MUMN IS PROVEN RIGHT ONCE AGAIN

"Commissioner finds potential for children’s exposure to abuse at Mt Carmel Hospital"
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Cempel fuq 21446205 ghal aktar informazzjoni fuq dan il-prodott
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IL-MAHGĦA
MALTA NURSING AND MIDWIFERY JOURNAL

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BORD EDITORJALI
Louise Cini (Editur) SN, BA Hons. (Youth Work),
Christa Galea (Membru) SN SJ 6 SVPR
Norbert Debono (Membru) EN

KUNSILL MUMN 2011-2015
Paul Pace President
Colin Galea General Secretary
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Lora Pullicino Vice-Chairman Education Committee

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of Midwives and Nurses

Les Lapins Court B, No.3,
Independence Avenue, Mosta MST9022
Tel/Fax: 2144 8542
Website: www.mumn.org
E-mail: mumn@maltanet.net

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"For many of us, the idea of having a job that is truly satisfying — the kind where work doesn't feel like work anymore — is pure fantasy. Sure, professional athletes, ski patrollers, and golf pros may have found a way of doing what they love and getting paid for it. But is there actually anyone out there who dreams of sitting at a desk and processing paper, or watching products fly by them on conveyor belts, or working to solve other people's problems?

Career dreams are one thing; practical reality is often another. When they happily coincide, seize the opportunity and enjoy it! Luckily, when they do not, it's good to know that it is possible to get job satisfaction from a practical choice of career. Job satisfaction doesn't have to mean pursuing the ultra-glamorous or making money from your hobby. You can work at job satisfaction, and find it in the most unexpected places... even in a nursing and a midwifery job satisfaction can be achieved.

The heart of job satisfaction especially in nursing and midwifery, is in ones attitude and expectations; it's more about how you approach your job than the actual duties you perform. Whether you work as a nurse or a midwife, the secret is to understand the key ingredients of your unique recipe for job satisfaction.

There are three basic approaches to nursing and midwifery: is it a job, a career, or a passion? Depending on which type of work you are in right now, the things that give you satisfaction will vary.

- If you work at a JOB, the compensation aspects of the position will probably hold more appeal than anything else, and have the greatest impact on whether you stay or go.
- If you work at a CAREER, you are looking for promotions and career development opportunities. Your overall satisfaction is typically linked with your status, power, or position.
- If you work at a PASSION, the work itself is the factor that determines your satisfaction, regardless of money, prestige, or control.

Inevitably, these are generalizations, and you will probably find that you get satisfaction from more than one approach to work. Being aware of the type of work one is doing, and the things needed for job satisfaction, will help you to identify and adjust your satisfaction expectations accordingly.

Work plays a significant role in our lives. In our quest to be happy and productive, having a strong sense of job satisfaction is important. When you are dissatisfied with your nursing or midwifery job, this tends to have an influence on your overall outlook on life. While you may not be in the career of your dreams right now, it is still your responsibility to make sure that what you are doing is satisfying to you.

By knowing the key elements that go into job satisfaction, you can choose to take control and make the changes you need to feel really satisfied and motivated by what you do. Make one small change at work today that makes you feel good or different — build on that change and create a satisfying environment for yourself.

Let us all together look for the positive thread that nursing and midwifery can give for the good of the patients and for the nurses and midwives themselves.
As you are aware, recently MUMN issued a press release that a child is being exposed to sexual and aggressive behaviour in the admission ward at Mt. Carmel Hospital. MUMN issued such a press release after the nursing staff sent a petition to MUMN stating that this situation would surely result in repercussions attributed to a criminal or a disciplinary action on the nursing staff. Such child should have never been admitted in the admission ward in the first place where even paedophiles can also be admitted.

During these last three months the nursing staff was informing management that such a child is to be removed from their ward. Unfortunately none of the wards in Mt. Carmel are in a position to take such a child as a patient. In the meantime two serious episodes occurred to the boy in the ward which made MUMN take the necessary action.

With all the boasting of the Whistle Blower Act, I was called by the police for interrogation due to political pressures and payback time on me for protecting the nurses. For me having a police superintendent calling at my door was shocking. Especially even having the police commissioner phoning to check that I was being interrogated. But I was glad it was me being summoned by the police and not one of MUMN members. If someone in the health ministry thinks that sending policeman at my door will close my mouth or discourage me from defending MUMN members...I pity that person. I gave the statement and it is even published in this edition of ‘Il- Musbieh’...and I am proud to stand for the nurses since MUMN owns it to its members.

The Minister admitted of not knowing anything which is happening at Mt. Carmel Hospital...no one knows if it is the truth or as we call it, the politics of convenience. Recently a mediator intervened which I have great respect for...since the process of consultation was not existent within the health division. At this stage, it is too early to say if the difficulties being faced by all nurses and midwives will be at least partially addressed through this mediator...but let us hope for the best for the nurses and the midwives.

The nurses' shortages, the lack of staff compliment on the wards, the fear of transfers, the cancellation of leave, the removal of nurses from their wards on a temporary basis, the verbal abuse and harassment from management such as the one at Karen Grech Hospital are just few of the phone calls we receive as MUMN officials. Not to mention the strong stand we had to take as MUMN even to employ the new nurses and midwives. An uphill battle in everything which concerns nurses and midwives.

According to the Health Division it is the directives which are wrong. MUMN removed several directives where an acceptable agreement was reached. MUMN is hoping for more collaborative process which not only the nurses and midwives benefit but also the people who make use of these health services.

Recently another call for application with a number of portfolios was issued again. The Appointments for the last batch of Deputy Nursing Officers was settled and at the Primary Care Department we are promised that with the November pay the payslip is going to be upgraded. A lot of other individual cases including disciplinary actions were settled by all MUMN Officials.

But rest assured, nurses and midwives have a strong voice....a voice loyal to them....a voice which will never be silenced....a voice which is always there for them....a voice which is ready to discuss for the good of both professions it represents....a voice which is ready to take a stand when needed....that voice is MUMN.

Take care and safe guard your health from stress and back injuries.

Paul Pace, President
mis-Segretarju Ġenerali


Colin Galea
Segretarju Ġenerali
Basic Facts of Female Genital Mutilation

Female genital mutilation (FGM) is a widespread practice that is carried out on young girls between the ages of 4 and 12 years, and in some countries on grown women as well. Unlike male circumcision, FGM is not a Religious obligation required by Islam, Christianity, or any of the other known religions. The practice is nevertheless a cultural tradition. The World Health Organisation (WHO) estimates that between 100 million and 140 million women and girls worldwide have been subjected to FGM. It is estimated that 3 million girls and women are subjected to FGM worldwide each year. In Europe, an estimated 500,000 girls and women are suffering from the lifelong consequences of FGM. Every year around 20,000 women and girls from FGM-risk countries of origin (mostly from Somalia, Eritrea or Guinea) seek asylum in the European Union (EU). An FGM-related application for asylum may fall into one of three categories:

- A girl/woman who has not undergone any form of FGM but is at risk.
- A girl/woman who has undergone an FGM procedure and is at further risk of a more severe form and/or at risk of infibulation, defibulation or reinfibulation.
- Women who refuse to become cutters themselves.

The continued practice of FGM is a function of culture, tradition and social norms determining gender identity, giving rise to complex dynamics in which women themselves play a key role. The decision to submit a girl to FGM is not an individual or rational decision, but rather one influenced by complex relational, psychological, social and emotional factors. The practice is ostensibly a female matter. However, men’s opinions carry significant weight, particularly family members and community elders, who are the transmitters of the values and practices that define community identity. As with other social norms, the practice of FGM is upheld by social dynamics ensuring that the individual believes others expect it of them – just as they believe that abandoning the practice might expose them to social sanctions and marginalization. Such feelings can be exacerbated by the fact that campaigns to end FGM are often perceived as the imposition of “Western” cultural and development models. FGM plays an important part in upholding women’s hierarchies of power and in regulating access to networks of social capital. Such networks can be critically important in providing access to employment, childcare, financial support or other forms of help, such as in resolving disputes with another member of the community.

