), Sweden

and Norway. These participants stated that at national level the care and the specialist service offered in their countries could serve as a benchmark service. The services provided, are mostly community based and aim to encourage women not to drink during pregnancy and to reduce the incidence of alcohol related birth defects. Midwifery counterparts from the UK attested that as part of the 'Responsibility Deal Alcohol Network (RDAN)', the British Government is working with the alcohol industry to 'foster a culture of responsible drinking' and to ensure that alcohol products will have 'a warning about drinking when pregnant' (Department of Health, 2011). In addition the UK Alcohol Strategy encourages hospitals to identify and support pregnant women who drink during pregnancy (HM Government, 2012). In support of this policy Diageo (an International drinks retailer) will provide funding for the National Organisation for Foetal Alcohol Syndrome (NOFAS-UK) to provide face-to-face, online and distance learning to 10,000 midwives (one-third of the England and Wales workforce) (Department of Health, 2012). The National Organisation for Foetal Alcohol Syndrome in the UK train midwives to:

Provide information and advice about the dangers of alcohol during pregnancy,

Encourage complete abstinence from alcohol during pregnancy. NOFAS believe that any amount of alcohol carries a risk of FASD,

Screen women for patterns of alcohol use,

Deliver brief interventions or referral to appropriate specialists for all women who drink alcohol.

The Swedish and Norwegian midwives present for the workshop attested that the pregnant woman who is using alcohol during pregnancy may not attend for antenatal care or do not reveal this to her midwife or to her health professional. There are a number of reasons for this, with the main ones being fear of perceived lack of confidentiality, fear of losing custody of their children and feeling of being 'policed'. For many women, telling a professional the real picture of their lives, how much alcohol they use; which they often use as their crutch to just cope, is so very difficult. These women already self-blame, carry guilt and reproach themselves for their need, so rationalising a woman's fear about so many concerns is probably the best place to start (Economidou et al., 2012). Most alcohol users' women will explain or at least voice their concerns regarding their babies being affected by withdrawal. They often express anxiety over the possibility of losing their children or being forced into some form of treatment, and they want to safeguard against these possibilities.

The Swedish and Norwegian midwives stated that as a matter of fact, these problems have meant that it has taken a great deal of time for good communications to build up between the specialist services and maternity services. The

close communication that develops over time begins with open and honest discussion, and leads to direct access to the agencies involved. The emphasis of management of a pregnant woman using alcohol receiving specialist care as mentioned below appears to mainly focus upon protecting the fetus and influencing women to change their lifestyles. These midwives (working in the UK, Sweden and Norway) stated that such specialist service is provided through a multidisciplinary approach to provide antenatal and general health care, and help in stabilising and reducing alcohol use with the help of a carefully supervised alcohol reduction programme. The role of professionals providing care to these women in pregnancy and childbirth is to provide information and choice to women, via a supportive service that is easily accessible in order to give back to them control over their bodies and lifestyles. Women are seen by a team of professionals including a consultant obstetrician, a neonatologist, a specialist midwife and a specialist social worker. Maternity centres in the above mentioned countries run a one stop shop, as in addition to the routine antenatal care provided by the community midwife, they offer an enhanced service. These are vulnerable women who

need continuity of care, time, empathy and compassion, and so this is where the role of the midwife comes in – a midwife with the specialist knowledge to assist them through what for some can be a difficult phase in their lives, whilst reducing maternal and fetal morbidity and mortality. The specialist midwife can be pivotal in generating an atmosphere of trust and continuity with the pregnant woman and is a vital link in sharing information with other professionals involved in the care.

