

# IL-MUSBIEH

MALTA NURSING AND MIDWIFERY JOURNAL

Malta Union of Midwives and Nurses

No.59 - Lulju 2013



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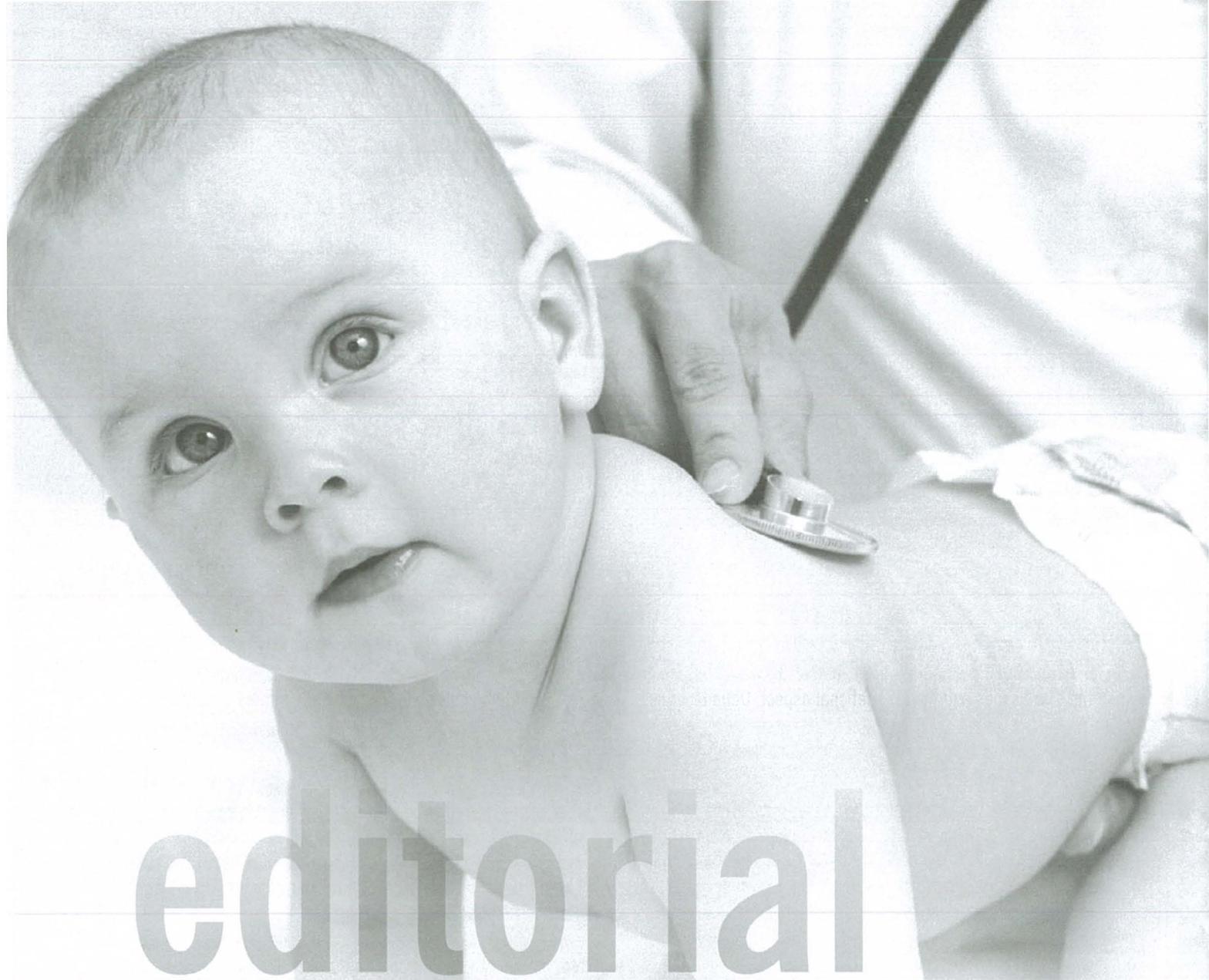
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# editorial

It is often said that attitude is everything. I submit to you that this statement must be qualified to say that the proper attitude is everything. This seems to be a particularly important characteristic of a good nurse and a good midwife. In these times of increased awareness for patient's satisfaction, I see plenty of nurses and midwives, with attitude but the satisfactory level appears to have been level, and there were times when the levels went down, for the past few years.

Having lived most of my hospital life in and around different areas, there is no shortage of nurses and midwives who are willing to show you their attitude. This is particularly true when any new safety item trickles down from the high towers of academia, accreditation or outside organizations. I have listened to nurses and midwives discuss why this procedure or that process won't work in their ward. Apparently, wards are like snowflakes, in that no two are alike. What works at one particular area will never work in any other ward, or so many would have you believe. When I ask what method will work, to move forward I am either met with a blank

stare or a comment about how that problem has never happened at their ward. The big question is how can that attitude change?

We probably need to first look at how the negative attitude set up shop to begin with. Have nurses and midwives been nurturing a bad attitude since they started their healthcare training? Did this attitude accumulate over the years? If we can identify any common ground, then we should be able to perform some attitude readjustment before nurses and midwives start to work with patients. Lacking that information, we still need to change the prevailing attitude that prevents us from making progress in patient satisfaction. I think that the only way we will be able to grab someone's attention to start changing attitude is to make it such an overwhelming event that there will not be any doubt about the nurse's and midwives intent.

When everyone, that is nurses, midwives, and all the other health care professionals has the same destination in mind, projects like patient satisfaction, safety, are much easier to accomplish.

## President's message

MUMN officials has been stretched to the limit in these last three months. We were intensively active on both the local issues and the international aspect. Definitely the local aspect is the most important. The issues were several. The sectoral agreement had to be discussed since the Public Service Commission (PSC) has been dismantled and appointments could not be issued. Discussions had to take place on this aspect. Then various issues in SVPR such as the transfers of nurses and the lack of carers on the wards. The lack of carers was the cause of several emails from various nurses and MUMN even had to resort to directives ....but such an issue was resolved and directives were withdrawn.

Transfers without replacement were what caused severe hardships to the nurses in Karen Grech hospital and Mt. Carmel hospital. While MUMN understands that nurses and midwives would sometimes want a change in work place...such a transfer does not come at the detriment of other colleagues. Mt. Carmel hospital alone had more than twenty nurses transferred from the beginning of this year... all without replacement...not to mention retired nurses and again there was no replacement for these nurses either.

For the health minister who is suppose to be the minister of all the health division, making office at the casualty in MDH for a long period of time was a big mistake and gave a very wrong message to the media and the public. As a health minster ...all the health division is important and all the health division is riddled with problems. This was purely a publicity stunt which gave the media the impression that the waiting time in the E/A at MDH is the only important issue important to the health minister. In fact both the media and the public got an impression of a quick fix...or that the most important patients are the once waiting in the E/A department. As a result of such action, health centers, Karen Grech hospital, Mt. Carmel Hospital and Gozo General hospital were plagued by huge problems of nurses'

shortages with no action being undertaken by the health ministry to address their problems. Managements in varies entities literally started cancelling the nurses vacation leave due to such abduction of the health authorities to distribute the available nurses evenly and equally.

As regards meetings with the new health minister. There was never one meeting as a consultation process with MUMN on anything really. If any nurse or midwife was to ask any MUMN official on the road map of Mater Dei hospital, on the elderly, on the primary care or on Gozo Hospital....the answer would be in the negative. We are not aware if a road map exists and if it does exist...we were not even requested to contribute. Pity, MUMN expected to be more involved in the reforms and the policy making... but as usually the minister seem more interested to take advice from his consultants. Well what are the first 100 days for MUMN....a struggle /// in the dark /// astonished by certain decisions...if I was to describe it mildly. Really nothing much changed for MUMN....just the people who are in the Health division but otherwise same amount of problems. Well, there is always room to change ...so let us be optimistic. Till now the impression MUMN officials receive is that the new administration either knows everything or has its own set of consultants to get there advise so nurses are not needed.

Well, MUMN will always be the union of the nurses and the midwives and our service to these professionals is evident by the record number of members in MUMN. Political agenda, hidden motives or personnel agendas are non existent ...and that what makes MUMN strong. Since nurses and midwives are the ONLY people we serve and next to the nurses and midwives come the patients themselves.

Enjoy summer with your families and friends...We only live once they say.....happy summer

**Paul Pace  
President**

# Kelmtejn tas-Segretarju Generali

L-Elezzjoni Ġenerali waslet u għaddiet! Naturalment L-għandna Ministru tas-Saħħa ġdid. Hija l-ewwel esperjenza għalih mhux biss bħala Ministru iżda wkoll bħala membru parlamentari. Nifhem u napprezza li d-Dipartiment tas-Saħħa hu wiehed mill-aktar li fih problemi però hemm mod u mod kif wiehed jista' jmexxi sabiex taffronta dawn l-istess problemi u tibda ssib is-soluzzjonijiet għalihom. B'kull rispettt lejn kulhadd l-MUMN issa ilha 17-il sena mwaqqfa. Ma bdiex il-bieraħ u l-għaqal jitlob li jekk fil-Ministeru għandek Union b'numru ta' snin b'esperjenza warajha u trid tikkopera miegħek, allura hu l-opportunità u aħdem magħha fl-interess ta' kulhadd.

F'dawn l-aħħar xarhejn kellna numru ta' laqgħat importanti fl-Uffiċċju tas-Segretarju Permanenti Ewlieni u nista' ngħid mingħajr tlaqlieq li f'dan l-Uffiċċju sibna koperazzjoni sħiħa fuq diversi problemi u kwistjonijiet pendent. Kienet deċiżjoni għaqlija ħafna li f'din il-kariga gie nkarigat persuna li għamel snin twal fil-karriera tiegħu bħala trejdunjonista għaliex jista' jifhem b'mod dirett l-issues mressqa u s-soluzzjonijiet għalihom.

Minn dan ix-xahar stess ser nibdew naqtaw il-frott mill-Ftehim Settoral. Kulhadd f'xi hin jew iehor ser igawdi minn dan il-Ftehim però mhux kulhadd mill-ewwel f'kollox. Jien personalment, b'mod immedjat ser ingawdi biss mill-klawsola tal-EDP's, però 'l quddiem ser ingawdi mill-klawsola tan-nursing premium u l-progression fl-iskali. Kollox jasal fil-hin u l-waqt tiegħu.

F'dawn ix-xahrejn li ġejjin ser nibgħatu n-nominazzjonijiet biex jinħatru l-Group Committees il-ġodda fl-isptarijiet u ċ-ċentri tas-saħħa. Nheggek tiegħu interess u tinvolti ruħek fix-xogħol tal-Union fuq il-post tax-xogħol tiegħek. Dan huwa investiment dirett lejn kundizzjonijiet aħjar għalik stess. Fil-bidu kulhadd ġdid kien però nassigurak li malajr titgħallem u tingrana.

Importanti li l-komunikazzjoni bejn il-membri u l-Union u viċi-versa tkun effettiva. L-aħjar mod fil-prezent li dan jista' jseħħ huwa permezz tal-emails. Għalhekk inheggek sabiex jekk għadek m'intiex tirċievi l-korrispondenza tagħna huwa importanti li tinfurmana bl-email tiegħek. U jekk tibdel l-email address huwa importanti li tavżana minnufih bl-indirizz il-ġdid.