The practice of FGM, in any form, is internationally recognised as a gross violation of the human rights of girls/ women, more specifically, as a harmful ‘customary’ or ‘traditional’ practice. FGM contribute to gender-based discrimination and to power imbalances faced by women, preventing them from advancement and full participation in society. FGM is a direct act recognised as involving extreme pain and causing significant harm, both in the short and long term, and constitutes physical and emotional abuse of girls and women. FGM attempts to control women’s sexuality and to enforce stereotypes that deprive girls and young women of their right to make independent decisions about their autonomy and control over their lives and bodies. Any type of FGM has immense, negative effects that require professional care and attention. The practice of FGM denies girls and women their right to:

- Physical and mental integrity
- Freedom from violence
- The highest attainable standard of health
- Freedom from discrimination on the basis of sex
- Freedom from torture and cruel, inhuman and degrading treatments
- Life (when the procedure results in death)

These rights are protected in a range of treaties, consensus documents and other international and regional instruments. International human rights bodies have set standards that address FGM and the human rights it violates. These international and regional standards require countries to fulfil their human rights obligations by protecting women and girls at risk of FGM. From a Western perspective, FGM is a useless practice that is simply a form of violence against women. However, those who practise FGM think the opposite; without FGM one cannot be a “real” woman, a “respectable” woman. Without a common understanding of this aspect of FGM, there is little chance of engaging in a persuasive dialogue that can foster an end to the practice.

Where it is practised?

FGM has been documented mainly in Africa (28 countries), and in a few countries of the Middle East (e.g. Yemen, Kurdish communities, Saudi Arabia) and Asia, and among certain ethnic groups in Central and South America. Prevalence rates in Africa vary between countries. Countries with high prevalence rates (> 85%) are, for example, Somalia, Egypt, Ethiopia and Mali. Lower prevalence rates (< 30%) are found in, for example, Senegal, Central African Republic and Nigeria. Prevalence rates also vary within countries and regions, the decisive criterion being ethnicity.

In some countries FGM is performed on all or most women while in others it may be performed only on some women belonging to certain ethnic groups. Anecdotal evidence and case studies show that FGM is now being encountered in various European countries as well. Because of the immigration and population movements, the practice is emerging among refugee populations in Europe and North America where the medical and obstetrical complications that mutilated women and girls are seeking treatment for is causing a lot of concern among health-care providers in Western countries. This concern is expressed through the constant attention FGM receives from international health and human rights organizations as well as from the world media.

To be continued in the next edition....
The Florence Nightingale Benevolent Fund (FNBF) aims at acting as a means of social support for its members who are passing through particularly difficult times. Benefits for members who have been contributing for at least six months include:

### Claim submission
- Claims are to be submitted to the FNBF Group Committee (GC) within twelve months from the date of occurrence. No funds will be given if the requested documents by the FNBF GC are not submitted.

### Medical treatment abroad
- Should a member require medical treatment abroad (which treatment is not available locally), an air ticket is offered to the member and another ticket to the person accompanying him/her. If the member's ticket is funded by the state, an air ticket is offered to the accompanying person only.
- FNBF also offers D50, for each day spent abroad for treatment, up to a maximum of 28 days. These funds are allocated for the expenses of transport, food etc. during the stay abroad.
- A married member's spouse and his children or legally adopted children or fostered children can also benefit from this clause. The provision for the children lasts until they arrive at the age of 18 years.
- For a single status member who lives with his parents, his parents can benefit from this clause while the brothers and/or sisters can benefit until they arrive at the age of 18 years.
- For a married member who lives with his spouse and his parents, his parents cannot benefit from this clause.
- For members who are separated or divorced and their children live in a different address, their children can still benefit from this clause. When applying for this benefit a child birth certificate from the public registry has to be presented to the GC.
- If a married member regains the single status and will start living with his parents, only his children will benefit from this clause. If the member does not have children or partner then his parents will benefit.
- When a member lives with a registered partner, the partner can benefit from the fund but the partner's own children will not benefit. The partner will benefit after six months being registered with the GC.
- The member is obliged to inform the fund for any changes in his status, and to send a copy of the partner's identity card to the fund.

### Sick Leave
- If a member is on sick leave half pay he/she may receive €232 every fortnight for a maximum of €464. The list of illnesses remains that specified in OPM Circular 38/98.
- If a member exhausts all his/her sick-leave entitlement on full and half pay and is on sick leave without pay, he/she may receive €464 every fortnight for a maximum of €1395. The list of illnesses remains that specified in OPM Circular 38/98.

### Loss of allowances due to an injury on duty
- If a member is not able to work due to an injury sustained while exercising his/her duties and, although receiving a basic salary, misses out on more than D230 in allowances, he/she will benefit from half of the allowances lost, up to a maximum of D700. It is important to note that funds will be given only to the injuries sustained during the full-time employment, and in the cases of part-timers, where this part-time employment is the only employment.

### Financial support in conditions of terminal illness.
- If a member is diagnosed with a terminal illness, he/she has the right to apply to the FNBF GC, for a one time only, a maximum sum of D2000 to help in paying the treatment prescribed by the consultant doctor.
  - If the treatment is being paid by the Government, then the member has no right to apply. If the member opts to receive a different treatment, from that being offered by the Government and/or seeks treatment abroad, the member must present a note from a local medical consultant stating the advantages that the member would be receiving by taking a different treatment from that given by the Government and/or the advantages of receiving the treatment abroad. The FNBF GC has the right to seek a second opinion from an independent local medical consultant.
  - The member applying for this benefit can also...
apply for the benefits listed in the 'Medical Treatment Abroad', 'Sick Leave' and 'Counseling Services'. If the FNBF GC receives other claims that are not attributed to terminal illnesses but are as serious as these cases, they must refer them to the MUMN Council for its decision.

Retirement from work
• Once a year a social function is organised in recognition of the service carried out by FNBF members who would have retired during the previous year. Each member is awarded a thanksgiving memento and treated to a reception. Members have to inform the GC that they are going to retire from work.

Counselling services
• Members are entitled to individual/group counselling sessions with a professional counsellor from the Richmond Foundation. Where group sessions are concerned the GC may opt to refer the members to an alternative professional counsellor besides the Richmond Foundation. The GC is entitled to evaluate all requests related to group counselling.

Death of members
• In the case of a death of a member, the sum of €1000 is given to the person who pays for the funeral as a contribution towards the funeral expenses.

Newsletters
• Information about FNBF Benefits and activities organized by the GC are published in the MUMN Magazine 'Il-Musbieh' periodically.

Diary
• Each year a diary is provided for free to all FNBF members.

Annual Meeting
• Each year the FNBF GC shall organize a meeting to all the FNBF members. During this meeting the secretary of the GC reads out the administrative report while the treasurer will read out the financial report.

MUMN Council April 2012

TIMESOFMALTA.COM
Saturday, September 21, 2013
Commissioner finds potential for children’s exposure to abuse at Mt Carmel Hospital

An investigation carried out by the Commissioner for Mental Health has found that the potential for exposure of children to sexual and/or physical abuse at Mt Carmel Hospital, as alleged by the MUMN 'cannot be excluded.'

The results of the investigation were issued a week after the union made its claims.

The Ministry for Health said it was taking the matter very seriously and would be implementing the report recommendations.

The Commissioner noted that the hospital management was now developing a strategy to provide a more efficient and effective mental health service to children and adolescents.

As a result of the new report, a review of all cases is being carried out, leading to a significant reduction of minors being treated in adult wards.

"The present structure and set up of Young People’s Unit (YPU) is not sufficient to cater for the case mix of adolescents currently requiring admission in a mental health facility. There is general consensus that the treatment of minors in adult wards is not ideal," the commissioner said.

The Health Ministry said the Health Minister has twice met children and adolescents, together with their health care multi-disciplinary team professionals.

The Ministry for Health, together with the Ministry for Education and Employment and the Ministry for the Family and Social Solidarity, has also set up a core group of four experts to draw up a holistic approach in the speciality of children and adolescents with challenging behaviour and has embarked on a project headed by Prof. Angela Abela and which will see the construction of new adequate facilities for this specific niche of health care.
DISINVESTMENT IN NURSING JEOPARDISES EU JOB CREATION PLANS

"The EU needs to turn the rhetoric on jobs led growth into reality and ensure that short term cuts do not jeopardise long term investment in health systems and citizens’ future health and wellbeing”
Paul De Raeve, EFN General Secretary

The economic downturn and the demographic challenge have been determinant factors for the employment crisis Europe faces today. In 2012, 50 million jobs were lost, including from nursing. Cuts in the health and social care workforce have add a particularly strong impact on women, being the biggest group of workers in two sectors that also require a better skill mix and a highly competent workforce. However, political decisions are making nurses’ posts redundant and are substituting them with an unqualified workforce, storing up major problems for the future and leading to worse patient outcomes, major costs and threatening quality care (Aiken, 2012).