Conclusion

From this workshop it was established that the role of the specialist midwife in this aspect of care varies from one country to another. Consensus amongst participants' part of this workshop was that the ethos as a specialist midwife in this role is to build trust and confidence and to encourage the women midwives care for, through joint working to take control of their addictions, their futures and the health and well-being of themselves and, most importantly, that of their unborn baby. The importance of the midwives' role in caring for women who use alcohol during pregnancy cannot be over-emphasised. The midwife has both an educational and a supportive role with pregnant women. Part of the role of the midwife providing care to these women involves explicitly tailored education for the women and their families, education for those professionals caring for them and setting goals and plans for the future through a coordinated, comprehensive and individual service. Midwives in this role must aim to inspire women to take control, give up tobacco and alcohol, eat healthily, to stabilise the pregnancy and so improve outcomes. This is not easy; even the most motivated of women will struggle. However, by encouraging early and continuing antenatal care and by being readily available to talk to, can significantly enhance compliance to the service. Giving control to the woman is a good place to start – this can only happen if specialist midwives and other health care professionals are prepared to put aside prejudice, and employ compassion, understanding, and engage with this vulnerable but complex woman.

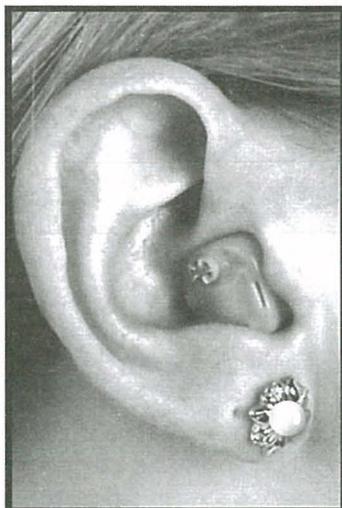
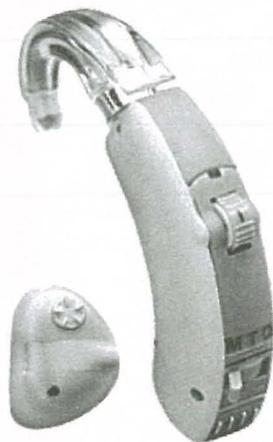
Recommendations for practice

Maternity services for alcohol use by pregnant women and their families should be co-ordinated, putting the woman and her family at the centre, offering her both confidentiality and support. This will require a link professional within the maternity services, preferably a specialist midwife, to liaise with all agencies that care for these women.

Every effort should be made to gain the trust of women by offering a service that is both confidential and non-judgemental. Reassurance, encouragement and support should be given to the woman and her partner or family to prepare her for parenting her child.

Guidelines for the management of pregnancy and care of the neonates should be designed, and all staff should be aware of them.