Nixtieq niegħu din l-opportunità sabiex ninfurmakom li fit-23 ta' Awwissu ser norganizzaw BBQ ta' veru f'Għajn Tuffieħa. Nhegġgkom thallu din id-data vojta biex niltaqgħu flimkien u niegħu gost bħas-snin preċedenti.

**Colin Galea**  
Segretarju Ġenerali

## WORKPLACE MENTAL HEALTH



# It pays to

### BACKGROUND

As a concept, mental health is not simply concerned with mental disease; it also means promoting mental health and preventing such illnesses. The definition by the World Health Organisation (WHO) identify that mental health is central to the wellbeing and functioning of both the individual and the community. According to the WHO's (2010, 2001) constitution, mental health is not just the absence of mental disorder or disabilities but is the state of wellbeing in which every individual realise:

- his or her own potential;
- can cope with normal stresses of life;
- can work productively and fruitfully;
- is able to make a contribution to his or her community.

Research based evidence indicate that mental health problems are common and increasing worldwide (Vos et al., 2012), with major depressive disorder being on the rise (Murray et al., 2012). According to this evidence mental health diseases are one of the major burdens in care and costs of national health services. Mental health diseases (such as depression, anxiety, substance abuse and stress) manifest in every class age and are linked with difficulties in activities of daily living, work, interpersonal and family relationships. In addition, mental health problems have a direct impact on workplaces through increased absenteeism, reduced productivity, and increased costs. The WHO (2012) stated that almost one million people die from suicide around the world every year and mental disorders are one of the major risk



# be proactive

factors. Mental health is a matter of everyone at any stage of life course. Mental illness generates poverty, impedes access to education, accentuates inequalities, and at times fosters violence. Workplace mental health is a crucial factor to consider when building and maintaining a successful organisation. Organisations are realizing that overlooking it is something they can no longer afford, as it impacts productivity, employee retention and ultimately the organisation's sustainability.

Mental health problems are the result of a complex interplay between biological, psychological, social and environmental factors. There is increasing evidence that both the content and context of work can play a role in the development of mental health problems in the workplace. Key factors include:

- workload (both excessive and insufficient work);
- lack of participation and control in the workplace;
- monotonous or unpleasant tasks;
- role ambiguity or conflict;
- lack of recognition at work;
- inequity;
- poor interpersonal relationships;
- poor working conditions;
- poor leadership and communication;
- conflicting home and work demands.

Mental health is thus a matter of major concern for health systems and organisations throughout the world due to the increasing prevalence of mental health diseases. The economic cost of this phenomenon is bound to have repercussions for the world economy in

terms of labour productivity, the organisation of preventive and therapeutic assistance and the need to develop the requisite human and therapeutic resources. Meanwhile, addressing mental health in workplaces settings is complex and multi-layered.

Many of the mental disorders are preventable and curable; however, mental health problems tend to remain undiagnosed, untreated or unreported. This is because at times patients present to health professionals with physical symptoms and thus many of the patients are not correctly diagnosed for mental illness and thus not treated (WHO, 2001; Thornicroft, 2007). Such a scenario presents a major challenge for the service system.

## WORK AND MENTAL HEALTH

Work is an essential feature of most people's adult life, and has personal, economic and social value. Work substantially contributes to a person's identity; it provides income for an individual and his/her family, and can make a person feel that he/she is playing a useful role in society. It is also an important source of social support. Participation in work also contributes to the economic and social development of communities. Work is important for mental health and indeed the right to work in just and favourable conditions and with protection from unemployment is enshrined in the United Nations Universal Declaration of Human Rights (Article 23). Work produces personal and health benefits, while the absence or loss of work can potentially damage a

person's mental health (Huxley, 2001).

In today's business arena, the nature of work is changing rapidly. Factors such as the globalization of markets, advances in information technology, urbanization and migration have an impact on the nature of work and on the health – including mental health of employees. The Tokyo Declaration (1998) acknowledged the economic and technological changes in the workplace that are contributing to stress among employees. Changes in the workplace that increase the income of employees, facilitate access to education and training, and improve working conditions will have a positive effect on the mental health of employees. However, workplaces characterized by poor organisation of work, unstable jobs, low wages, long working hours, sexual harassment, temporary contracts and subcontracting (Gutierrez, 2000; Rantanen, 1999) are likely to have a negative impact on the mental health of employees and their families.

The economic cost of mental illness is high. However like many diseases mental disorders have risk factors that can be prevented or reduced. It has been estimated that work-related stress negatively affected at least 40 million workers in 15 countries of the European Union, costing 20 billion euros annually (European Commission, Employment and Social Affairs, 1999). This survey revealed that 45% of workers had monotonous tasks; 44% did not rotate tasks; 50% had short, repetitive tasks; 35% had no influence on task order; 28% had no influence on work rhythm; 54% reported working at very high speed, and 56% worked to tight deadlines. One consequence of long-term exposure to stress may be burnout. The use of the expression burnout has become increasingly popular around the world to describe the result of a long-term exposure to a work situation that is beyond the person's capacity to cope. Burnout is characterized by feelings of intense fatigue, a sense of isolation and loss of control, as well as a feeling of accomplishing nothing at work. It is often accompanied by insomnia, headaches, gastrointestinal symptoms, a variety of muscular and joint pains, and lapses in memory.

## IMPACT OF MENTAL HEALTH PROBLEMS

Mental health problems have an impact on employers and businesses directly through increased absenteeism (WHO, 2003a; Liimatainen and Gabriel, 2000), reduced production (WHO, 2003a), increased costs (Harnois and Gabriel, 2000; Mentality, 2003), and reduced profits (Mentality, 2003). Employee mental health problems also affect employers indirectly through factors such as reduced morale of staff. Epidemiological surveys and clinical studies in Europe and elsewhere indicate that work and employment play an important role in relation to mental health (Liimatainen and Gabriel, 2000; WHO, 2003a, 2004a). However, this role is not fully understood and, as a result, not properly managed in relation to the protection and promotion of good mental health (Cox et al., 2004). The workplace can contribute positively

to a person's mental health, may exacerbate an existing problem, or may contribute to the development of a mental health problem. The failure to prevent, recognize and treat mental health problems in the workplace has an impact on employers, employees and their families, and the community generally.

For individuals, mental health problems can lead to a reduced quality of life, as well as having significant economic and social effects. Absence from work is likely to affect the person's income. In combination with the costs of health care, this may cause significant financial hardship for employees with mental health problems. These employees are often not able to access the health services they need to treat their mental health problem, and may not be able to afford the time off work required for recovery. In addition to the obvious suffering caused by mental disorders, individuals with mental health problems often experience stigma and discrimination (WHO, 2001). Families also experience the impact of mental health problems. They may have economic difficulties related to the reduced income and increased health care costs, the stress of coping with altered behaviour, disruption to the household routine, and restricted social activities (WHO, 2001).

The cost of mental health problems to the overall community includes the cost of treatment, particularly when this includes hospitalization. In addition, other costs to the community include those related to the loss of productivity, loss of lives, social exclusion and human rights abuses. Mental health problems in the workplace adversely affect the national economy. In the European Union, for example, it is estimated that the cost of mental health problems in the workplace may amount to 3-4% of the gross national product (GNP) (Liimatainen and Gabriel, 2000). Governments and employers have a critical role in promoting mental health, preventing mental health problems in the workplaces, and ensuring that mental health problems are recognized early and treated effectively.

## ARGUMENTS FOR IMPROVING MENTAL HEALTH IN THE WORKPLACE

Inadequate management of mental illnesses can result in a myriad of business costs, including absenteeism, disability payments, medication costs, accidents, and recruitment expenses. In addition, there are indirect expenses such as lost productivity, replacement payroll, training expenses, and time spent administering disability claims. If an employee experiencing symptoms of mental illness does not get timely managerial support and medical attention, the outcome is likely to be negative and costly. Organisational behaviourists attest that 'Good health equals good business' - A positive, inclusive approach to mental health issues in the workplace can have a positive effect on the employees and the business as there will be:

- enhancement of skills acquisition;
- lesser absence;

- better work relations;
- increased productivity and motivation;
- employing the best person for the job;
- improvement of knowledge and skills;
- fostering of acceptance and diversity;
- making workplaces more efficient.

### PUTTING IN PLACE A WORKPLACE MENTAL HEALTH POLICY

For many businesses, addressing mental health problems at the workplace will begin with the development of a policy. A mental health policy for the workplace helps to define the vision for improving the mental health of the workforce and to establish a model for action. Such a policy will also identify and facilitate the agreements needed among the different stakeholders in the workplace. The decision to develop a workplace mental health policy may be a result of many different factors, including evidence of the impact of mental health strategies on productivity, an understanding of the importance of addressing mental health issues in the workplace, and the need to comply with regulations. It is important to make the case for developing a mental health policy in the workplace in order to gain the explicit endorsement and commitment of the employer and other key stakeholders. The employer is more likely to support the development of a policy if its potential cost impact can be demonstrated. In making the business case, general data showing the link between mental ill-health and reduced productivity and increased costs should be presented. In addition, any readily available data from the workplace itself should be analysed and presented in order to make the business case.

Without policy direction, lack of coordination and fragmentation will reduce the impact of any workplace mental health strategy. A mental health policy for the workplace can be developed separately, or as part of a broader health and safety policy. Putting the policy in place should involve the following steps:

- Step I. Analysing the mental health issues.
- Step II. Developing the policy.
- Step III. Developing strategies to implement the policy.
- Step IV. Implementing and evaluating the policy.

While these steps are presented in a sequential manner, the practice is often more complex. The guidance should be adapted to meet the needs of specific workplaces. A workplace mental health policy usually comprises a vision statement, a statement of the values and principles on which the policy will be based, and a set of objectives. The policy should be developed only after comprehensive consultations with employees. Employees can be consulted formally or informally, individually, in groups, or through a collective organization, such as a union or staff association. Whichever mechanism is used, it is essential that all stakeholders are involved in the process. Employees are the consumers of mental health programmes, and it is essential

that they are actively engaged at the beginning of the process. Lack of control and influence are independent risk factors for stress and the participation and inclusion of employees should be a fundamental principle of any mental health programme in the workplace.

The strategies to be implemented in the workplace will depend on the nature of the workplace, the mental health issues identified and the resources available. Issues such as the acceptability of the strategy to employees and the sustainability of the intervention are also important. While some workplaces may invest in many different strategies simultaneously, many will need to begin more slowly, with only one or two strategies. The decision about whether to focus on education, employees at risk, treatment services, the organization of work, or the reintegration of employees with mental health problems needs careful consideration of the evidence and consultation with all stakeholders.

### KEY POINTS: DEVELOPING A MENTAL HEALTH POLICY FOR THE WORKPLACE

- A workplace mental health policy comprises a vision statement, values and principles and a set of objectives.
- The vision statement represents a general image of the future of mental health in the workplace.
- Values are judgements or beliefs about what is worthwhile or valuable while principles refer to the standards or rules that guide actions.
- Objectives translate the policy into concrete statements of what is to be achieved.
- All stakeholders should be consulted when a workplace mental health policy is being developed.