As highlighted in the Eurofound conference “More and Better jobs in Home-Care services”, held on 12 September 2013, the EFN considers that an appropriate formal health and social care workforce will be the support in which citizens and patients will become empowered to better manage their health. Long term care cannot be left alone to informal carers and non–qualified staff, both groups reporting they can barely cope with the increased needs imposed.

Furthermore, the EFN trusts that appropriate investments in the health and social care sectors are the precondition for growth. As demonstrated in EFN’s report on “Caring in Crisis – the Impact of the Financial Crisis on Nurses and Nursing” (June 2012), the EU needs to do much more in using EU social funds available to implement integrated care and invest in a high competent and qualified nursing workforce, a cornerstone for the coordination, sustainability and quality of care.

Please contact Mr Paul de Raeve, General Secretary of the European Federation of Nurses Associations, for more information. Email: efn@efn.be – Tel: +32 2 512 74 19 – Web: www.efnweb.eu
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**APPLICATION**

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**CHEMICAL/PHYSICAL PROPERTIES**

pH-value: ca. 5.5 +/- 0.5

**DELIVERY UNITS**

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**APPLICATION AIDS**

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Dr. Voß, Dermatost GmbH, Münster: Expert's report on the skin tolerance of **BIALIND®** (patch test).

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"I used to think having a celebrity as a patient was cool, but their entourage just makes my job a lot harder."

HUMORISTIC MOOD

"SORRY I’M LATE, I HAD GREAT NURSES."
A few months ago as I was surfing the net in order that I would be somehow inspired by some novel ideas regarding spiritual care of patients I met an interesting quote which just fits in so nicely and, all the more, is certainly the most appropriate description of every committed nurse worthy her or his own salt. The American author and poet, May Angelou, wrote: "They may forget your name but they will never forget how you made them feel". Patients are infinitely grateful when a nurse gives her/his constant and focused attention to them.

If a person comes up to me and openly disagrees with me concerning this point my personal experience as a patient in Mater Dei Hospital during my hospitalization which took place from May 4 till May 11, 2012, is practically replete with small incidences that amply show our nurses’ compassionate and perseverant care. I am not talking here of the sheer fact of them being professional. In other words, of just fulfilling one’s nursing obligations and that’s it! I do not believe that by simply following mechanically one’s job description one can be describes as the best nurse the world has ever seen. Had that been the case I doubt how the outstanding reputation which many hospitals around the globe presently enjoy (including our own) can continually remain within the same standards they are currently in. The stark reality is that nurses truly go out of their way in order to help the patients that are under their care to cope better with their illnesses. Many a time they do this silently and at the dear cost of great personal sacrifices, including their very health!

My curious question as a hospital chaplain, who is exceptionally blessed, by working side by side these heroic figures of mercy, is this: Can a nurse be engaged in spiritual care? Or the latter is strictly reserved for priests or faith ministers? A quick look at some of the literature available on the subject clearly demonstrates how nurses, due to their inherent professional nature of caring, are essentially called to be special ministers of God’s compassion.

As many might know, compassion, which is one of the core values that underpins every nation’s serious national health service under the sun, can make itself present in many ways. In spiritual care it basically means boldly accompanying the patients under one’s care in the spiritual journey they are undertaking. Experience shows that such a mission is not everybody’s piece of cake since it is heavily charged with emotional and spiritual issues that may hit back at the person who is walking hand in
Christ's mercy

hand with the patient in question.

Within our local Catholic context it makes perfect sense to view spiritual care as starting from the distinctive charitable acts the nurse is called to do. In the first encyclical as the Successor of Saint Peter, named “Deus Caritas Est”, Pope Benedict XVI rightly says that “following the example given in the parable of the Good Samaritan, Christian charity is first of all the simple response to immediate needs and specific situations: feeding the hungry, clothing the naked, caring for and healing the sick, visiting those in prison, etc” (§ 31). Thus, when a nurse gives medicine, shots, hangs IV drugs, gives baths, checks orders, double checks medicines and doses, alerts doctors to mistakes, checks tests and results, assesses patients, keeps patient comfortable, starts IV's, draws blood, monitors patients condition, notifies doctor of changes, evaluates what is and isn’t an emergency, answers patients’ questions, deals with their families, cleans up vomit and feces in other words assisting patients in every way, s/he is showing Christ’s care with the suffering ones. As the Pope says in the year’s message for the twenty-first World Day of the Sick, health care workers are to imitate God’s “deep love for every human being, especially those afflicted by sickness or pain”. Hence, the concluding words of the parable of the Good Samaritan, “Go and do likewise” (Luke 10:37), serve as a vital impetus for nurses to carry out their singular profession with the compassionate spirit of the Good Samaritan.

Responding to the immediate patients’ needs naturally creates a sacred bond between the nurse and the patients s/he is serving. An automatic query comes to mind: Is nursing simply relegated to responding to present needs of the person? Can the nursing vocation be enriched in other ways? If yes how?

Paraphrasing the Pope’s message I think that nurses need “the strength to live day by day with concrete concern, like that of the Good Samaritan, for those suffering in body and spirit”. Patients have a right for nurses’ spiritual care. An interesting theory regarding this subject is undoubtedly that of Sr Mary Elizabeth O’Brien, an ordinary professor of the Catholic University of America school of Nursing. In her book entitled “Spirituality in Nursing: Standing on Holy Ground”, O’Brien presents three fundamental activities for spiritual caring that nurses are called to accomplish with their patients. The first one is being with patients as they struggle with their experiences of pain, suffering, or other problems or needs. Secondly, taking the time to listen to patients when they verbally express their anxieties or emotions such as fear, anger, loneliness, depression, sorrow, which may block the attainment of wellness. Thirdly, touching physically, emotionally, or spiritually to assure them of their connectedness with others in God’s family. Per se the acts of being with, listening to, or touching a patient cannot always mean that spiritual care is being done. However these behaviors, when supported by a sound nurse’s spiritual philosophy of life like that expressed by the parable of the Good Samaritan (Luke 10:25-37), assume the feature of ministry. In fact they end up assuming the nurse’s theology of caring!

The Catholic environment of Malta and Gozo also informs me that nurses can successfully accompany their patients, especially those who have undertaken the terminal line, by praying the Divine Mercy Chaplet with them and their families. The time of illness desperately calls a discovery of God’s unconditional love and acceptance. Such a prayer can be in fact a powerful catalyst both for the patients and their loved ones to let God’s infinite mercy infiltrate their hearts, minds, bodies and spirits.

May every nurse take up the subsequent Prayer of St Francis modified by Charles C. Wise, and make it his/her professional life program:

Lord,
Make me an instrument of your health:
Where there is sickness, let me bring cure;
Where s injury, aid;
Where there is suffering, ease; where there is sadness comfort;
Where there is despair hope;
Where there is death, acceptance and peace
Grant that I may not:
So much seek to be justified, as to console;
To obey as to understand;
To be honored as to love
For it is in giving of ourselves that we heal,
It is in listening that we comfort, and in dying that we are born to eternal life”.

Dear Nurse never forget that you are a healer, an ambassador of Christ’s mercy! Live up to this holy calling which is already present within you!

Fr Mario Attard OFM Cap
Wara li l-MUMN harģet stqarrija għall-istampa u x-xandir fejn gibdet l-attenzjoni tad-Dipartiment tas-Sahħa dwar tifel li kien qed jijji kkurat f’Sala tal-Adulti fl-Ispitar Monte Carmeli, il-ġurnata ta’ wara intbaghtu l-pulizija fl-uffiċini tal-Union u fir-residenza tal-President tal-Union. Din hija d-dikjarazzjoni magħmula mill-President tal-Union lill-Pulizija.