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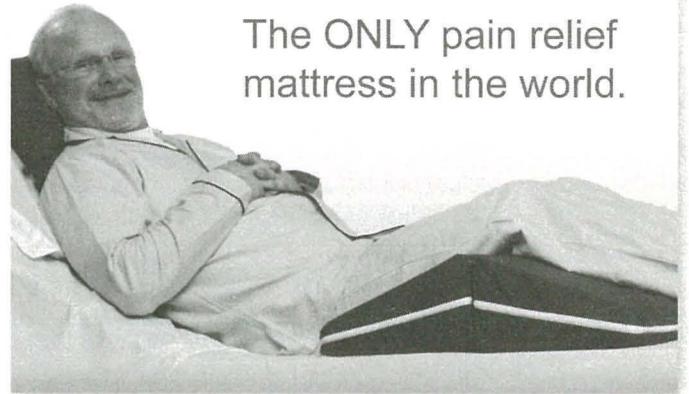
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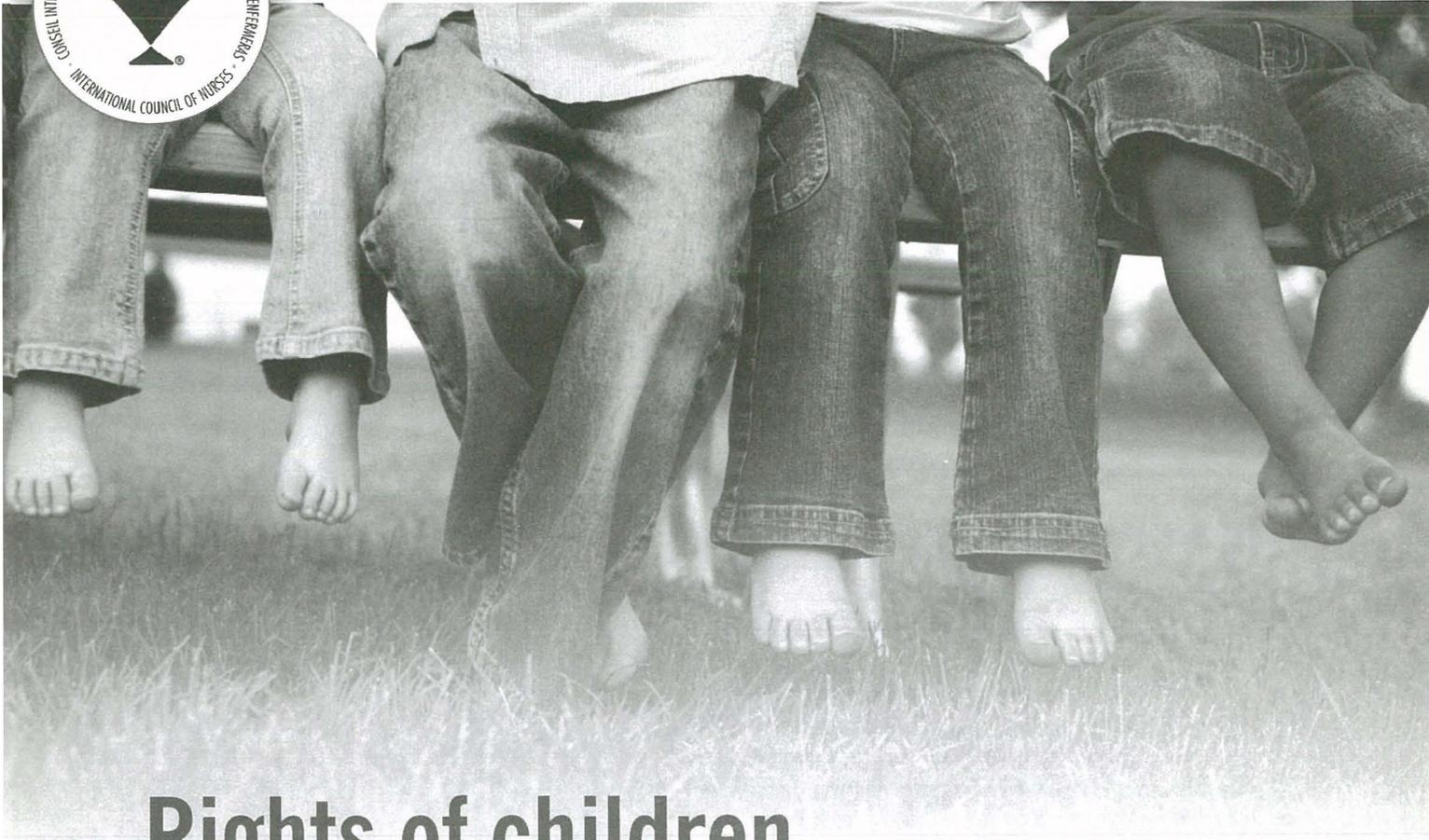


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Rights of children

The International Council of Nurses (ICN) endorses the Declaration of the Rights of the Child and the Convention on the Rights of the Child¹ and supports efforts made by its member national nurses associations (NNAs) to promote the principles set forth in the Convention. More specifically, ICN supports:

- Protecting children from any form of abuse, sexual exploitation or child labour, involvement in armed conflict, child prostitution, child pornography and forced marriages, which damage their health and intellectual, physical, social and psychological development.
- Enhancing protection and care for children with special needs such as orphans, abused or neglected and refugee children as well as assisting children who experience post traumatic stress disorder related to war and conflict, sexually transmitted infections and pregnancy.
- Promoting family health and welfare so that the family unit is the place where children are wanted, protected, cared for and grow up in health and dignity.
- Lobbying for equitable distribution of goods and services so that all children have adequate nutrition, housing, education and health care.
- Promoting equal opportunities for education of female children, orphans and those of minority groups.
- Fostering the delivery of primary health care services

for children with emphasis on the promotion of health and the prevention of disease and disability.