### CONCLUSION

There is no one "right way" to create a mentally healthy workplace policy because every workplace is different - from the people doing the work, to the work that needs to be done, to the leaders running the organization, the size of the organization, the external environment that influences the community, and the external resources the organisation draws. All of these factors play a role in employee mental health. Therefore, including a mental health policy within the organisational context is important to a healthy workplace. Several key issues have been shown to have a significant effect on employee mental health. These issues can be developed as part of a continual improvement process to improve the work environment (physical, psychosocial, organizational, economic), and to increase personal empowerment and personal growth. Organizations need to consider all of these in their efforts to create a mentally healthy workplace. Poor mental health not only hurts the individual employee, but it also reduces corporate profits and sustainability.

**Maria Cutajar**  
Vice President

# Let's talk about thrush...

One of the most common infections of the vulva and vagina is thrush or vulvo-vaginal candidiasis. Thrush is very common, generally affecting women of childbearing age. It is very rare for anyone to get thrush before puberty or after menopause. Candidiasis affects 3 in 4 women at some time in their lives, of which 40-50 per cent will have recurring problems with thrush. Many who have suffered more than once may opt for self-treatment with a pharmacy product. Therefore the patients that are likely to come to you with this problem may be first-time sufferers or patients with recurrent or persistent symptoms. They may also have associated risk factors such as pregnancy, poorly controlled diabetes, compromised immunity, or debilitation.

## CAUSES OF THRUSH

Thrush is caused by an overgrowth of the yeast *Candida albicans*. This fungus is usually a harmless inhabitant of the gastrointestinal tract, skin and vagina, but it can overgrow opportunistically and cause infections.

Normally, host defenses act locally in the vagina to combat infection and to keep levels of *Candida* under control. 'Protective' vaginal bacteria produce lactic acid to create an acidic vaginal environment that is hostile to other invading micro-organisms such as *Candida albicans*. However, there is a multitude of factors, or triggers, such as side-effects of broad spectrum antibiotics or levels of oestrogen hormone, which may alter the vaginal pH balance, destroy the 'protective' bacteria and increase risk of infection.

Gynaecological fungal infections are the body's response to external and internal influences.

Main triggers of thrush include:

- Intake of medicines such as antibiotics
- Trauma of sexual activity or tampons
- Stress
- Perfumed soap, shower gels and bubble baths
- Periods and menstruation
- Wearing of tight clothing
- Pregnancy

Fortunately, thrush is generally straightforward to treat and manage. The infection usually responds well to topical preparations or systemic treatment with oral antifungals, but patients do need to understand how to use treatments so that they get the maximum benefit out of them. Your role in offering advice and guidance is vital in helping patients find a treatment that best meets their needs, and to help them gain an understanding of how to identify and prevent thrush in the future. Thrush that is recurrent or severe (for example in women suffering from diabetes) should be referred to a doctor for further investigation.

For further information log-on to <http://www.canesten.co.uk/hcp>

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## It takes... two

### Canesten Oral & Cream Duo

This is a convenient pack containing two effective treatments for thrush - a single Canesten Oral capsule, to help clear the infection and a handy tube of Canesten 2% Thrush Cream to immediately treat the external symptoms.



### Soothes and Clears

**Canesten® Oral & Cream Duo** (fluconazole 150mg partner's penis, cream should be applied two or three times capsule, plus 10g tube of clotrimazole 2% w/w cream), daily for two weeks. **Children:** Paediatric usage is not **Indications:** The capsule is for treatment of candidal recommended (in under 16). **Contra-indications:** vaginitis, acute or recurrent. Also for treatment of Hypersensitivity to fluconazole, clotrimazole, related azole partners with associated candidal balanitis. The cream compounds or any of the excipients e.g. cetostearyl is for the treatment of candidal vulvitis. **Dosage and Administration:** **Adults (16 - 60 years):** Swallow one ergot-derivatives. **Warnings and Precautions:** Adequate capsule whole. Apply cream to vulva and surrounding area contraception necessary. A physician should be consulted two or three times daily and rub in gently. Treatment with if the patient or partner have had exposure to sexually infection disappear. If after concomitant treatment of two infections of thrush in the last six months; is vaginitis, symptoms do not improve within seven days, the experiencing thrush for the first time; has known patient should consult a physician. For treatment of sexual hypersensitivity to other vaginal antifungal products; is

taking any medicine other than the Pill; has any disease or dysuria, or their sexual partner does not have thrush. illness affecting the liver or kidneys or has had unexplained jaundice; suffers from any other chronic disease or illness; is uncertain of the cause of symptoms. Or if the patient has been relieved within one week of treatment. Fluconazole has been associated with rare cases of serious hepatic any of the following symptoms: abnormal or irregular toxicity, including fatalities primarily in patients with vaginal bleeding or a blood-stained discharge; vulval or vaginal sores, ulcers or blisters; lower abdominal pain or dysuria; any adverse events such as redness, irritation or swelling associated with the treatment; fever or chills; nausea or vomiting; diarrhoea; foul smelling vaginal discharge. In men, medical advice should be sought if they have penile sores, ulcers or blisters, there is abnormal penile discharge, the penis has started to smell, they have serious underlying medical conditions. Fluconazole must be taken with particular care in patients with congenital or acquired QT prolongation and torsades de pointes or history thereof, known cardiomyopathy, sinus bradycardia, cardiac arrhythmia, or are treated with a co-medication potentially leading to QT prolongation. Patients with rare hereditary problems of galactose intolerance, the Lapp lactase deficiency or glucose-galactose malabsorption

should not take this capsule. The cream contains cetostearyl alcohol, which may cause local skin reactions (e.g. contact dermatitis). The cream may damage latex contraceptives so patients should be advised to use alternative precautions for at least five days after using the product. **Side-effects:** Oral capsule may cause nausea, diarrhoea, vomiting, gastrointestinal and abdominal pains, abdominal distension and flatulence. Leukopenia, neutropenia, agranulocytosis and thrombocytopenia. Torsades de pointes/QT prolongation. Mild transient elevations in transaminases, hepatitis (non infective), jaundice, cholestasis and acute hepatic failure, including fatalities. Allergic reaction, anaphylactic reaction, anaphylactic shock. Hypersensitivity reactions including rash, urticaria, oedema, pruritus, cardio-respiratory distress. Electrocardiogram QT prolonged, electrocardiogram QT corrected interval prolonged, hypercholesterolaemia, hypertriglyceridaemia and hypokalaemia. Seizures, dizziness, headache, dysgeusia. Rash, pruritis, alopecia, exfoliative skin reactions including Stevens-Johnson syndrome, toxic epidermal necrolysis. Cream may cause allergic reactions, blisters, discomfort/pain, oedema, irritation, peeling/exfoliation, pruritus, rash, stinging/burning. **Use in pregnancy:** Do not use during pregnancy, suspected pregnancy and breast-feeding.

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### *How much do you really know about your baby's skin?*

The first few years of a baby's life are the most crucial for skin development. Damage that occurs during the first five years of life affects a person's skin in the future. Most skin damage occurs in this time because a baby's skin is thin and highly absorbent, meaning it is more susceptible to chemicals and sun damage.

Babies are prone to dry skin as the sebaceous glands do not fully develop until they reach the age of 9. What's more, a baby's skin surface area is over twice the size of an adult's, when compared to their body mass, which means there is greater necessity to protect.

### *So how can you protect your baby's skin?*

It is essential to use a high factor sunscreen at all times, but due to the high absorption levels of a baby's skin not just any product will do. Most sunscreens contain harmful chemicals such as Parabens and while initially these will protect from sunburn they sensitise the skin and can lead to skin allergies and problems in the future.

It is a common belief that exposure to sunlight is beneficial to babies as the sun's rays boost Vitamin D levels in the skin, however UV's rays can be harmful and not only when in direct sunlight. Sunscreen should be used at all times as sunlight can penetrate windows in homes and cars. It is imperative that this sunscreen is water and sand resistant with mineral protection qualities.

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**100% mineral filter:** ABCDerm Protection Solaire creates a physical barrier on the skin's surface, staying on top of the skin to provide total protection against harmful UV's rays. A mineral filter is important as it will not be absorbed by the fragile skin of a baby, unlike the chemical filters used in normal SPF products.

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ABCDerm caters to all skin types, with 15 different skin care products especially for babies, catering to every baby's needs from sun protection to daily hygiene. ABCDerm has high ethical standards and a commitment to educating parents about the risks of sun exposure. The production of products follows an exclusive set of dermatological standards including safety, efficacy, tolerance and traceability.

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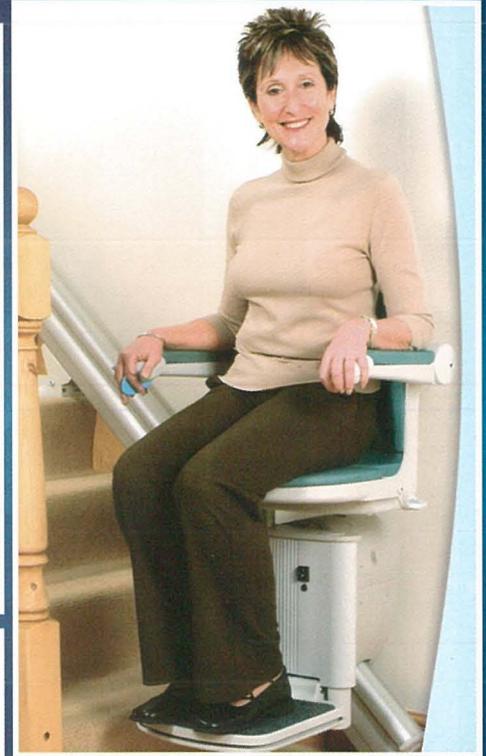
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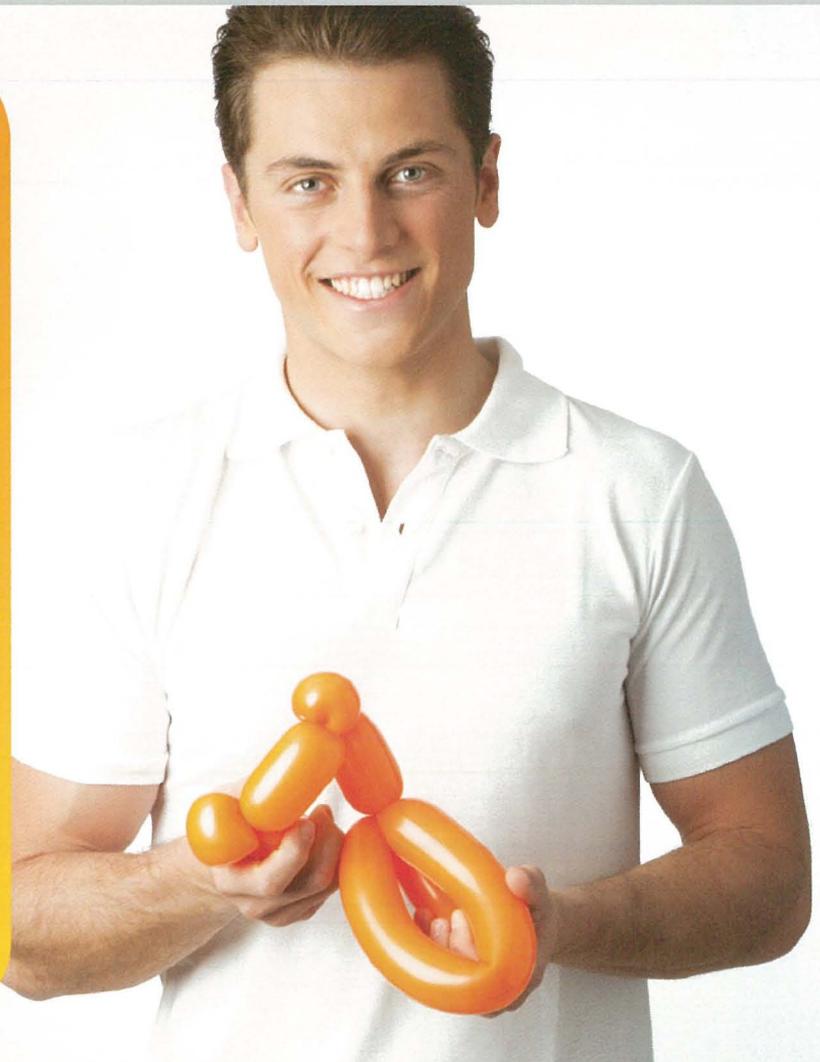
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## SILVER IN WOUND CARE