Illum, it-13 ta’ Settembru 2013
Dikjarazzjoni ta’ Paul Pace, iben Emanuel u Carmen nee Schembri, mwieled tal-Pieta fis-26 ta’ Frar 1964 u li jirresjedi fil-fond Paulann, Triq Antonio Miruzzi, Mosta, detentur tal-karta tal-identita bin-numru 126164(M)

Jienna naħdem bhala Nursing Officer u bhalissa nokkupa l-kariga ta’ president tal-Malta Union of Midwives and Nurses (MUMN).


Ahna nafu li dawn il-persuni vulnerabbli jistgħu jinjxtraw faciliment peress li m’għandomx il-fakoltażijiet kollha mentali. Fil-passat, kellna allegazzjoni li kien hemm minuri li għamel sess orali ma’ pazjent ieħor għal pakkett sigarieti izda meta l-istaff indaga, dan it-tifel cahd kollox u ma’ kien hemm ebda prova biex wieħed jagħmel rapport.


Apparti ir-riskju li hemm għall-pazjenti, ahna bħala MUMN irridu nipproteġu n-nurses tagħna milli jiġu esposti għal xi passi dixxiplinari jew kriminali minħabba xi incident li jista’ jinqalja f’xi sala.

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or visit: www.mumn.org

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Price: including 2 coffee breaks and a Buffet Lunch €55
Cheques should be made payable to MUMN

At the Corinthia San Gorg
15th November 2013
MUMN has been at the forefront to offer training to its members on several issues. Based on the premise that professionals and community groups must play an important role in the campaign against Female Genital Mutilation (FGM), and in the provision of good quality services and support for women that have undergone FGM, MUMN will be organising a half day seminar on “Female Genital Mutilation: The Challenges it brings”. This half day seminar is being organised to raise awareness and provide health professionals with specialized training sessions that would enhance their knowledge and skills in providing quality, gender-sensitive and culture-sensitive health services to women and girls affected by the life-long consequences of FGM. Additionally, this seminar is aimed at the improvement of inter-departmental cooperation among health professionals involved in obstetric, gynecological health treatment, first aid and other sections of the health system were women or girls affected by FGM may be referred. Hence the seminar attempts to contribute in the improvement of the quality and effectiveness of the health support system for women victims of violence. The main objectives of the seminar are:

- To provide accurate information and create thorough understanding in relation to the practice of FGM.
- To empower FGM practising communities and organisations as well as relevant government agencies in Malta to take action against FGM.
- To raise awareness of the negative health consequences (both physical and psychological), and human rights violations associated with FGM.

For more information please email MUMN to administrator@mumn.org or phone 21448542. We look forward to hearing from you.
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PREPARATION
• Preheat oven to 400°F.
• Pierce potatoes in several spots with a fork. Bake directly on the center rack until tender when pierced with a knife, 45 minutes to 1 1/4 hours, depending on the size and type of your potatoes. Remove to a wire rack and let stand until cool enough to handle. 15 to 20 minutes.
• Scrape the insides out of the potato skins and push through a potato ricer fitted with a fine disc onto a clean counter. (If you don’t have a ricer, mash the potatoes until smooth.) Gather the potato into a mound on the counter, sprinkle with salt and let cool, about 15 minutes.
• Meanwhile, soak sun-dried tomatoes in boiling water until soft. 10 to 20 minutes. Place the egg yolk in a food processor.
Drain the tomatoes: transfer to the food processor with the egg; pulse until pureed.
• Put a large pot of water on to boil.
• Pour tomato puree over the cooled potato and then sprinkle 1 cup flour on top. Use a bench knife or metal spatula to gently fold the flour and tomato puree into the potatoes until combined (it will not look like dough at this point). Gently squeeze, knead and pat the dough until it holds together and resembles biscuit dough or cookie dough. The dough will be a little sticky; if it’s very sticky, add more flour, about 1 tablespoon at a time, as necessary. Be careful not to overwork the dough: overworked dough will yield tougher gnocchi.
• Pat the dough into a 1 1/2-inch-thick disk and then divide it into 4 equal pieces. Working on a lightly floured surface with lightly floured hands, roll each portion into a 24- to 26-inch-long “snake,” 1/2 to 3/4 inch wide. Start at the center of the dough and roll out using your fingertips and very light pressure, gently pull the dough out as you roll. Cut the snake into 3/4-inch pieces. Use your fingertip to make an indentation (or “dimple”) in the center of each gnocchi. Place the gnocchi on a lightly floured baking sheet as they are made. Repeat with remaining dough.
• Mean while prepare sauce for the potato gnocchi, by adding the fresh cream in a sauce pan, add the parmaggiano reggiano and finally with some fresh basil.
• Adjust the heat so the water is at a gentle boil. Add about one-quarter of the gnocchi at a time. When the gnocchi float to the top, transfer to a parchment or wax paper-lined baking sheet with a slotted spoon. Continue boiling the gnocchi in batches until they are all cooked, returning the water to a gentle boil between batches. Toss into the cream sauce and serve immediately.

TIPS & NOTES
• Make Ahead Tip: Toss cooked gnocchi with olive oil and refrigerate in a single layer for up to 2 days. (Or freeze cooked gnocchi in a single layer on a lined baking sheet, transfer to an airtight container and freeze for up to 3 months. Defrost in the refrigerator.) Reheat gnocchi in boiling water until they float.
• Tip: To get a golden-brown crust on the outside of the gnocchi, cook about one-quarter of a batch of the gnocchi at a time in 1 teaspoon extra-virgin olive oil in a large nonstick skillet over medium-high heat, stirring gently, about 2 minutes.

Robert Preca (Chef at Tal-Familja Restaurant)
www.talfamiljarestaurant.com +356 21632161 +356 99473081

Sun Dried Tomatoes Gnocchi

900g medium potatoes
3/4 teaspoon salt
1 large egg yolk, beaten
50g cup sun-dried tomatoes 
( not oil-packed)
1-1 1/4 cups all-purpose flour, 
divided
250ml Fresh Cream
Fresh basil
70g Parmagggiano reggiano

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Food allergies and our lifestyle

It is common today to hear people mentioning that they feel bloated, heavy, nauseated after eating a meal. Others complain of tummy aches, cramps, itching, pain in the abdomen or other symptoms which they feel regularly without knowing the reason for them. Others actually go to the doctors, undergo several investigations of every kind, such as blood tests, endoscopies, X-rays and other investigations without finding anything wrong.

70% of clients visiting a nutritionist nowadays, rather than being for weight loss, are for ailments that are often related to food allergies. Many clients say, "How can it be that I have become allergic to certain food which I have been eating for the past 25 years?"

Many people, nowadays, are experiencing symptoms of food allergies. These can be various. They can effect the head, such as by causing headaches and other symptoms like sinusitis, running nose, hay fever and acne. They can cause symptoms related to the mind and coordination of our body, such as insomnia, depression, hyperactivity and anxiety. In the stomach area, one can experience diarrhoea, gas, colic, constipation. Food allergies can also affect the joints and the immune system. The figure above shows all the common symptoms of food allergies.

Some people say, "What is the difference between a food allergy and food intolerance?" Food intolerance is negative reaction, often delayed, to a food, beverage, food additive, or compound found in foods that produces symptoms in one or more body organs and systems, but it is not a true food allergy. A true food allergy requires the presence of Immunoglobin E (IgE) antibodies against the food, and a food intolerance does not. The main difference is that a food intolerance is a delayed reaction which one can experience after, for example, a month of eating a certain product; an allergic reaction is an immediate reaction which is experienced as soon as an item is eaten. The symptoms experienced are due to the

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allergy/intolerance which damages the villi lining the intestines. The damaged villi cause malabsorption due to a decreased surface area for absorption of the food. The difference between healthy and damaged villi can be seen in the picture above.

Diagnosing a food allergy can be tricky but easy at the same time. One can start by an elimination diet, where one starts with a basic diet made up of fruit, vegetables and rice. Then one can start gradually introducing different food items, one at a time. Every time an adverse reaction is experienced this item is removed for a month or two. Then a new item is introduced. An easier way to diagnose a food allergy is by undertaking a food allergy blood test, which tests for IgE and IgG antibodies. Most tests test the reaction of 20 to 40 items of food and give a quick picture of what a person is very allergic to, slightly allergic or intolerant to and what he can eat at will. A healthy diet can then be based on these results. One has to be especially careful when eating in restaurants, above all where the menu is specialised, such as at Chinese, Thai, fish restaurants etc., as these are high-risk places for people suffering from some kind of food allergy due to the spices and ingredients included in the food.