- Promoting the rights of the hospitalised child, including parental involvement in caring for the sick or institutionalised child or the child being cared for in the community.

ICN supports the right of children to be registered at birth as a prerequisite for identity and dignity and for access to their fundamental rights of protection, education, health care and other services.

ICN believes national nurses associations should:

- Be familiar with the complementary relationship between health and human rights and advocate for human rights training for nurses and others.
- Collaborate with human rights groups and government bodies in monitoring implementation of children's rights.
- Report any risk of abuse, neglect and exploitation of children to appropriate authorities.

Background:

The UN Convention on the Rights of the Child affirms that:

Every child shall enjoy fundamental rights and freedoms, including the right not to be disadvantaged on the basis of race, ethnicity, culture, language, religion, gender, political

Rights of children

or other opinion, national or social origin, property, birth or other status, whether of him/herself or of his/her family.

The child shall enjoy special protection and opportunity to develop physically, mentally, morally, spiritually and socially in conditions of freedom and dignity. The child shall be entitled from birth to a name and a nationality.

Special care and protection shall be provided for child and mother, including adequate prenatal and postnatal care. The child shall have the right to adequate nutrition, housing, recreation and health services. The physically, mentally or socially handicapped child shall have special treatment, education and care.

The child shall grow up in an atmosphere of affection and of moral and material security. Wherever possible the child shall grow up in the care of and under the responsibility of parents and only in exceptional circumstances shall the infant be separated from the mother. Society and public authorities shall have the duty to extend particular care to children without family and those without adequate means of support.

There shall be equal opportunity to free and compulsory education, at least in elementary stages, which will promote the child's individual abilities, judgement and sense of moral and social responsibility. There shall be opportunity for play and recreation. In all circumstances the child shall be among the first to receive protection and relief.

The child shall be protected from practices, which cause racial, ethnic, cultural, language, religious or any other form of prejudice and discrimination, and be brought up in a spirit of respect, friendship among peoples, peace and consciousness of a responsibility for his/her fellow human beings.

War and conflict increase children's vulnerability to post traumatic stress disorders, sexually transmitted infections and unwanted pregnancy from which they must be protected.

Children who are not registered often lose the protection that the law affords, since without a birth certificate their age cannot be established. Furthermore, lack of or an inadequate birth registration system means that a government does not know the true number of its citizens, and is hampered in planning for their needs.

Cultural and traditional practices that harm children and violate their rights should be eliminated.

Partnership with human rights groups and government bodies is vital for safeguarding children's rights.

The health and human rights of children are intricately linked and it is important to educate nurses and others about human rights.



**Nights so long they wear
you down from room to
room without a sound,**

**Who stands between a life
and death, returns that life
with just a breath,**

**Who makes the doctors
look so grand, but is hardly
seen from where they stand,**

**When no one seems to
give or care, you can count
on nurses, they're always
there.**



Abuse and violence against nursing personnel

The International Council of Nurses (ICN) strongly condemns all forms of abuse and violence against nursing personnel, ranging from passive aggression to homicide and including sexual harassment. Such actions violate the nurse's rights to personal dignity and integrity, and freedom from harm.

ICN condemns acts of abuse and violence perpetrated against *any person*, including other health care professionals, patients, children, the elderly, and other private citizens. However, within the employment sector, nurses are a category of worker particularly at risk and, thus attention must continue to be placed on eliminating all forms of abuse and violence against nursing personnel.

ICN firmly believes that violence in the health workplace threatens the delivery of effective patient services and, therefore, patient safety. If quality care is to be provided, nursing personnel must be ensured a safe work environment and respectful treatment. Excessive workloads, unsafe working conditions, and inadequate support can be considered forms of violence and incompatible with good practice.