## The delicate balance!

**Background:** Treatment of antibiotic-resistant bacterial infected wounds poses a major problem in wound care. The development of silver-containing wound dressings has improved the local management of critically colonised and infected wounds. Silver is a broad-spectrum agent effective against a large number of Gram-positive and Gram-negative microorganisms, many aerobes and anaerobes, and several antibiotic-resistant strains such as methicillin-resistant staphylococcus aureus and vancomycin-resistant enterococci<sup>2</sup>. Unfortunately, released silver ions are cytotoxic to human cells, and there is an inherent problem balancing antimicrobial activity against cytotoxicity. Technically, this issue can be addressed by controlling silver ion release by varying the amount of available silver in the dressing, the surface area of the silver particles and the chemical composition of the silver preparation<sup>1</sup>. Although all silver dressings are assumed to be safe and effective, it is important to note the ways in which silver acts physically and chemically<sup>2</sup>.

**How it works:** Silver ions absorbed into the wound site, bind to bacterial cell membranes and are transported into the cell. Interfering with the membrane transport system, silver ions impede the bacterial cell's energy source and disrupt peptidoglycan within the wall, causing structural damage. Inside the cell they bind to DNA, impairing cell replication; they also bind to and inactivate intracellular enzymes. The bacterial cell is then prevented from growing or replicating, and often dies as vital components leak through a weakened cell wall<sup>2</sup>.

**Physical and Chemical Properties:** Different isotopes of the same element behave the same chemically but have different physical properties, which can affect their clinical behavior. The total amount of silver in a dressing, as well as its crystalline structure, contributes to how much and how quickly silver is dispersed from the dressing onto the wound surface. If a given amount of silver is divided among a large number of smaller crystals, its chemically active surface area will be greater than when the same amount is divided among fewer, larger crystals<sup>2</sup>.

**Antimicrobial Effects and Toxicity:** Silver compounds in various wound products differ in the manner and speed with which they release the bactericidal silver ions<sup>5</sup>. With enhanced bacterial killing effects, there is also concern clinically that too much silver could be delivered into the tissue, resulting in adverse effects on wound healing<sup>6</sup>. Three in-vitro studies have shown that the release of nanocrystalline silver from dressings is toxic to keratinocytes and fibroblasts<sup>3</sup>. A comparative study of 5 different Silver dressings showed a strong inhibition of wound re-epithelialisation occurring when using 2 of the dressings<sup>7</sup>. Another comparative study of 3 different silver dressings showed that nanocrystalline silver results in a fast and strong silver release, associated with significant cytotoxicity<sup>1</sup>.

**The way forward:** Indiscriminate use of any material is inappropriate and product choice should be based on published scientific evidence<sup>4</sup>. Although some silver product companies will boast about how much silver their dressing contains, it has still not been shown that a larger amount of silver in a dressing necessarily results in better clinical outcomes<sup>2,5</sup>. Cytotoxic effects of silver should also be considered when deciding on wound care dressings<sup>9</sup>. The choice of an appropriate antibacterial dressing should be based on the wound type and condition and on clinically applicable measures and not on any single laboratory parameter<sup>6</sup>. Cost is also an important factor to guide dressing choice<sup>10</sup>, considering that NHS (UK) expenditure on silver dressings in 2006/7 amounted to £25million<sup>11</sup>.

**Conclusion:** Selection of the right dressing is vital for successfully managing infected wounds and those prone to infection. Besides balancing the antimicrobial action with cytotoxicity, the ideal dressing should also minimize trauma on application and removal and conform well to the wound bed<sup>12</sup>. Clinical evidence and laboratory tests have shown the beneficial profile of action, of low toxicity and potent antimicrobial action, of sustained release silver dressings<sup>1,8,12</sup>.

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helps healing. Tanya Carabott, P.Q.Dip.HSc (Mgmt)

Note: This is a revised version of the original article published on "IL-MUSBIEH - NRU. 48 • SETTEMBRU 2010".

## THE HOSPITAL, PLACE OF EVANGELIZATION

# A human and spiritual mission

In the nineteenth century the English poet, political thinker and feminist, Elizabeth Barrett Browning, wrote these stunning words: "How many desolate creatures on the earth have learnt the simple dues of fellowship and social comfort in a hospital". Her words greatly exceed the literary domain and forcefully enter into the prophetic aspect of life! After more than a century and a half later it seems that the Pontifical Council for the Pastoral Care of Health Care Workers seriously undertook Browning's reflection and enfolded it within a three-day conference, which took place from November 15 to 17, 2012, in the Synod's new Hall in the Vatican. The theme chosen for this 27<sup>th</sup> International Conference centred on "The Hospital, Place of Evangelization: A Human and Spiritual Mission."

Historically, the Church has always been faithful to Jesus' command, (which the Latin Vulgate translates it from the original Greek as) *Euntes docete et curate infirmos* (see Matt 10:6-8, meaning, "Go, preach and heal the sick). Throughout the ages Christ's believing community sought in many different ways to apply concretely her Founder's directions: "Go rather to the lost sheep of the house of Israel. And preach as you go, saying, 'The kingdom of heaven is at hand.' Heal the sick, raise the dead, cleanse lepers, cast out demons. You received without paying, give without pay" (Matt 10:6-8). In the Johannine Gospel Jesus reassured us that "the poor you always have with you" (John 12:8). In other words, irrespective of our world's progress, there is always and surely will remain till the end of time the dire need to care for the suffering population. This point has been poignantly emphasized by Pope Benedict XVI in his

first encyclical on Christian love, *Deus Caritas Est*, when he said: "Love—*caritas*—will always prove necessary, even in the most just society. There is no ordering of the State so just that it can eliminate the need for a service of love. Whoever wants to eliminate love is preparing to eliminate man as such. There will always be suffering which cries out for consolation and help. There will always be loneliness. There will always be situations of material need where help in the form of concrete love of neighbour is indispensable" (§ 28).

In his interesting presentation piece to the Conference, Archbishop Zygmunt Zimowski, president of the Pontifical Council for the Pastoral Care of Health Care Workers, stated that within the context of the seemingly relentless secularization process which western societies are deeply entrenched in, the respect due to the uniqueness of every person concomitant with his or her dignity and experience always remain as a top priority in the health care sector. The technical-scientific progress of medicine can never eclipse or neglect such a key principle in the art of health care. Moreover, animated by Jesus' word, "I was sick and you visited me" (Matt 25:36), Christian health care workers are duty-bound to see Jesus Christ himself in every suffering person they are to serve. Archbishop Zimowski wrote: "For the workers of pastoral care in health and for all baptized people, there is thus a solicitation to see in the face of the suffering person the face of Our Lord Jesus Christ, to offer help without prejudice by implementing what was demonstrated by the Good Samaritan in the gospel parable named after him".

It is when the patients' human dignity is respect

and promoted that hospitals truly become special places of evangelization. The Church has always nourished a deep respect for the suffering's dignity. This explains why, according to the Doctrinal Note on Some Aspects of

Evangelization, the Church is existentially "the bearer of the presence of God . . . [and] the instrument of the true humanization of man and the world" (§ 9). By her extraordinary apostolate of mercy the Church is an authentic teacher of God's compassion for the needy ones.

Compassion is one of the core values that make up an effective hospital setting. In fact, in his address to the participants of Health Care Workers Conference, the Holy Father expressed his ardent desire that health care employees endorse the enduring value of compassion in order that the hospital environment becomes more human. "It is to be hoped that the language of the "Christian science of suffering" – to which pertains compassion, solidarity, sharing, abnegation, gratuity, the gift of self – becomes the universal lexicon of those who work in the health care field. It is the language of the Good Samaritan of the Gospel parable, which can be considered, according to Bl. John Paul II, 'one of the essential elements of moral culture and universally human civilization' ("Salvifici doloris," 29)".

Compassion can easily become a cliché if it is not appropriately translated into life-giving initiatives which champion the value of life. Fundamental questions such as the absolute respect of life from conception till its natural end; the humanization of care, in other words, the complete respect owed to the sick person because of his identity and lived experience together with the quality of palliative care, should be responsibly fostered. When this occurs the carer's job becomes really a saving mission because he/

she is personally transformed into a faithful icon of the charitable Good Samaritan who learns and welcomes the suffering face of Jesus Christ, sacramentally present in the suffering face of the human person in need.

Hospital is a teandric place. In it God and the human person encounter one another. The more the Christian health worker is deeply enamoured with Jesus the more his values become his/hers. By cultivating Jesus' attitude of staunchly defending the human dignity by the way the health carer cares for the whole person under his/her care the Christian care worker ends up being a valuable witness of the Risen Christ victorious over sin, death and any kind of narcissistic and utilitarian tendencies. Thus, hospital is an extraordinary opportunity to celebrate human weakness and the strength of the human spirit. Furthermore, hospital demonstrates that humanization and communion prevail over loneliness, self-pity and the closing of oneself. The sickbed can be turned into a refreshing meeting with the divine through the sacraments of reconciliation, anointing of the sick, communion and baptism. Hence, the hospital can be a sanctuary of humanity and a melting pot of peoples.

Towards the end of his address to the participants of the Health Care Workers Conference the German Pontiff said: "Now more than ever our society needs 'good samaritans' with a generous heart and with arms open to all with the awareness that the 'measure of humanity is essentially determined in relationship to suffering and to the sufferer' ("Spe salvi," 38). This 'going beyond' the clinical approach opens the dimension of the transcendent to you". Will you and me, as health care workers, facilitate the glory of the risen crucified Christ to shine in the various wide spectrum of health in which both of us serve?