Persons with a food allergy or intolerance can live a normal life. It is crucial however that someone qualified will develop a diet plan which is individual and according to their needs. Their diet needs to eliminate all allergens but include other food items that can replace the items that will be removed from the diet through the omitted food. This is important for a person with a food allergy not to end up with a deficiency of a mineral, vitamin or element. In the case of people with food allergies, a professional dietary advice by a qualified professional is crucial to ensure the health of people with food allergies or intolerances. Once one has an adequate diet and gets used to it, although his life can never be totally normal, one's lifestyle can be made as normal as possible. His/her life will also be much more comfortable and healthy than it ever was before.

Geoffrey Axiaq
Practice Nurse
St. Vincent de Paule's Residence

COMMON SYMPTOMS OF FOOD ALLERGIES
Nine out of 10 nurses working in acute and emergency care believe current pressure on A&E services is putting patients in danger, a nursing union has warned.

The Royal College of Nursing (RCN) said a survey of its members found that 89% of nursing staff thought the people they were meant to be caring for were being put at risk.

Some 85% said patient safety was being compromised by the strain on departments, while one in five said this was the case on every shift.

The poll of 416 RCN members found 89% said they had experienced increased pressure in their A&E department in the last six months.

More than three quarters cited increased attendance at A&E as the reason for increased pressure, while 74% blamed inappropriate attendance at A&E where patients could have been treated elsewhere.

The survey also found 57% cited a lack of beds for patients coming into A&E, while 54% said there were too few health care staff on duty to cope with demand.

Dr Peter Carter, chief executive and general secretary of the RCN, said: “Our member survey demonstrates the same picture that NHS Confederation leaders are paint­
ing – that emergency services and the staff working within them are under increasing pressure which is putting patient safety at risk.

“Staff enter the health profession to save and improve lives through first class care.

“However they simply cannot deliver this if there are too few staff to properly treat and monitor the increasing numbers of patients, not enough beds to put them in and no clear signposting to community care that could prevent attendance at A&E.”

The survey was conducted in July.

A Department of Health spokeswoman said: “We know A&E departments are under pressure. There are over one million more people visiting A&E compared to three years ago.

“However we know, on the whole the NHS is performing well, latest weekly figures show 96% of patients were seen in under four hours and there are more clinical staff, including 4,300 more doctors since 2010.

“We have given A&E departments an additional £500m to make sure the best care is available for every patient this winter and the next and have set aside an additional £3.8bn to help join up health and care services.”
The MDH Istrina Fund Raising

The MDH Istrina Fund Raising Committee are once again, for the 4th consecutive year organising the Great Christmas Event as fund raising for I-Istrina between the 2nd - 8th December 2013. This activity will include 2 bazaars, one with natural plants, while the other of home made cakes and other pastries. During this week there will be also an 8 Ball Pool Exhibition. Entertainment also including singers and dancers.

Another great event is the Arts Exhibition to be held from 10th October till 10th November 2013. All artists exhibiting their works are health care professionals.

Administering the piggy banks to wards, units and sections is another event. Our only intention is of collecting more money for this national cause.

Mr. Simon Vella SN
Chairperson - MDH Strina Fund Raising Committee
Mobile : 79703433
E-Mail : simon.a.vella@gov.mt
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Shields: ABCDerm Peri-oral cream protects the skin from the acidic pH of saliva, by providing a guard over sensitive areas.

Soothes: The cream stimulates the skin's natural soothing ability to reduce redness and calm irritation.

Strengthens: By preserving the natural active ingredient in the skin, ABCDerm Peri-oral encourages it to strengthen and becomes less sensitive in the future, reducing risk of recurrent irritation.

Purifies: To prevent the risk of infection, ABCDerm Peri-oral cream has essential anti-bacterial and anti-fungal properties.

Repairs: The cream's ingredients assist damaged skin cells in the affected area to re-pair themselves in order to reinforce the protective skin barrier.

Why use ABCDerm Peri-oral

Hypoallergenic: ABCDerm Peri-oral cream is a hypoallergenic product that will not cause allergic reactions or irritations.

Chemical free: ABCDerm products are free from Parabens, preservatives, colouring, fragrances and additives, using only essential ingredients.

Dermatological safety: ABCDerm Peri-oral cream guarantees safety by undergoing high standard tests run by dermatologists.

About ABCDerm

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

ABCDerm skincare lines are available exclusively in pharmacies across the UAE, Kuwait, Oman and Qatar.
As the weather cools, the risk of certain infections increases.

A baby's mouth is the most sensitive area on its face, and is most prone to irritation. Everyone knows that the purpose of saliva is to decompose food, protect from anti-bacterial infection and to keep the mouth and throat moist, but not everyone knows that it can also cause infections.

**What is Perioral Dermatitis?**

Perioral Dermatitis is a common facial skin irritation which affects the skin around a baby or young child's mouth. Inflamed red skin is the first sign of irritation and can quickly develop into small red spots, pus-filled bumps, and scaling or peeling of the skin. It is very uncomfortable for the baby and can extend at times onto the cheeks and occasionally reaching the eye area or forehead, if not treated quickly.

**How is Perioral Dermatitis caused?**

The cause of perioral dermatitis is unknown; however, it is believed that the infection can be produced by the combination of acidic saliva and friction against the sensitive mouth area, this friction could result from the repeated rubbing of a child's thumb to a pacifier or security blanket. The irritation is most commonly developed in the cooler winter months and affects young children aged 3 months to 5 years.

Irritated Perioral Dermatitis can lead to a more serious infection if not treated immediately. The best way to treat it is with an adequate and specialized repair cream.
NURSES AND MIDWIVES: Agents of Change

2nd Commonwealth Nurses Conference
Saturday 8 and Sunday 9 March 2014
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CALL FOR ABSTRACTS

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

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

Abstract submission

Email your abstracts (of no more than 300 words) to the Commonwealth Nurses Federation at cnf@commonwealthnurses.org by 31 October 2013.
ICN ON HEALTHY AGEING: A PUBLIC HEALTH AND NURSING CHALLENGE

By 2020 world population will include more than 1000 million people aged 60 and older; with more than 700 million living in developing countries

Nearly one million people cross the 60-year threshold every month. The 20th century has seen a serious increase in the absolute and relative numbers of older people in developed and developing countries. Accordingly, nursing has sharpened its attention on the issue of healthy ageing.

Projections for population ageing into the first quarter of the 21st century include:

• By 2020, the Japanese population will be the oldest in the world, with 31% over 60 years of age, followed by Italy, Greece and Switzerland.
• By 2020, five of the ten countries with the largest populations of older persons will be in the developing world: China, India, Indonesia, Brazil and Pakistan.
• By 2020 the population of older persons from developing countries will rise by nearly 240% from the 1980 level, as a result of a rapid decline in fertility and an increase in life expectancy, due to the use of advanced technology and drugs.
• Women outlive men in almost every country. They make up the majority of the oldest old and the elderly widowed, and are most frequently the carers of the worlds' older persons.

Impact on Health

Health of the older person is best measured in terms of function rather than pathology. Good health and successful ageing is defined in terms of the ability to function autonomously, within a given social setting. If socially and intellectually active, the older person may be considered healthy, even in the presence of chronic disease. Health care of the older person includes helping the individual maintain adaptive behaviour, promoting wellness, providing care during acute and long-term illness, and furnishing care and comfort in dying. The reality of an increasing population susceptible to a chronic or debilitating disease must however be faced.