ICN promotes and assists in the development of policies that reflect a "zerotolerance" of violence, e.g. legislation, staff regulations, judicial sanctions, workplace environment standards, cultural norms. Sanctions should be taken that reflect the seriousness of any particular incident. Cooperation with other organisations having common goals in the campaign against violence is important.

ICN believes that every nurse has a personal responsibility to report and effectively intervene when incidents of violence occur in the workplace. Appropriate security measures must be applied to protect nursing students who are particularly at risk of workplace violence.

ICN urges national nurses associations (NNAs) to actively:

- Sensitize the public and the nursing community to the various manifestations of violence against nursing personnel.
- Ensure access to counseling services for nursing personnel (victims and perpetrators of violence), including supporting nurses during reporting/compensation and claim procedures.
- Negotiate the introduction and maintenance of appropriate security measures and confidential grievance procedures in the work and learning environments.
- Support nurses, including facilitating access to legal aid when appropriate.
- Meet with top officials of relevant employer groups, national health and other organisations to gain their assistance in providing safe and respectful work and learning environments.
- Work to ensure that employers meet their

ICN POSITION



- occupational health and safety obligations, including developing adequate staffing levels, work methods that support quality care, and promoting safe behavioural patterns. This may include monitoring and denouncing employers that fail to meet these obligations.
- Ensure awareness of and access to existent resources available to nurses to deal with workplace abuse and violence.
 - Provide and advocate for improved education and ongoing training in the recognition and management of workplace abuse and violence.
 - Assist in creating a nursing culture that does not perpetuate nurses' tendency to selfblame for incidents of violence.
 - Foster positive nursing images and respect for nurses' rights to dignity and personal safety through role modelling. Integrate courses on the elimination and/or management of violence in nursing curricula.
 - Assist in the collection of reliable data regarding violence in the health sector.
 - Assist in the development of work methods that provide quality care, maintain adequate staffing levels and promote safe patterns of behaviour.
 - Negotiate workplace violence reduction strategies that incorporate organisational and environmental as well as individualfocused interventions.
 - Create or facilitate userfriendly, confidential and effective reporting mechanisms.
 - Support educational institutions to introduce formal training with regard to workplace abuse and violence.

Background

Sickness and potential lifethreatening factors cause stress in patients, their family members, and personnel in the health workplace. Such stress can aggravate factors that lead to violence; the levels of which are reportedly on the increase in society in general, and in the health workplace in particular.

Workplace violence is universal and pervasive. The impact of psychological violence is as great if not greater than physical violence. It is also more widespread.

Working conditions in the health sector place nursing and other health personnel at greater risk of violence, because of:

- Staffing patterns, including inadequate staffing levels and supervision, the use of temporary and inexperienced staff, heavy workloads and being solely responsible for health care units.
- Shift work, including commuting to and from work at night.
- Poor security measures in health facilities.
- Interventions demanding close physical contact.
- Demanding workloads, often occurring in emotionally charged environments.
- Highly accessible worksites with little to no privacy.
- Home visiting with its associated isolation.

Research demonstrates that amongst health personnel, nursing staff are most at risk of workplace violence. The prevalence and impact of violence against nursing personnel, both male and female, is troubling when compared to other professions. The effects of violence extend beyond the workplace affecting the victim's family and observers, known as third party violence. Verbal abuse must not be minimised the effects of which are similar to physical assault including its repercussions on care provision.

Traditionally, many cultures have covertly accepted physical violence, sexual harassment or verbal abuse against women although a violation of their human rights. Also, nurses often passively accept abuse and violence as "part of the job" — an attitude sometimes shared by the public and the judiciary. The pressures on female and male victims to remain silent are great and underreporting has hampered the development and implementation of effective strategies to reduce violence in the workplace.

Nurses have been expected to cope with violence, although few programmes train nursing personnel to identify potentially dangerous situations and develop effective mechanisms to deal with aggression.