Fr Mario Attard OFM Cap

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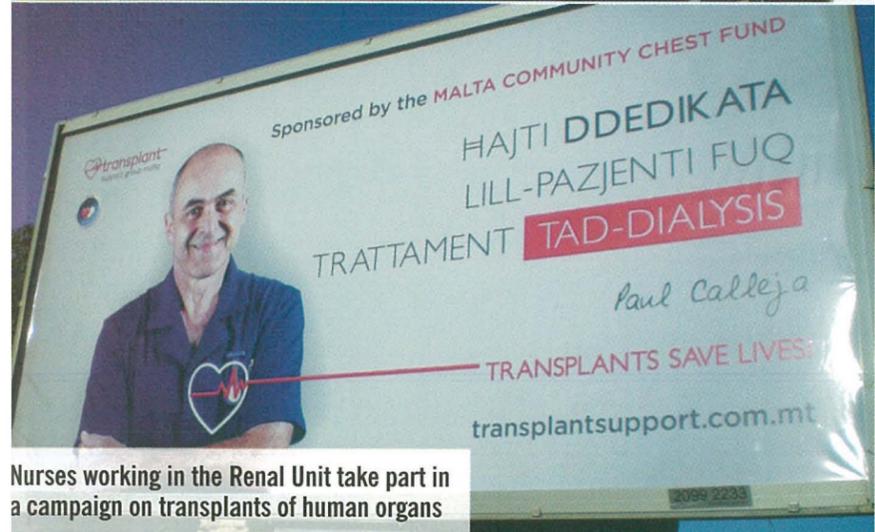
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MUMN is continuously organising courses on several topics at the Union's Offices. Two courses that were organised this year were the Management Course and the ECDL Course



MUMN attended ICN Conference in Melbourne



Nurses working in the Renal Unit take part in a campaign on transplants of human organs



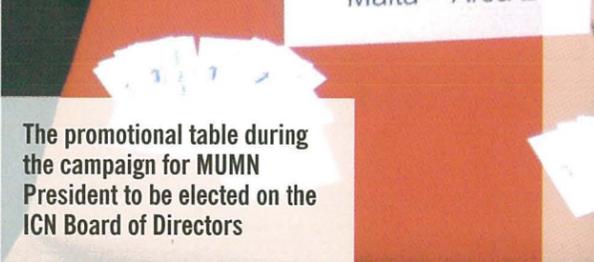
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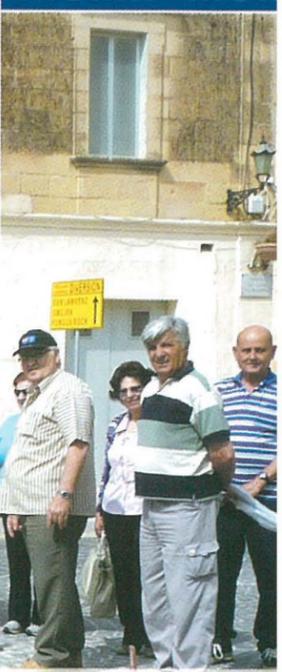
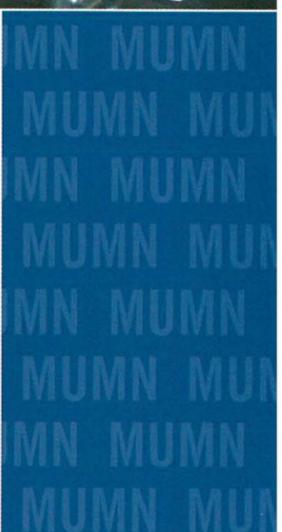
Mr. Mario Cutajar Principal Permanent Secretary, addressed FORUM Officials at MUMN Offices



Billboards were set up as part of MUMN's nursing marketing campaign



The promotional table during the campaign for MUMN President to be elected on the ICN Board of Directors



The MUMN Pensioners' Group Committee organised an event for their members

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## Chocolate Mascarpone, Amaretti Biscotti

### Preparation

In a mixer with the whip attachment, whip the yolks and the sugar until white and fluffy. Add mascarpone and whip until incorporated. Add the double cream, vanilla essence and whip slightly more until thick consistency. Melt the chocolate, leave to rest a bit and fold with the mascarpone mix.

Meanwhile wet the crushed amaretti biscuits with the brandy and divide into the individual glasses. Place the chocolate mixture in a piping bag and pipe into each glass. Garnish with raspberries and sage flowers.

### For 6 people:

- 5 egg yolks
- 150g sugar
- vanilla essence
- 250g Mascarpone
- 100ml Double Cream
- 150g melted dark chocolate
- 100g Amaretti Biscuits crushed
- 1 tot brandy

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# Latest updates on EU Policy & Legislation

April 19, 2013

## Industrial Relations in Europe 2012

The European Commission Staff Working Document, 'Industrial Relations in Europe 2012', reviews trends and developments in the relationship between workers, employers, their respective representatives and public authorities at national and EU level during 2010-12. It looks at how the continuing crisis and reforms implemented in response may be having a more fundamental impact on industrial relations, as conflict is increasing. In certain countries, fiscal consolidation has resulted in unfavourable settings for social dialogue, especially in the public sector, where reforms have been accelerated. Despite this, the report concludes that structured social dialogue is still the right approach for building consensus and ensuring the sustainability of economic and social reforms.

The involvement of the social partners (workers' and employers' representatives) in government reforms is vital, as solutions found through social dialogue tend to have wider acceptance in society, to be easier to implement in practice

and to be less liable to give rise to conflict. Consensual agreements involving the social partners therefore help to ensure the long-term sustainability of economic and social reforms. Well-structured social dialogue can effectively contribute to the economic resilience of Europe. In fact, countries in which social dialogue is well-established and industrial relations institutions are strong, are generally those where the economic and social situation is more resilient and under less pressure. The problem-solving potential of social dialogue can help to overcome the current crisis. The report illustrates how the outcomes of European social dialogue can make a real difference to the working lives of Europeans, for example on improved health and safety at work and working conditions.

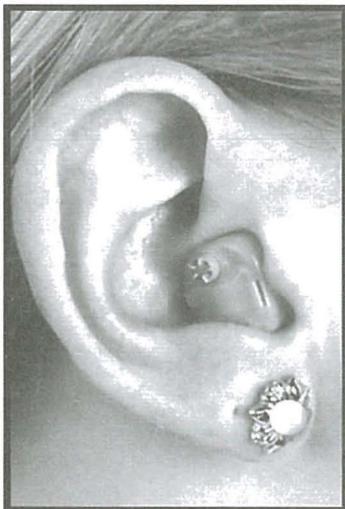
In light of the government spending cuts in many Member States, the report focuses on industrial relations in the public sector: public administration, education and healthcare. Governments have prioritised efficiency gains within public sector restructuring. In some countries this process has continued, with a more balanced approach and limited conflict, preserving the scope for collectively agreed solutions between trade unions and the public sector. Elsewhere the methods chosen to implement decisions have often excluded the use of social dialogue. This trend is not limited to those countries receiving financial assistance from the EU and the International Monetary Fund. As a result, in many Member States, tax increases and government spending cuts triggered a wave of industrial conflicts and highlighted the contested nature of some of the reform measures that were not subject to social dialogue.

The report also analyses in depth the state of social dialogue in Central and Eastern Europe. While there is wide diversity between countries in the region, all of them - with the notable exception of Slovenia - have weak and fragmented industrial relations institutions. In fact some reforms actually undermine the involvement of social partners in introducing changes. The report shows that revitalising national industrial relation systems in order to promote and restore consensus is essential to ensure the long-term sustainability of the economic and social reforms underway.

Other issues examined in the report include the involvement of social partners in unemployment and pension system reforms and in the transition towards an economy that is more sustainable and less dependent on fossil fuels. While in countries such as Belgium, France, The Netherlands and Spain trade unions were involved in the pension reform process, elsewhere the role of social partners has been minimal, leading to conflict. With respect to climate change, the report documents that social partner activities in this area are on the rise and that their attitude to the green agenda is increasingly supportive.

Commission Staff Working Document, 'Industrial relations in Europe 2012'

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## Apprezzament Tislima mill-qalb... Valerie Ghigo (1972-2013)

Sirna ħbieb f'Labour Ward fl-Isptar Karen Grech. Dan Simur lura 18-il sena ilu, eżattament meta bdejt naħdem bħala *midwife*. Għamilt żmien naħdem ma' Valerie fl-istess *shift* u għaldaqstant, il-ħbiberija tagħna bdiet tikber sew.

Madwar 5 snin ilu, Valerie giet fuqi u qattli li kellha l-marda tal-kanċer. Inħsadt mal-aħbar li qattli u wgħedtha li ser inkun magħha tul it-triq kollha sabiex tkun tista' tiġġieled din il-marda. Matul dawn is-snin, kienu diversi kollegi ta' fuq il-post tax-xogħol li flimkien għamilna dak kollu possibbli sabiex ngħinu lil Valerie. Niftakar li l-ewwel ħsieb kien li norganizzaw attivitajiet ta' *fundraising*; minn *Breakfasts* f'Lukandi ewlenin, ħargiet diversi filgħodu, il-festin f'għeluq l-40 sena tagħha li sar fil-Kazin tal-Banda San Gabriel f'Hal Balzan u l-aħħar attività kienet il-*Party* tal-Milied fis-Sala tal-Kappillan għewwa s-Swatar. Dawn is-swali kienu ngħataw b'xejn biex dawn l-attivitajiet saru possibbli.

Niftakar l-ewwel attività kien il-*Breakfast* fejn wieħed seta' jinnota li diversi kollegi u benefatturi oħra wrew li kienu lesti jagħtu l-kontribut massimu tagħhom kemm permezz ta' għotjiet u kemm ta' diversi rigali. Dan kien il-bidu li tani d-determinazzjoni u l-kuraġġ li ngħin lil Valerie għax il-bżonnijiet tagħha kienu kbar. Niftakar x'sorpriza kienet ħadet dakinhar tal-party tal-40 sena u x'biċċa xogħol kienet biex inżommu kolloxx sigriet ħalli s-sorpriza tirnexxi. U s-sorpriza rnexxiet

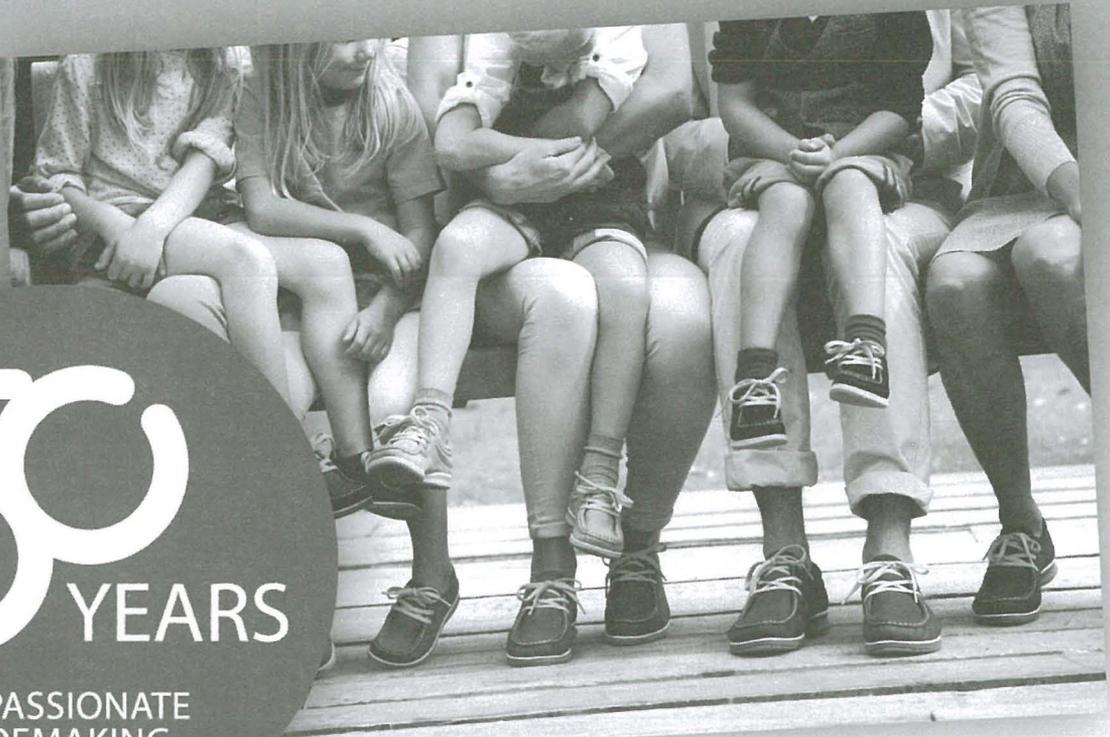
għax fis-sala kien hemm 'il fuq minn 140 persuna li attendew. Ir-radd ta' ħajr tiegħi jmur lejn dawk kollha li għenu f'din il-ħidma ta' ġbir ta' fondi għall-ħabiba tagħna Valerie.