• The most common chronic conditions affecting older adults around the world are cardiovascular disease, cancer, diabetes, osteoarthritis, pulmonary disease, Alzheimer’s disease and psychiatric disorders, most commonly depression and dementia.
• By 2020, it is projected that three-quarters of all deaths in developing countries could be ageing-related. The largest share will be caused by non-communicable diseases, such as diseases of the circulatory system (CSDs), cancers and diabetes.
• Hypertension rates and diabetes prevalence is rapidly increasing in the developing world. CSDs and cancer are the leading causes of mortality in Argentina, Cuba, Uruguay and parts of Asia.
• In developing countries, all acute and chronic diseases of the older person are exacerbated by the presence of persistent poverty.
• Among developing countries, malaria continues to be a major cause of impairment or disability.
• Ophthalmic diseases such as cataracts, glaucoma, trachoma, and xerophthalmia underlie visual disabilities in the developing world. It is worth noting however, that in the United States alone, there are approximately 1.35 million cataract operations performed yearly.
• In more developed regions, major chronic conditions affecting older persons are arthritis and other musculoskeletal diseases, sensory impairments (sight and hearing) and edutulism (toothlessness). It has been estimated that as many as 27% of people over 60 years have problems with incontinence.
• Among the oldest old, the most frequently encountered conditions are dementia, stroke, and fracture of the neck of the femur.

Impact on Nursing

The increase in life expectancy results in a greater number of older persons in need of a wider range of health services, including health promotion, illness prevention, rehabilitation, acute/chronic care and palliative care. The goal of nursing care is to assist older persons in achieving optimal health, wellbeing, and quality of life, as determined by those receiving care or consistent with the values and known wishes of the individual.

• Nursing care is recognised as the largest single component of the services required to care for the frail, sick and dying, while increasingly contributing to the maintenance of health and prevention of disease.
• Nursing research indicates that older persons often describe health as a “state of mind”. When discussing health they tend to emphasise psychological attributes, social relationships, and attitude toward life, rather than merely physical state.
• The most important clinical issues in care of the older person were found to be: a) confusional states, b) immobility, c) sensory loss, d) nutrition, e) loss/grief, f) depression, g) incontinence, h) mental illness, i) substance abuse, j) death and dying.

| continued on page 37 |
By 2020 there will be more than one billion people aged 60 years and older in the world. This demographic trend has many implications, both for the demand for care and the demand and availability of carers. It will affect all segments of society.

In relation to effective workforce policies, attention and reference to ageing of the workforce have increased markedly in the last decade. For example, in the European Union, concerns about the sustainability of pensions, economic growth and the future labour supply have stimulated a range of policy processes and recommendations to promote the health and working capacity of workers as they age; to develop the skills and employability of older workers; to examine raising the pension age; and to provide suitable working conditions as well as employment opportunities for an ageing workforce.

Within nursing, the situation in many industrialised countries is that the nursing workforce is ageing. Over the next 10 to 15 years these countries will experience a large exodus of nurses from their workforce as nurses retire just at a time when demand for nursing and health care is on the rise; one of the reasons being the growth in the older population.

This trend, if left unaddressed, is set to deepen the current shortage of employed nurses, particularly in countries where there is a shortfall of new nurses entering the labour market. It will also have a knock-on effect on developing countries where the age profile may be very different but where aggressive international recruitment efforts may drain the supply of nurses in active practice.

**Facts, figures and trends**

The average age of the nurse in many countries exceeds 40. See the table below.

- The legal age of retirement is not necessarily the average age at which a nurse will leave the workforce. For instance, in Canada, Ireland and Singapore the average age of retirement “in practice” is 60 while, in Iceland, the average age is 64 – several years below the legal retirement age.
- In the United Kingdom (UK), an estimated 180,000 nurses will reach retirement age over the next decade.
- By 2010 predictions indicate that 40 percent of nurses in the United States (USA) will be over 50 years of age. A survey of 1000 nurses (mostly managers) indicates over 55 percent of respondents plan to retire between 2011 and 2020.
- Recent figures from Canada reveal that registered nurses between age 50 and 54 years make up 17 percent of the workforce, compared to 11 percent in 1994.
- In some countries (e.g. USA and Ghana) ageing is affecting the nursing faculty providing education and training to the next generation of nurses. For instance, a wave of faculty retirements is predicted across the USA over the next 10 years and, if left unaddressed, will increasingly put restrictions on enrolments into nursing programmes.
- There is a trend in some countries, such as the UK and USA, of increasing numbers of people entering the profession at an older age (e.g. late twenties and early thirties). As a result, projections indicate that by 2010 the USA will have more nurses in their fifties than in any other age group.
- There have been cases where nurses have taken industrial action because their right to early retirement has been challenged. For instance, prior to 1999, nurses in Panama had the right to early retirement at the age of 50, with benefits amounting to the last yearly income – the same percentage that is given to all public employees (e.g. firemen, clerks, sanitation, etc.). However, in 1999 the law was changed and nurses must now work until age 57 and then only receive a percentage of their last yearly income. In other words their acquired rights have been taken away and their pension benefits cut.
- A representative of the Zambian Ministry of Health recently reported that strategies to address the country’s nursing shortage will include extending the retirement age by 10 years, while new graduate nurses are unable to find employment due to frozen positions and no-growth financial policies.
- Results from a study of 290 health care facilities in the USA found that, while most administrators were aware of the ageing workforce and desired to retain their older nurses, only 6 percent had policies in place to address the needs of older nurses. Eighty-seven (87) percent had no immediate plans to address the ageing nursing workforce issue.
- In the USA, nursing ranks third among the top 10 most injury-prone jobs. Research indicates that nurses (14.7%) experience a higher incidence of back pain per year than non-nurses (11.5%), and that occurrence increases with age.
- In a survey of 308 nurses over the age of 50, close to one-quarter reported having experienced a job-related injury within the past five years, and over one third suffered from health problems related to the job (e.g. back pain, anxiety, depression, etc).
- Job re-design and modifications in the work environment are being introduced in a number of countries (e.g. Canada, USA). For instance, limiting heavy workloads, redesigning patient handling methods to reduce back...
injuries, and allowing greater flexibility in scheduling enable experienced nurses to reduce the physical demands of nursing care while increasing their role as mentors and clinical instructors.

- A survey of nurses and doctors in Australia reported that the three most important factors in determining retirement behaviour were anticipated income on retirement, availability of flexible hours, and health status.

**Strategies to attract and retain older, experienced nurses**

Older nurses are a rich human resource pool. In many countries, they represent the fastest growing segment of the nursing workforce. Their premature or forced exit from the workforce and/or reduction in working hours means a loss of much needed and experienced nurses to care for patients. When they retire, their knowledge, wisdom and clinical expertise are lost, as is their contribution to training and mentoring the next generation of nurses. Tailoring employment strategies to this group is important to their retention. The literature suggests that older, more experienced nurses are more likely to extend their work life when the following conditions exist:

- Supportive and flexible work arrangements and practices (e.g. modified workloads, flexible scheduling options, reduction in hours of work, etc.).
- An organisational culture that promotes participation in decision-making and autonomy over practice.
- Work recognition, encouragement and positive feedback from supervisors.
- Ergonomically friendly, safe and effective work environments.
- Access to professional development activities that target the needs of experienced nurses.

**ICN/ICHRN actions**

The International Council of Nurses and its International Centre for Human Resources in Nursing:

- Advocate/campaign for positive practice environments for all health professionals across all age groups, to end age related discrimination and improve working conditions.
- Publish scholarly material on managing the multi-generational nursing workforce and supervising and mentoring this workforce in order to inform and improve policy and practice in this area.
- Collect, collate, analyze and disseminate data on the nursing workforce (e.g. ICN nursing workforce profiles) in order to better assess the profile of nurses in different countries, regions and sectors.
- Raise awareness through position statements and at meetings and other forums on the specific issues facing the older nurse, including the promotion of a “living” pension.
- Develop and promote nursing human resource management competencies in order to improve the abilities of managers to develop and implement HR policies that effectively address the needs of an ageing nursing workforce.
- Evaluate and disseminate good HR management practice in this area, to lead to improvements in policy. This is accomplished through presentations at meetings and other forums and through the ICN-ICHRN website and published case studies.

- Present and discuss research and analysis of age related issues at international conferences, congresses and regional forums.
- By publishing scholarly material and making information available via the ICN/ICHRN website to support national nurses associations in their efforts to promote effective policies for an ageing nursing workforce.
- Discuss job redesign, pension benefits, and retention strategies particularly relevant for an ageing nursing workforce during Workforce Forum meetings.

The International Council of Nurses is a federation of 129 national nurses' associations representing the millions of nurses worldwide. Operated by nurses for nurses, ICN is the international voice of nursing and works to ensure quality care for all and sound health policies globally.