The consequences of physical and verbal abuse, and sexual harassment include:

- Feelings of shock, disbelief, shame, guilt, anger, depression, fear, self blame, powerlessness, and exploitation.
- Physical injury and disorders (e.g. migraine, vomiting), and sexual disturbances.
- Increased stress and anxiety.
- Loss of selfesteem and belief in one's professional competence.
- Avoidance behaviour, which may negatively affect the performance of duties, including absenteeism.
- Negative effect on interpersonal relationships.
- Loss of job satisfaction. low staff morale, and increased staff turnover rate.

Violence is destructive and has a profoundly negative impact on observers, the victims, their family members and ultimately on patient care and safety. Violence may be said to "poison" the work environment.

Latex Allergy

A Potential Health Risk in the Medical Field

Part 2 - Importance of Effective Prevention Strategies

Latex allergies affect 5—10% of the general population⁶. In the healthcare scenario, the incidence of latex allergies is much greater. This is possibly due to a greater exposure to the allergen, since 50% of medical devices contain latex¹; and frequent and prolonged exposure to latex, is associated with an increased risk of acquiring this type of allergy^{1, 2}. Latex allergies can range from skin rash to involvement of multiple organ systems, leading to fatal anaphylaxis⁸. In 1989, the Food & Drug Administration Authority received an alarming number of cases of latex allergies including 15 deaths². This issue poses a great challenge for patients, healthcare workers and institutions and can threaten both health status and sustainability of livelihood². It is of utmost importance that healthcare providers are aware of the issue and its management³.

Patients who undergo frequent medical and surgical procedures have the highest risk of developing a latex allergy^{2, 3}. Children with Spina Bifida, have a prevalence rate of up to 65%. The risk of intra-operative anaphylaxis in this group amounts to 80% of all cases in children. Many healthcare authorities recommend avoidance of exposure to latex from birth, in this group of patients. Manifestations indicative of latex anaphylaxis during surgery range from flushing to cardiopulmonary arrest. Anaphylaxis may occur with any type of latex exposure and can mimic a drug reaction. Any systemic or allergic reaction during surgery should be considered as a possible reaction to latex². In order to avoid peri-operative anaphylaxis, it is very important to give all necessary attention to the possible predisposition of a patient to latex allergy. If medical staff is unaware of the severity of the issue, pre-anaesthetic evaluation of the history of latex allergy in patients due for surgery, does not ensure the safety of such patients¹.

In healthcare workers, the prevalence of latex allergy is 9—12%⁶. In medical occupations, latex allergy, as occupational dermatoses, is very common⁵. In 1998, the United States National Institute for Occupational Safety and Health issued an alert, warning workers with on-going exposure to latex products, of the risk of developing allergic reactions⁷. The Washington State Department of Labour and Industries warns that a skin rash may be indicative that a worker has developed an allergy to latex and that further exposure may result in a more serious allergic reaction⁸. A case study of a 51 year old nurse with latex induced anaphylaxis, exposed several implications. Workers tend to ignore skin problems related to wearing latex gloves for fear

of losing their job. Insufficient awareness, of the serious risks, might lead workers to omit seeking medical help with initial symptoms. This is very dangerous, since it might lead to worsening of hypersensitivity and failure to prevent life-threatening anaphylaxis. Timely diagnosis of latex allergy should be encouraged⁶. Nursing students are also at risk. However, prevention policies may ensure the safety of students whilst also reduce risks of legal liabilities for nursing schools⁹.

Latex gloves have been used, in healthcare, for the prevention of transmission of disease^{4, 5}. This might have been the main source of exposure to trigger an “epidemic” of latex allergies in the medical field². It is estimated that 350,000 tons of latex are used annually for the production of gloves⁵. In the United States, 9 billion latex gloves are sold annually² and in Germany, 60 million surgical gloves and 600 million examination gloves were used in 1993⁵.