Minkejja l-problemi li kienet għaddejja minnhom, Valerie kienet dejjem bit-tbissima. It-tgergir ma kienx parti minnha u wisq aktar ma approfittat mis-sitwazzjoni. Kienet l-hena tagħha li tiegħu ħsieb omm fil-ħlas, minkejja li xi drabi ma kinitx b'saħħitha biżżejjed. Ħaġa li għallmitni kienet il-mod kif wieħed għandu japprezza l-ħajja u juża l-ħin kollu possibbli kemm fuq il-post tax-xogħol kif ukoll id-dar mal-familja. Kien jinħass il-vojt tagħha wkoll meta kienet tkun imsiefra għat-terrapija u ma' min kont niltaqa' li jkun jaf lil Valerie, kien jistaqsini dwarha.

Ħdimna flimkien, ħriġna flimkien, iċċajtajna flimkien u studjajna flimkien ukoll. Għamilna d-*Degree* fil-*Midwifery*, fejn għal darb'oħra reggħet spikkat id-determinazzjoni ta' Valerie li minkejja li kienet qed tiegħu t-terrapija, kienet qed tistudja sabiex tikseb id-*degree*. Dan imnaxxielha tagħmlu wkoll b'ħilitha kollha.

Diffiċli li wieħed jispjega l-vojt li ħalliet Valerie. Il-fidi tagħna tgħina nifhmu u naċċettaw li Valerie qegħda f'post aħjar mingħajr tbatija. Valerie, minn fejn qegħda itlob għalina ħalli għada pitgħada nerggħu niltaqgħu fil-ferħ li ma jispicċax.

Doreen Cassar - Midwife



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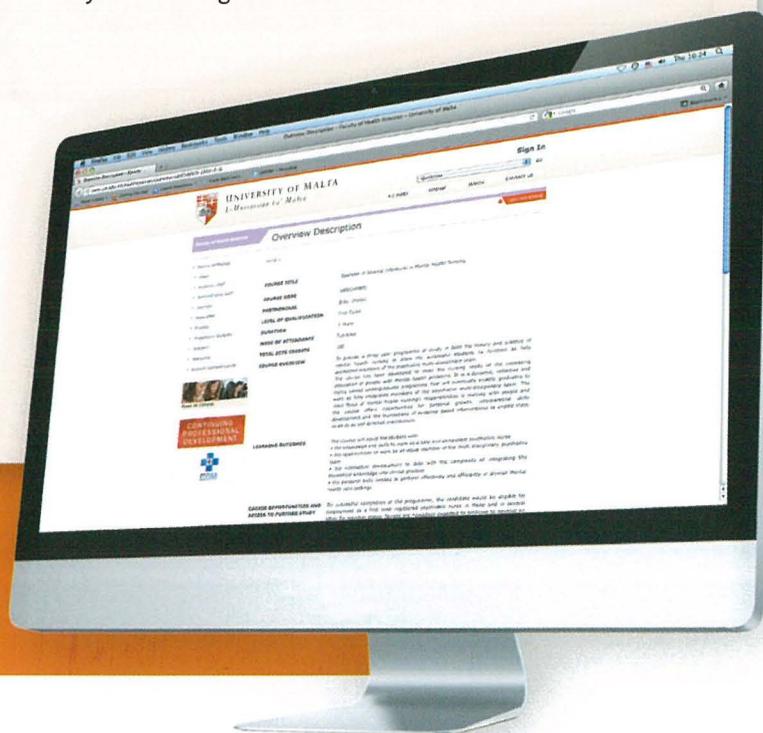
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**References:** 1. Fewtrell MS *et al*. *Paediatrics* 2001;107(6):1291-1297. 2. Lucas A. St James-Roberts I. Presentation at the 105th Ross Conference on paediatric research, Florida, November 1994. 3. McGeorge DD. *Br J Plast Surg* 1995;48(2):115. 4. Fewtrell MS *et al*. *J Hum Lact* 2001;17(2):126-131. 5. Infant Feeding Bottle Design, Milk Intake, Growth & Infant Behaviour: A Randomised Trial. Presented at Second Congress of the European Academy of Paediatrics, Nice, October 2008. 6. Postpartum Care of the Mother and Newborn: a practical guide, Report of a Technical Working Group, World Health Organization Available at [http://www.who.int/reproductivehealth/publications/maternal\\_perinatal\\_health/MSM\\_98\\_3\\_en/index.html](http://www.who.int/reproductivehealth/publications/maternal_perinatal_health/MSM_98_3_en/index.html) Last accessed February 2010.

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## PROMOTING THE VALUE AND COSTEFFECTIVENESS OF NURSING

Evidence shows that nursing is a cost effective yet often undervalued and underutilized health care resource.

Nurses must clearly articulate and demonstrate the value and costeffectiveness of nursing and nursing outcomes to consumers, other health providers and policymakers at all levels. They must also be able to negotiate and advocate for the resources needed to provide safe care.

Nurses have a responsibility to engage in research and develop innovative models of care delivery that will contribute evidence of nursing effectiveness to planning, management and policy development.

Nursing education, especially management and leadership development programmes, must help nurses become skilled and articulate in demonstrating the value and cost effectiveness of nursing to the health services. Nursing education institutions, and where relevant nursing regulatory bodies, should regularly review curricula to ensure the inclusion of content related to the value and cost effectiveness of nursing.

National nurses associations (NNAs) have an important role in helping determine and influence health and public policy that promotes cost effectiveness and quality of care.

National nurses associations must develop strategies to actively promote the participation of nursing in health service decisionmaking, nursing and health research, and health and public policy development. This requires developing and supporting strategies for the preparation of nurse leaders who are skilled and articulate, and able to demonstrate as well as promote the value and cost effectiveness of nursing to the health services.

Nurses must assert their professional involvement in policy formulation at all levels.

With rising health needs and health care costs, which includes costs associated with the provision of nursing services, nurses must take the initiative in defining, examining and evaluating the health outcomes and costs of their activities.

Nurses, especially nurse leaders, must have a good understanding of the purpose and nature of health care reform, and the contribution nursing can make at all levels of health care delivery, and in planning, management and policy development for health care services. Where health care reform is in its planning stages, nurse leaders must play a leadership role in policy development related to the appropriateness, nature and purpose of health reform.

The International Council of Nurses (ICN) and member associations can assist nursing to develop the capacity for dealing with costeffectiveness in health care, by:

- Promoting the role of nursing as a core resource in cost-effective care and as a critical contributor to decision making on healthcare spending.
- Offering nurses educational opportunities to gain knowledge of political skills, economic principles, budgeting and resource use and costeffectiveness in health.
- Supporting leadership and management development that includes the role of nurses in resource management, decisionmaking and policy development.
- Promoting and supporting research and evaluation that links and validates costing methodologies to nursing and health outcomes.
- Encouraging the development of database systems that permit comparison of outcomes across settings to best approaches to care and the most effective design of nursing systems.
  - Facilitating information dissemination and interactive networking on costeffectiveness research, costsaving strategies and best practice standards.
    - Establishing professional networks with relevant stakeholders, to foster collegial collaboration and exchange of ideas and information aimed at promoting quality and cost effectiveness.
      - Promoting equity in terms and conditions of service for nurses, to recognize and support their role in promoting cost effectiveness and quality of care in multidisciplinary settings.

# INDUSTRIAL ACTION

The International Council of Nurses (ICN) expects nurses to have equitable remuneration and decent working conditions, including a safe environment. As employees, nurses have the right to organise, to bargain collectively, and to take industrial action. Strike action is considered the measure of last resort; to be taken only after all other possible means to conclude an agreement have been explored and utilised. ICN defines a strike as employees' cessation of work or a refusal to work or to continue to work for the purpose of compelling an employer to agree to conditions of work that could not be achieved through negotiation.

Effective industrial action is compatible with being a health professional so long as essential services are provided. The complete abandonment of ill patients is inconsistent with the purpose and philosophy of professional nurses and their professional organisations as reflected in ICN's Code of Ethics for Nurses.

When taking industrial action, including during a strike, a minimum essential service to the general public must be maintained.

Other principles to be upheld include:

- Crisis intervention by nurses for the preservation of life;
- Ongoing nursing care to assure the safety and survival of those unable to care for themselves;
- Nursing care required for therapeutic services without which life would be jeopardised;
- Nursing involvement necessary for urgent diagnostic procedures required to obtain information on potentially life-threatening conditions;
- Compliance with jurisdictional legislation and the NNA-specific policies or guidance on the implementation of industrial action;
- Strike action should only be undertaken as a last resort and following a participative process which observes the principles of industrial democracy and representation within the NNA;
- Nurses' right to take industrial action in the case of a breakdown of negotiations may only be curtailed if independent and impartial machinery such as mediation, conciliation or arbitration is established.

National nurses' associations (NNAs) are responsible social partners and must develop education and training programmes that adequately prepare their representatives, nursing leaders and nurse employees in the practice of the various methods of negotiation as a means for resolving their employment concerns - i.e. conciliation, arbitration, collective bargaining - as appropriate in each country/province. Individual nurses must provide input to their NNAs so that policy and decision-making are relevant and consistent with the realities encountered in daily practice.

ICN provides technical support to NNAs addressing labour issues and encourages the International Labour Organization to positively influence national policy in each country.

NNAs, as professional associations and/or trade unions, are affected by health sector industrial action. They must therefore develop proactive policies and contingency processes as well as structures to guide their members' professional attitude and behaviour in such situations. At the same time, NNAs must be proactive and assertive to improve the nurses' socio-economic

welfare before industrial action becomes necessary. Evaluations of industrial actions (including the responsibility of main stakeholders) must be undertaken so that lessons learned may improve future negotiations.

Any industrial action undertaken should comply with jurisdictional legislation. The ICN condemns any form of victimisation against strike leaders and participants or their relatives or associates.

ICN and NNAs recognise the potential strength of interdisciplinary partnerships within the health and social sectors during negotiations with public and private employers.

ICN and NNAs oppose the deliberate use of strike breakers, a practice that weakens the pressure for credible social dialogue.

## BACKGROUND

The fundamental responsibility of the nurse is fourfold: to promote health, to prevent illness, to restore health and to alleviate suffering. In certain cases, nurses may find themselves in situations where industrial action is necessary to ensure the future delivery of quality care by qualified personnel.

While social dialogue is widely recognised as the principal and most effective means of resolving professional and workplace-related problems, frustrated employees may take industrial action in cases where the option of employer/employee negotiation has been unsatisfactory, unsuccessful or refused. Where deficiencies in the quality of working life and the economic rewards of nurses have become so serious as to affect the long-range prospects for maintaining high standards of nursing care, nurses may choose to take industrial action to bring about needed changes. In extreme situations, strikes have occurred and on occasion have resulted in wide public and intra-professional debate.