The International Centre for Human Resources in Nursing was established in 2006 by the International Council of Nurses and its premier foundation the Florence Nightingale International Foundation. The Centre is dedicated to strengthening the nursing workforce globally through the development, ongoing monitoring and dissemination of comprehensive information and tools on nursing human resources policy, management, research and practice.
Mental Health: Tackling the Challenges

Mental health is an integral part of general health and quality of life through which a person realises his or her full potential. Despite the close interrelationships of mental and physical health, mental health is largely neglected, including in the allocation of fiscal and human resources. The World Health Organization estimates some 400 million people in the world suffer from mental or neurological disorders or from psychosocial problems, such as those related to alcohol and drug abuse.

Mental disorders represent more than 12% of the total burden of disease. However, the true extent of the problem is difficult to measure. Mental health problems tend to remain undiagnosed and unreported because of stigma and exclusion. About 24% of patients who seek primary health care suffer from some form of mental disorder.

A majority of these patients (69%) usually present to health personnel with physical symptoms; consequently, many of them are not correctly diagnosed for mental illness and thus not treated.

In most countries health care providers are not prepared to address the mental health needs of their patients. With proper training and supervision, health professionals could become more competent in identifying and treating mental disorders.

Mental health problems are common worldwide and their impact in psychological, social and economic terms is very high. We have the knowledge to prevent and treat many mental health disorders and to permit persons with mental illness to be socially and economically productive members of their community. Yet, societies still create barriers to the care and reintegration of people with such disorders.

Risk factors for mental illness

Like many diseases, mental illness has risk factors that can be prevented or reduced. Understanding these risk factors provides a framework for strategies in mental health promotion and illness prevention. The main risk factors include adverse living conditions such as extreme poverty, war and displacement, biological predisposition, and stressful relationships at home or in the workplace. Abused women and children, victims of armed conflict, migrants and refugees are among the high-risk populations for mental illness.

Stigma of mental illness

Unlike those with physical illness, people with mental health problems are generally subjected to stigma, prejudice and exclusion from access to social services and health care. Stigma is often due to public ignorance about the underlying causes of mental health problems. One of the main challenges is to remove the stigma of mental illness so that people will talk freely about their emotional problems with health care professionals.

In some societies, people believe that evil spirits or a curse for some transgression cause mental health problems. People with mental illness are often believed to have ‘weakness in character’ or ‘immoral behaviour’. These myths about the cause of mental health problems are sometimes used to deny care and compassion or even to administer cruel treatment such as confinement, abandonment or isolation. As a result, people with mental illness suffer doubly: from their illness and from shame and social stigma. The challenge for nurses and other health professionals is to create an understanding of mental illness, an illness that has risks and is subject to prevention and treatment.

Strategies for nurses, NNAs and others

Despite advances in health care, the development of humanistic, holistic and scientific methods in mental health services have been relatively slow compared to other specialisations such as surgery. Nurses have a vital role in the promotion of mental health, prevention of mental illness and improving access to care and services. To combat the stigma and fear of ‘madness’ and to promote a culture of care and compassion for people with mental illness, activities can include the following:

1. Promote mental health and prevent illness by collaborating with other professions and sectors through:
   • Public education on risk factors
   • Advocacy groups that support access to food, shelter, education and other resources
   • Positive parenting programmes
   • Life skills education
   • Child-friendly schools
   • Early detection
   • Referrals and treatment services
   • Early intervention for children with psychological problems

2. Improve access to mental health care services:
   • Support a network of community-based services
   • Increase outreach and informal support groups
   • Get involved in national mental health policies and plans
   • Focus on vulnerable populations
   • Integrate mental health into primary health care services
   • Lobby for allocation of resources for mental health promotion
   • Improve quality of mental health services
• Lobby for a 24-hour crisis intervention service
• De-institutionalise mental health services

3. Stop exclusion and Dare to care:
• Talk openly about mental illness in the community
• Educate the public about risk factors of mental illness and reduce them
• Protect human rights and ensure legislation to reduce stigma, illness and ways to improve care and health issues through events such as the World Mental Health Day, October 10 each year

4. Promote community participation in mental health services planning, operation and evaluation:
• Lobby for citizen and consumer group involvement
• Sensitise the community that mental health is the concern of the entire community
• Support self-help programmes such as volunteer services
• Train health care providers to be partners and facilitators of care
• Encourage networking and mutual aid groups
• Hold briefing meetings and information exchanges with health providers and other sectors

5. Influence policy makers and the public about the importance of:
• Mental health and the environmental and social risk factors
• Increasing financial and human resources for mental health promotion, prevention and care
• Creating healthy environments and caring societies that reduce stress and enhance well-being

6. Address educational needs of health personnel in mental health issues:
• Use culturally sensitive curriculum models
• Lobby for nurses and others as mental health managers, researchers, educators and role models in clinical settings
• Provide continuing education for health care providers
• Undertake research to determine effects of nursing interventions and health outcomes
• Develop guidelines and other training materials

Conclusion

Nurses and other health professionals have a key role in promoting mental health, preventing mental illness and improving access to mental health services. They also have a role in educating the public and reducing stigma. Health professionals need to focus on reducing the treatment gap of mental health disorders. Advances have been made regarding new treatment and care, and on the causation, associations, characteristics and prevention of mental health problems. The benefits of this knowledge should reach all people with mental health problems, particularly the vulnerable populations.

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

Sometimes nurses cry....

http://nurses.org/cry

No matter how good or bad you think life is, wake up each day and be - - - thankful for life.
Someone somewhere else is fighting to survive.
Compression therapy is a strong therapy which can promote venous leg ulcer healing, and enhance a person’s quality of life. Persons suffering from chronic venous insufficiency are predisposed to develop venous leg ulcers, due to impairment of the blood return circulation, to the heart. The squeezing effect of compression onto the leg, results in reduced oedema and improved venous blood flow towards the heart. Although hosiery or intermittent pneumatic compression devices are available to induce compression, bandages are most often used to achieve this effect.

The amount of compression required during treatment, is generally based on the patient’s morbidities and ability to tolerate treatment. Treatment of venous leg ulcers generally involves application of sub-bandage pressures >40mmHg. However, high resting pressures may not be suitable for such patients, whose majority is elderly and frail. Sub-bandage pressures, vary according to posture, movement of patient and also bandage application techniques. The resting pressure is the pressure exerted by a bandage or stocking, onto the treated leg, while the patient is resting. This tends to be lower than the working pressure, which during exercise, results from expansion of the calf muscle against the stiff resistance created by the bandage. This effect, improves the actions of the calf muscle pump, to pump blood back, from the leg towards the heart.

Bandage Materials and features: The pressure created by a bandage mainly depends on the tension of the material, the number of layers applied and the shape of the leg. Tension is dependant on the amount of stretching of the bandage during application. Sustainability of this tension depends on the elasticity of the bandage material; which is the ability of the material to return to its original length on decreasing applied tension. Elasticity directly depends on the composition of the threads and the method of construction of the bandage. High compression bandages are usually classified according to their amount of extensibility, or their ability to stretch. Although non-stretch materials, such as those used in Zinc Paste bandages are available, the most common materials used are short-stretch, for minimally elastic or extensible bandages; and long-stretch, for highly elastic, extensible bandages.

Long-Stretch bandages are able to accommodate expansion or contraction of the leg circumference during exercise or due to reduced oedema, with minimal changes in sub-bandage pressures. Long-stretch bandages, sustain high pressure for long periods of time, even whilst the patient is resting.

Short-Stretch cotton bandages are able to create high working pressures during exercise, and low resting pressures. They are less able to accommodate changes in leg circumference and retain their rigidity against the calf muscle, thus improving the action of the calf muscle pump. Hence, they have a greater effect on deep venous blood return, when compared to elastic compression stockings, which mainly effect the superficial venous circulation. During rest, the sub-bandage resting pressure is quite low, and hence such bandages are considered safer in patients with moderately impaired arterial circulation. Short-stretch bandages are therefore considered as the treatment of choice for patients with extensive deep vein reflux.

Multi-layer compression systems have been found to be more effective than single layer compression systems. The concept of multi-layering is that compression is applied in layers, thus achieving an accumulation of pressure. Such systems may be simple, using only 2 layers; or complex including both short and long stretch bandages in order to achieve the advantages of both materials.