Preventive strategies should reduce risks of workers from developing latex allergy and ensure safe employment of latex sensitive individuals. Such measures should reduce the risks of anaphylactic reactions among the healthcare population⁶. Persons with latex allergy should avoid contact with the allergen^{1, 5}. Poor glove quality is associated with an increased risk of glove-related disease. Hence, purchasers should demand and verify the reliability of information supplied by manufacturers¹¹. Prevention strategies in Europe, led to the issuance of the glove standardization document EN455:3¹². When powdered latex gloves are used, more latex protein reaches the skin, and during glove changes, airbourne powder carrying latex particles may be inhaled and cause serious allergic reactions^{5, 8}. If latex gloves have to be used, powder-free gloves, possibly with an inner polymer coating, and with a low protein content should be chosen^{5, 7, 8, 11}. Eliminating powdered gloves from the workplace drastically reduced the presence of airbourne latex particles and prevented the emergence of further cases of sensitised persons^{2, 5}. In Germany, since 1997, inhalation latex allergy has been prevented through observance of the technical regulations for hazardous substances (TRHS 540). These prohibit the use of powdered gloves whilst stipulating the use of powder-free and low-allergen gloves⁵. As a result, a decrease of latex allergy notifications was observed since 1999⁵. This was confirmed in a consensus document issued by an Italian working group, which also stated that latex powdered gloves should no longer be commercially available¹¹.

Latex-free care of patients at high risk is recommended in order to avoid sensitization. Latex-free areas in hospitals can be created, where all medical devices containing latex, including gloves, urinary catheters, bandages, self-adhesive dressings^{1,2,5,10}, are replaced by latex-free alternatives. Many institutions avoid the uncertainty of potential sources of latex in latex-free designated areas, by forming a multi-disciplinary advisory committee to develop protocols for such units². Whenever, a patient's medical history indicates the possibility of latex allergy, the entire surgical procedure should be done in a latex free environment. Rescheduling such surgery to the first case of the day, ensures that the level, of airborne latex particles, is at its lowest possible^{1,2}.

Healthcare workers, who are allergic to latex, should also avoid exposure. Those, having a severe, life-threatening allergy, may require a totally latex-free environment².

Occupational preventive strategies include:

- Establishing awareness through the delivery of a standard educational programme for workers
- Provision of a standard questionnaire to help workers assess personal risk of latex allergy
- Encouragement of healthcare workers to report any symptom of a possible latex allergy
- Education of workers to protect themselves from exposure to latex at the workplace
- Consideration of limitation of the use of latex, as a long term prevention strategy⁶

The problem of latex allergy in the healthcare setting has medical, vocational and medico-legal implications. Fortunately, the problem is becoming quite manageable since there is increased awareness and a variety of latex-free devices available². Healthcare services should highlight the advantages of workers and patients in minimizing the use of latex devices in order to lower chances of exposure. The use of synthetic rubber gloves should be encouraged since these have similar physical and protective properties to latex and good biocompatibility¹¹. An evidence based practice approach ensures delivery of care, based on latest scientific knowledge, to enhance better quality of care and cost effectiveness¹. In the German healthcare system, primary prevention of latex allergy through education and intervention were effective in reducing the incidence rate of such occupational problems. Prevention of occupational latex allergy is achievable; if clear and practical interventions are undertaken and maintained¹³.

“Despite the demand of low priced dressing materials, which, it must be said, are rarely dependable or of high quality, I refuse to abandon my principle of delivering the best there is to offer, time after time.”

Paul Hartmann, 1885

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Cultural and linguistic competence

The International Council of Nurses (ICN) and its member organisations believe that nurses should be culturally and linguistically competent to understand and respond effectively to the cultural and linguistic needs of clients, families and communities in a health care encounter.

ICN believes that nurses should demonstrate cultural competence by being able to:

- develop an awareness of one's self without letting it have an undue influence on those from other backgrounds
- demonstrate knowledge and understanding of the client's culture
- accept and respect cultural differences
- adapt care to be congruent with the client's culture

ICN strongly supports nurses developing linguistic competence by understanding and responding effectively to the linguistic needs brought by the client to the health care encounter. Such means as being able to communicate directly in the client's own language or through the use of trained interpreters and qualified translators are required.