Industrial action, maintaining essential services has been used successfully by professional trade unions in the past to initiate social dialogue, improve the quality of care provided as well as the working conditions of nurses/health workers. A range of industrial action is possible. "Selective strikes" have provided the necessary impact to advance negotiations while generating less disruption to patient care. In certain cases, token strikes (e.g. one hour demonstrations) may generate the impetus to initiate social dialogue. Other forms of industrial action may be undertaken as an initial or complementary measure, including but not limited to the cancellation of all elective interventions, a work-to-rule policy and/or the withdrawal of services involving non-nursing duties, e.g. domestic, clerical, portering, catering.

The potential impacts and outcomes of a negotiation and/or strike process should be risk-assessed, including the impact on patients, other stakeholders and social outcomes. Relevant supports required for the parties involved in each step of the action undertaken should be identified and provided (e.g. financial, emotional).

If industrial action is taken, national/provincial legislation may determine the conditions under which such measures are implemented. Essential services are commonly accepted service levels applied during industrial action that are often based on evening/night shifts and weekend staffing ratios and protocols.



## MANAGEMENT OF NURSING AND HEALTH CARE SERVICES

Nursing has a responsibility to contribute to health planning and policy, and to the coordination and management of health services. The International Council of Nurses (ICN) expects nurses to contribute to health policy locally, nationally and internationally through management and leadership roles at all levels and through direct engagement and advocacy by National Nursing Associations (NNAs). The need for excellence in management of nursing and health systems must be actively promoted.

ICN firmly believes that nursing services must be directly managed by nurses. In a situation where there are non-nurse managers whose staff includes nurses, ICN believes that nurse leaders in these situations must have authority to give direction on matters pertaining to professional nursing. In all such situations it is the nurse who is accountable for the scope and standards of nursing practice.

In addition, ICN believes that nurses are well equipped to manage a wide range of health services.

ICN expects nurse managers to receive equal opportunity, preparation and remuneration for management, policy development and leadership as do other health personnel being prepared for senior positions in the health sector.

### BACKGROUND

The roles and functions of nurse managers are continually being re-defined in the context of health sector change.

Leadership is an essential component of management. It is critical that nurse leaders are well prepared to assume roles as managers in nursing and health care services, in education or in health policy. Nursing leadership includes coaching and mentoring others, and creating the environment for ongoing development and quality care.

Strong nursing leaders support staff in their practice by addressing both professional and clinical issues, promoting job satisfaction and improving the quality of care for health consumers. Specifically, nurses at executive levels play an integral role in the delivery of quality care by providing:

strong and effective leadership; social influence; strategic direction; and, authority within an organisation.

Excellence in the management of nursing and health care services must be actively promoted. Professional nurses associations can strategically influence to ensure that the profession is engaged in health planning and policy.

Cook M.J. 2001. The attributes of effective clinical nurse leaders. *Nursing Standard*, 15(35), 33-36.

Maintaining networks and linkages with and between key stakeholders is essential to effective leadership and management. Also critical is the ability to continually assess the environment, to monitor performance and to create or adapt to change as required.

Educational preparation for management will vary according to the roles and career paths of nurse managers. ICN has a role in promoting sound education for management and leadership. Professional nursing associations can assist by identifying relevant opportunities and promoting these to their members. Individual nurses must take responsibility for their own education, and develop the ability to plan and manage this strategically.

Nurses need to select appropriate uni- or multi-disciplinary programmes to prepare them effectively for management, policy development and leadership in different settings and at different stages of their professional and career development. Preparation should reflect the importance of continuous learning that is adapted to changing needs and expectations. It should include emphasis on the development of relevant skills and attributes, not just the acquisition of knowledge.

Achievements of nurse managers need to be rewarded in the same ways as other managers. At the same time nurse managers need to demonstrate the benefits of their inclusion in key positions. Appropriate position classifications, equal to other managers at the same level and according to their professional attributes and their level of responsibility, should apply to nurse managers.

# The 4-Generation Gap in Nursing

Laura A. Stokowski, RN, MS, Disclosures Apr 11, 2013

## CALLING ALL GENERATIONS

A nurse manager, desperate for more staff, telephones 4 of her nurses to ask whether they will pull an extra shift.

- The first nurse says, "What time do you need me?"
- The second nurse says, "Call me back if you can't find anyone else."
- The third nurse says, "How much will you pay me?"
- The fourth nurse says, "Sorry, I have plans. Maybe next time."

According to Bonnie Clipper, author of *The Nurse*

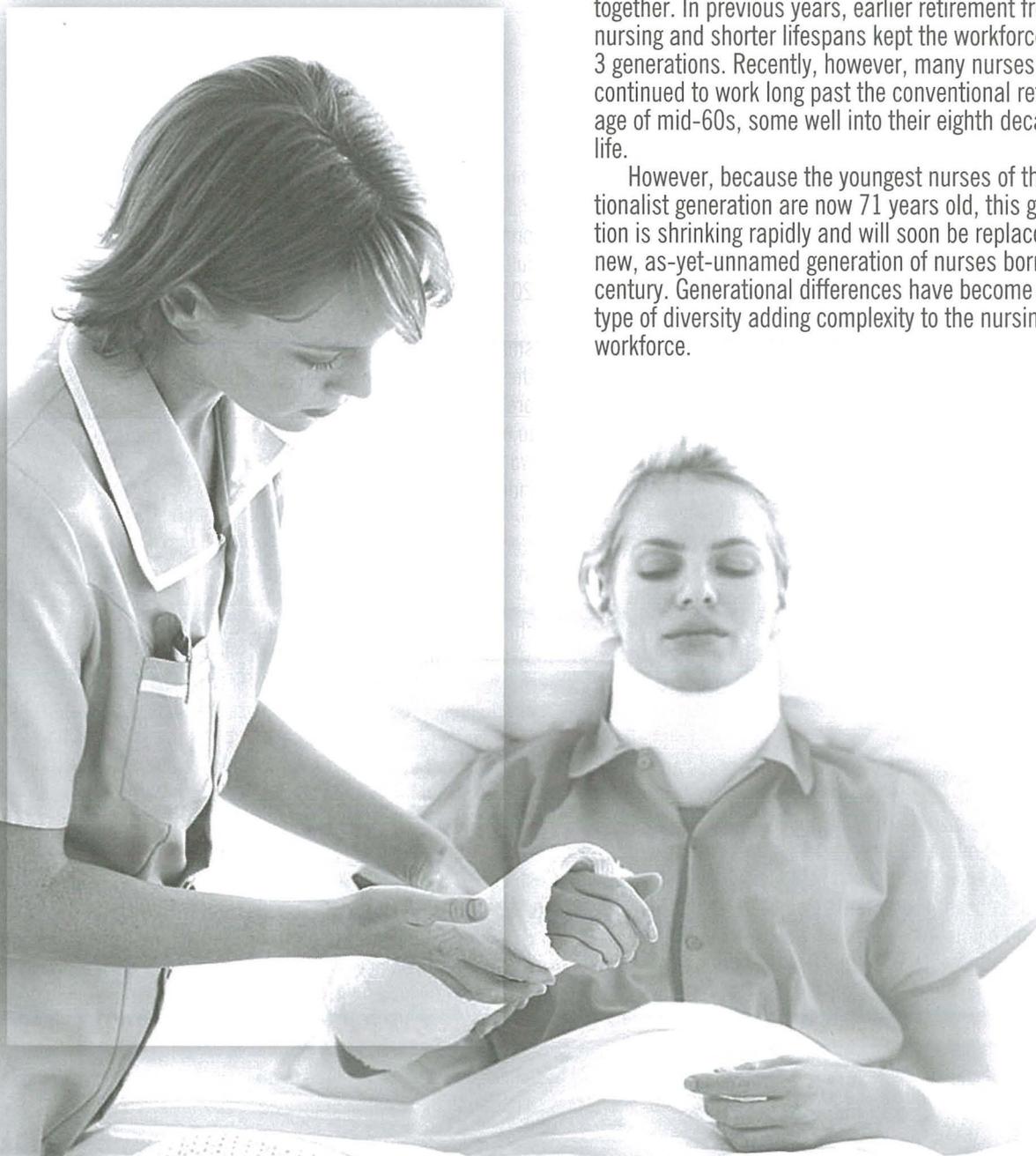
*Manager's Guide to an Intergenerational Workforce*, these different responses are typical of the 4 different generations of nurses currently working side by side in nursing.

In the same order as the responses above, these generations are:

- The "traditionalists" (also called the "veterans");
- The "baby boomers" ("boomers");
- The "X generation" ("Xers"); and
- The "Millennials" (also known as the "Y-generation" or "nexters").

Social scientists maintain that this is the first time in history that 4 generations of nurses have worked together. In previous years, earlier retirement from nursing and shorter lifespans kept the workforce to 3 generations. Recently, however, many nurses have continued to work long past the conventional retirement age of mid-60s, some well into their eighth decade of life.

However, because the youngest nurses of the traditionalist generation are now 71 years old, this generation is shrinking rapidly and will soon be replaced by a new, as-yet-unnamed generation of nurses born in this century. Generational differences have become another type of diversity adding complexity to the nursing workforce.



**WHAT ARE GENERATIONS?**

If you are averse to generalizations and stereotyping, you might resent being pigeonholed as belonging to a specific group defined largely by the year of your birth. However, if you have experienced the social phenomenon known as the “generation gap” in the workplace, you might appreciate a greater understanding of the intergenerational differences among your colleagues, from the youngest to the oldest.

A generation is defined less by age or time period than by having similar life experiences (people, places, major events, popular culture), and the various characteristics and attributes common to its members. “It is not a time constraint,” says Clipper. “Time is one of the elements, but you also must consider shared experiences.” Generations typically span about 20 years, although shorter periods can encompass cultural differences. People born around the same time tend to be affected by the same set of experiences, so age is one defining factor (Table 1).

**Table 1. Characteristic of the 4 Generations**

Generation	Birth Year	Proportion of Nursing Workforce	Characteristics
Traditionalists	1925-1942	5%	Dedicated, hard-working, loyal
Baby boomers	1943-1960	40%	Optimistic, productive, workaholic
Generation Xers	1961-1981	40%	Cynical, independent, informal
Millennials	1983-2000	15%	Confident, impatient, social

Clipper emphasizes that “It is important not to over-generalize about an individual based on his or her generation.” Moreover, there is substantial overlap in generations, and some people even straddle generations. Those born near the dividing line between generations (called “cuspers”) can understand, relate to, appreciate, and display the behaviors of both generations.

When defining generations by their typical characteristics, it can be difficult to distinguish a generational effect from a cohort effect. In other words, are the differences between the groups really reflective of generational values, or do they signify characteristics of people at different stages of their lives and careers?

As a colleague, understanding generational differences is important to maintaining effective and satisfying relationships at work. Managers in particular must strive to appreciate these differences if they want to build high-performing teams, establish respect, and create harmony among their staff. The pay-off is higher employee engagement and improved patient care.

**THE 4 GENERATIONS**

“It is natural for youth to be full of hope and full of confidence, and to think that the present is more important than the past, and it is natural for young nurses

to think their elders who advise are croakers and wet blankets.”

This observation, expressed by a nurse in 1935, shows that generational differences in nursing are far from new. With 4 generations, however, we are now seeing much more than just the young vs the old. Clipper describes the experiences and characteristics of the 4 generations of nurses currently working together in healthcare settings.