Patient Compliance makes an integral part of treatment with compression. It can be enhanced by encouraging patients to take an active role in their treatment. Patient-compliance, often depends on patient motivation, which can be affected by issues originating from the health condition itself, such as social isolation; or treatment discomfort, which might range from pain or inhibition of regular activities such as work or entertainment. Education of patients and relatives is very important, to gain their compliance.

Patients should be advised about the importance of:
- Wearing flat comfortable shoes that allow flexing of ankle joint
- Exercise such as walking, if possible participate in a rehabilitation programme
- Adequate skin care
- Proper care of compression bandages

Contra-indications and precautions: Compression therapy should be used with caution, since incorrect application of compression can lead to serious consequences. Strong compression in patients with arterial insufficiency, neuropathy, cardiac disease, or intolerance to compression material may be unsafe or painful. Prior to treatment, a Doppler test should be carried out to calculate the ankle brachial pressure index (ABPI), in order to evaluate arterial perfusion. In patients with cardiac failure, compression may be dangerous, as it induces rapid shifts of body fluids, which increase the pre-load of the heart. In patients with neuropathy, the risk of pressure damage underneath the bandages increases, since the protective response to pain is absent.

Cost-effectiveness ensures that scarce resources available for health-care, are used in the best possible way to achieve the greatest improvement in the health-related quality of life of patients. Budgetary constrains, stress the importance of presenting evidence of cost-effectiveness, prior to approval of reimbursement of a treatment. Evidence shows that treatment of patients with venous leg ulcers, with a multi-layer compression system in combination with normal wound-care, incurs less weekly costs due to a lower frequency of dressing changes. It is estimated to be 44% less expensive than usual wound-care alone. It is also more cost-effective than usual wound-care, since the majority of venous leg ulcers heal prior to 52 weeks of treatment with compression. An ideal cost-effective compression system should:
- Be clinically effective to provide evidence based treatment
- Provide sustained clinically effective levels of compression for about a week
- Enhance and support the function of the calf muscle pump
- Use bandaging materials which are non-allergenic, in order to avoid risk of allergy
- Be easy to apply and easy to train patient, or health-care professional, to apply
- Conformable and comfortable, to aid patient compliance
- Long-lasting, in order to enhance cost-minimisation due to re-use of bandages

Innovative 2 layer compression bandage systems, using...
2 cotton short-stretch bandages have been recently developed. Such systems are as effective as other multi-layer systems in achieving high working pressures and low resting pressures. Additional advantages of 2 layer systems include:

- the use of normal shoes, since they are not as bulky as 3 or 4 layer systems, the circumference of the bandaged foot will not increase much, thus fitting the shoes that the patient regularly uses, enhancing compliance
- more comfortable for patients to wear during warm weather due to lighter, air permeable material enhancing better quality of life and also compliance
- where innovative bandage weave structure provides bielastic properties to the bandages, these conform better to leg contours to distribute the pressure more evenly, hence providing also easier application
- where bandages used are able to regain their full elasticity after washing, such systems have a cost-minimisation impact on healthcare institutions due to their re-usability

In the treatment of leg ulcers, compression therapy has been used since the time of Hippocrates. Compression can dramatically reduce the amount of oedema and pain and promote healing of venous leg ulcers. Success directly depends on the use of the right materials and application technique. Preventive measures include the long-term use of compression bandaging, since sustained compression prevents recurrence of oedema and results in a lower incidence of ulcer recurrence. A high level of compression is associated with a lower incidence of ulcer recurrence. Medical professionals involved in the care of such patients, should be capable of choosing and applying the appropriate compression system according to individual patient needs. Accurate assessment, detailed diagnosis and effective compression therapy may lead a team of health-care professionals to develop their practice and provide the highest standards of care for venous leg ulcer patients. Multi-layer, high compression therapy provides safe and highly effective treatment for most patients with venous leg ulcers. A high healing rate of up to 70% of ulcers within 12 weeks can be reached, and if complimented with an ulcer recurrence preventive programme, it can greatly improve the quality of life of such patients and decrease the burden of venous leg ulcer disease on healthcare systems.

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

References:

ICN POSITION

ICN on Healthy Ageing
continued from page 31

- Care of the older person is increasingly acknowledged as a nursing specialty requiring specific professional knowledge, skills and career structure.
- Primary nursing has improved continuity and co-ordination of care during hospitalisation and facilitated discharge planning. Case management, where a single health care provider follows the same patient in repeated hospitalisations and assists or co-ordinates home care services, are also helpful to older patients.

Impact on Nurses

Nurses have a responsibility to maintain their level of competence, plan and deliver quality care, delegate tasks safely, and evaluate the services provided.

- The increasing reports of abuse of elders in health care settings must be addressed by nurses. Raising awareness of the causes and consequences as well as developing/enforcing ethical standards of practice are crucial.
- The average age of the nurse is increasing (43 years). The ageing of the nurse workforce needs to be considered when planning and managing human resources for the care of the older person.
- An increasing percentage of nurse-entrepreneurs offer a range of services to the older person as patient advocates, care givers, counsellors and educators in addition to providing their clinical skills.

Nurses and their professional organisations have the potential to influence broad debates on global ageing, the determinants of health and the impact of the social environment. The International Council of Nurses and their member national nurses' associations are increasingly involved in meeting the needs of the older person and act as advocates or facilitators in policy-making, including the allocation of resources within the health and social sectors.
Prevention of disability and the care of people with disabilities

The International Council of Nurses (ICN) strongly believes that equal rights for the disabled must be fostered and protected, including, rights to education and employment, and the right to full involvement in matters that affect their lives. ICN supports programmes designed to integrate people with disabilities in all aspects of daily life—in the family, school, workplace and community.

Nurses are key to early detection and intervention, and need to be involved in health promotion, prevention, teaching and counselling programs for people with disabilities and their families.

Nurses can play a significant role in policy and planning aimed at improving the quality of life and care for people with disabilities and in the prevention of disability.

Nursing education programmes should address the role of nursing in the prevention of disability as a result of injury or illness.

ICN collaborates with other concerned organisations and associations to increase cooperation in advocating for the rights and freedoms of disabled persons and to mobilise and support technology, research and resources for the benefit of persons with disabilities.

National nurses' associations (NNAs) should play a visible role in influencing and advocating public policy on the care of people with disabilities, including lobbying for the creation of environments that facilitate access and communication for those citizens with disabilities. Nursing research that contributes to effective policy development in this area should be supported.

ICN recognises the value of community based rehabilitation, where this is the choice of the disabled person.

BACKGROUND

A disabled person is someone with a physical, mental, sensory, or social impairment which, in the long term, adversely affects their ability to carry out normal day-to-day activities.

NNAs can support programmes for the care for persons with disabilities, the prevention of disability, and the rights and freedoms of disabled persons by collaborating with other disciplines and organizations to:

- Identify the major causes of disability and to assist in determining and implementing the measures needed to reduce and eliminate these.
- Ensure that services for prevention, care and rehabilitation are initiated and/or expanded.
- Educate the public so that people with disabilities may be integrated within society to the fullest possible extent.

Strategies to maximise nursing effectiveness include:

- Ensuring that nursing education addresses competencies necessary for the prevention of disability and the care and rehabilitation of people with disabilities; promotes fuller understanding of the particular problems faced by people with disabilities and their families; and, includes advocacy skills and a knowledge of programmes and resources in the community.
- Assisting, supporting and advocating for persons with disabilities and their families to access education, information and support services that allow them to lead fulfilling lives.
- Assessing:
  - Maternal/child and adolescent services, to ensure children/youth are not disabled through poor maternal and child health services, malnutrition, poor hygiene, lack of immunization, domestic violence or lack of appropriate counselling to parents;
  - Occupational health services, to ensure safety regulations are respected; — community health programmes, to ensure adequate health teaching is carried out for the prevention of accidents and illness.
- Carrying out research, for example into the prevention of disability, promotion of rehabilitation and the integration of people with disabilities within a community.

Adopted in 2000 Reviewed and revised in 2010

Resources:
WHO: www.who.int/disabilities/en
UN: International Convention on the Rights of Persons with Disabilities:
www.un.org/esa/socdev/enable
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*Representation of actual gamma scintigraphy images of paracetamol in the gastrointestinal (GI) tract.

References