For public protection, nurses need to communicate in a manner sensitive to client needs and in a language that can be clearly understood. Failure of the nurse to accurately comprehend client needs or if the client is not able to understand advice and instruction given can result in errors.

ICN firmly believes that nurses are responsible and accountable for their nursing practice. When dealing with clients from a cultural or linguistic group different from their own nurses should be aware that additional steps to ensure interventions are sensitive to the client's cultural and linguistic needs may need to be taken.

ICN expects employers to provide all newly hired nurses with an appropriate orientation or a period of adaptation to ensure they have the means of addressing the cultural and linguistic needs of their client group.

Background

The way a client perceives illness, the specific disease and its associated symptoms are tied to the client's underlying cultural values and beliefs. The way a person responds to these factors and how they relate to the nurse will be influenced by these values and beliefs and can affect the understanding and acceptance of any care offered.



The disease profile of a population is often linked to cultural factors. For example higher prevalence of cardiac disease in certain cultural groups or the incidence of malaria in people who live in certain geographic regions.

Nurses provide care designed to meet the individual needs of the client. This client centeredness has the goal of ensuring that client needs and beliefs are taken into account when deciding on interventions and that clients have the necessary information to participate in their own care.

In the broad sense, diversity encompasses acceptance and respect. For nurses it means understanding that each individual is unique, and recognizing individual differences. These differences may span the dimensions of race, ethnicity, gender, sexual orientation, socioeconomic status, age, physical abilities, religious beliefs, political beliefs or other ideologies.

Cultural and linguistic competence require cultural awareness; the deliberate, cognitive process in which health care providers become appreciative and sensitive to the values, beliefs, practices and problem solving strategies of clients' cultures.

A person's culture forms an important part of their identity and communication of cultural understanding and respect is an essential tool in forming a therapeutic relationship with the client.

Linguistic competence is demonstrated by a nurse who has the capacity to communicate effectively and convey information in a manner that is easily understood.

Nonverbal and verbal communication may differ in meaning according to different cultures. Awareness of this is vital in order to avoid misunderstanding, lack of cooperation or offence.

Assistance may be provided to nurses and individuals through services such as translation and interpretation. Translation is the process of transferring, between languages, ideas that are expressed in *writing*. Interpretation is the process used in transferring ideas expressed *orally* or (as with sign language) by *gesture*.



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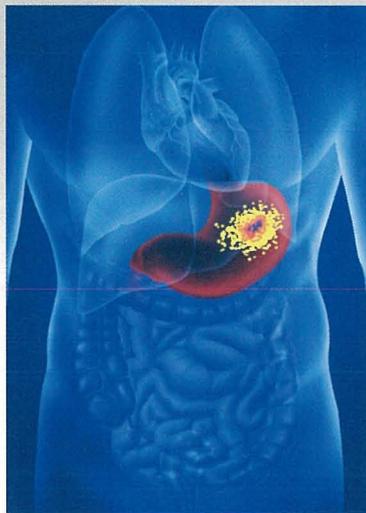
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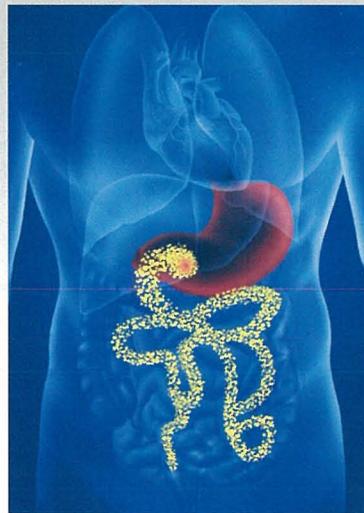
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*Representation of actual gamma scintigraphy images of paracetamol in the gastrointestinal (GI) tract.

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