**Traditionalists (born 1925-1942).** The oldest cohort of workers still in the workforce grew up during the Great Depression and World War II, events that taught them about hard work, responsibility, and sacrifice. This group understands rules, is patriotic and loyal, and dislikes waste. They have a strong work ethic and look to their leaders for direction and guidance. They are likely to remain with the same employer for many years, are the least comfortable with technology, and are the most resistant to change.

**Boomers (born 1943-1960).** Currently the largest cohort in the workforce, boomers were shaped by the equal rights movement, the Vietnam War, presidential assassinations, and the “peace and love” movement. Boomers are the original “workaholics” and “overachievers,” often defining themselves by the work they do and their success. They are independent, critical thinkers who seek financial security, promotions, and a sense of accomplishment and personal fulfillment from work. According to a survey conducted in 2008, boomers are the most productive of the generations.

**Generation Xers (born 1961-1981).** The Xers are the smallest cohort in the workforce. Xers were influenced by the fall of the Berlin Wall, the AIDS epidemic, and MTV. They are the latchkey generation -- the children who went home to empty houses after school because both parents were working. Many are children of divorce. They are considered independent, assertive, and innovative. This group is also well traveled and values individualism. Xers “work to live” rather than “live to work,” and they tend to be less loyal to the organization and less tolerant of authority than previous generations. However, they are flexible and adaptable to change, and they embrace technology.

**Millennials (born 1983-2000).** The Millennials, a large and fast-growing cohort, grew up in the age of domestic and international terrorism, and the explosion in social networking and information technology. They tend to be protective and careful, yet also confident, expressive, optimistic, and -- according to a recent survey -- self-indulgent. They are the least religious, best-educated, and most racially diverse of recent generations. The millennials are strong networkers, sophisticated and street-smart. They like to work in teams but also crave instant gratification, feedback, and recognition. A disadvantage is their impatience: If they are unhappy, they will give up and move on to another job at another organization. With this group, maintains Clipper, “We need to engage them early, allow them flexibility, like allowing them to change units, so they don’t get bored.”

| continued in next issue

## The Importance of Learning ECDL

**E**CDL stands for European Computer Driving Licence. Mainly it consists of ICT which stands for Information and Communication Technology. Learning ICT leads to a very good ECDL knowledge and as you might be aware, nowadays the ECDL certification is an asset mainly in all departments and institutions.

As you might be aware the ECDL Core Course consists of 7 modules and anyone who might have started the course and has not yet finished the 7 modules, must continue to do the tests within a duration of 3 years from the time he/she did the first module exam and got a passmark of 75% or over. New candidates who are to register as from the 1st October, 2013 onwards, are to follow the new ECDL Syllabus that is to be implemented in Malta and that is going to bring some slight changes.

Alas in this article I'm trying to give some brief information. There will be 4 base modules which are to be done as compulsory by all candidates and these consist of:

1. Computer Essentials;
2. Online Essentials;
3. Word Processing;
4. Spreadsheets

Then there are 5 standard modules from which we have to choose only 3. These are:

1. Presentation;
2. Using Database;
3. Web Editing;
4. Image Editing;
5. IT Security

Keeping in mind the basic need of using a computer in our everyday life, I do recommend to select the: Presentation, Using Database and the IT Security as our 3 standard modules. By that we still be working very near to the ECDL Core course and that will cause much less problems due to topics and of course time frame. If anyone would like to select *Web Editing* or *Image*

*Editing* it might cause the problem of time frame as they are more sensitive and new. So I do recommend not to choose these 2 modules.

Course duration will be that of 23 sessions of two hours a week; like previous ECDL courses. When a module is done, one has to attend to a suggested ICT institute where he/she must go to do the module examination. As soon as all the course is finished, a certificate will then be awarded to each candidate.

One must keep it in mind that professional training will be provided all the way during the course by a professional and well experienced tutor. It is an asset that any candidate who wishes to apply for this course must have a laptop on which to practice during the whole course and when at home.

MUMN looks forward to provide this opportunity to all the nursing and midwifery staff. In fact there is a discount in price to all MUMN members to fulfill them with encouragement and support.

This year a group of midwives and nurses attended the course and it was a great success. The lectures were done mainly in English due to present foreign students but I used to explain in Maltese as well to make sure that everyone understood and was able to catch up.

Please note that the next ECDL course will commence next coming October and I recommend that those of you who are interested to do the course, must apply as soon as possible so that one will avoid any disappointments. For further details, kindly contact MUMN and they will be glad to help you.

Looking forward to work with you,

**Ms. Flavia Joanna Grima** (ECDL Tutor)

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 STQARRIJA GHALL-ISTAMPA U X-XANDIR

## MUMN proven right on two occasions concerning the issues in Mater Dei Hospital

Finally two reports on Mater Dei Hospital literally just repeated what MUMN has been recommending for the last five years on the media regarding issues which have been causing huge waiting time in Mater Dei Hospital from its very opening both in the E/A department and the operating waiting list.

The first report was made by a veteran seasoned hospital ex- manager who today occupies the post of Health Commissioner, Mr. Messina, on the waiting time in the E/A department.

The whole Health Commissioner's report can be summarized on basically two solutions. Arranging doctors work practice in the E/A and increase beds in Mater Dei Hospital. For the last three years, MUMN has been stressing that Mater Dei hospital needs at least an added compliment of another 300 beds. Media and some politicians even criticized such recommendations with the dire consequences that the public was left to suffer. Unfortunately to this day, even with the current minister no consultation process has even begun with MUMN on this issue. But what is most important is not the just the consultation issue. But how will the current minister stop all repetitive work indicated by MUMN and confirmed through Messina report? Mr. John Dalli was tackling the same issues three years ago before he was send to Brussels as an EU Commissioner. Why does it take at least four doctors to be admitted in Mater Dei hospital whilst in the private practice just one doctor would be enough for an admission? Who will be changing doctor's practices ? Definitely not by using consultants or heads of departments as advisers who are actually more inclined to defend such practices in their departments !

The primary care will hardly solve the E/A issues since any serous conditions which need investigations or admissions, the primary setting (even with all the improvements) can never offer such a service. So let us stop blaming people who go directly to the E/A directly. Also having medical consultants leading certain committees with purposely chosen nurses by the same consultant is again being used by the same minister which no wonder no

improvements are being made. Thank you Mr. Messina, your input besides that of MUMN will hopefully make the health authorities to start consulting the rightful people.

The second report made by the General Auditor regarding the waiting list and the management of the operating theatre In Mater Dei hospital. I as President of MUMN have even openly challenged every politician that the waiting lists are unknown to the Government since such lists are only kept in the private diary of the consultants. Is this a coincidence, definitely not. Such lists are never given to the Government so that the consultant will maintain his prerogative who is to be operated first. Is the decision always clinical? The public knows better when and who is chosen to be operated at times. Also MUMN welcomes the statement of the General Auditor that theatres are run without a designated management, an issue which MUMN even had to issue industrial actions in Mater Dei hospital but to no avail. Most consultant's lists are over run, no official timings on operation list can be implemented so that certain consultants can operate at their convenience. Unfortunately the General Auditor's report did not refer to the number of operations per consultant (and not by his firm) that are being made ...pity.

This is not an issue where MUMN being a nursing & midwifery union is against doctors...or actually the consultants. But definitely it is time that the present Government gets the bull by the horns, stop beating around the bush like the previous administration and start addressing the hardships of the people. I would also encourage that similar reports either by Mr. Messina or by the General Auditor will be written also on Mt. Carmel hospital. The focus should not always be Mater Dei hospital since there are huge hardships on the patients who are either in patients or out patients.

For once in this country there are other authorities voicing and speaking what MUMN has been saying all along for these last years.

**Paul Pace, President**



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## Open Letter 2nd July 2013

Dr. Godfrey Farrugia  
Minister for Health

Dear Minister,

MUMN would like to point out that your meetings with various hospital managements regarding nursing staff levels are neither coherent, nor realistic and your expectations are far from the actual figures.

MUMN cannot understand how you are promising to provide the following:

1. 63 nurses for the opening of the oncology hospital, later on this year;
2. 54 nurses for casualty and pre hospital at MDH by July latest August, this year;
3. 17 nurses to Gozo to sustain the current services besides your planning of doing more operations would mean more nurses;
4. 40 nurses to Mt. Carmel Hospital which such hospital, due to the transfers taking place without replacement, the whole service collapsed with wards having no nurses. Also level one patients are being left without a nurse and nurses working in MCH will not assume responsibilities if a patient commits any personnel injury including suicide since this lack of staff is not the nurses' fault but your responsibility. Directives will surely be re-issued if not addressed.
5. 35 nurses to Karen Grech Hospital where MUMN is prepared to escalate the directives. Once again due to transfers without replacement the relieving pool for nurses which allowed nurses to take ones vacation leave has been also dismantled;
6. 146 nurses to Mater Dei hospital just to maintain the present services and not as you are planning for opening further areas in the corridors of MDH or other services;
7. 17 nurses to the Health Centers to maintain the current services without opening new clinics such as wound clinics and kidney disease prevention clinics etc.;
8. 15 nurses in SVPR for the dismantled relieving pool.

This implies that approximately the total number of nurses needed are 387.

You should be aware that if all recruits from University pass their exam this year, and if all recruits decide to join the Government service, the number of nurses will not exceed 150 nurses this year.

So between casual nurses who will be seeking re-employment (20 nurses in all) and the realistic figure that might join the Government's work force from University being optimistic might after all not exceed the amount of 140 nurses max in all.

The present situation is challenging even to maintain the current services yet you promise additional nurses to new services in Mater Dei Hospital, Oncology Hospital, Health Centres and the latest being Gozo General Hospital by proposing to increase in the number of operations without increasing the amount of beds in the wards. Not to mention that Gozo General hospital has become like Mater Dei Hospital with patients in the corridors.

It is your prerogative to deploy staff but it is then MUMN prerogatives to issue directives where ward compliments are not being maintained or that the right to take ones vacation leave is cancelled through such lack of insight. This is also a matter of health and safety for the nurses and an issue of safe practice for the patients in our care as nurses.

Due to your lack of consultation with MUMN you are not aware of the nursing shortages due to many factors including reduced hours, retirement, part time nurses and other family friendly measures.

Instead of addressing the problems of shortage of nurses left by the previous administration, you are making the whole situation untenable to all nurses in all Government hospitals and that will put MUMN under pressure to issue industrial actions. This is not a threat since MUMN does not threaten anyone but a "warning" which you always underestimated when coming from MUMN.

The health service is a chain, were all services are important and all depend on each other. Investing in one loop while abandoning other loops will mean disaster.

The ball is now in your feet and MUMN will be monitoring the situation through the 3000 nurses as its members.

**Paul Pace**  
President



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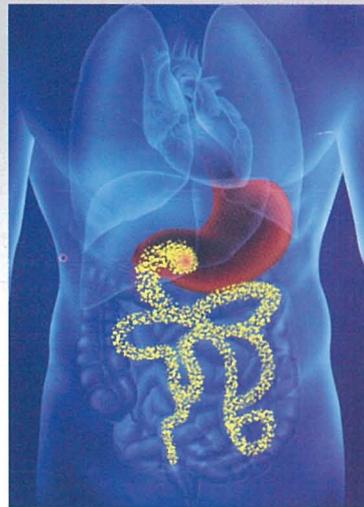
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