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MALTA NURSING AND MIDWIFERY JOURNAL

Malta Union of Midwives and Nurses

No.67 - Ġunju 2015

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Ġunju 2015

Pubblikat: Malta Union 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

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

L-MUMN ma tistax tinżamm responsabbli għal xi ħsara jew konsegwenzi oħra li jiġu kkawżati meta tintuża informazzjoni minn dan il-ġurnal.

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

Ċirkulazzjoni: 3400 kopja.

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

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

Kull bdil fl-indirizzi għandu jiġi kkomunikat mas-Segretarja mill-aktar fis possibbli.

Il-Musbieħ jiġi ppubblikat 4 darbiet f'sena.

Ritratt tal-faċċata: MUMN

Design u printing: Union Print Co. Ltd., Marsa

editorial

Are we smiling enough?

Smiling and being cheerful is seen by some patients as an indicator of good nursing, but some days we find smiling at patients easy, and on others, it is not. Our personal life makes it at times difficult to smile especially when there is bullying in the workplace and serious family problems. One can always smile when such problems are around but this is not a genuine smile. Some institutions insist that smiling is part of the uniform and even create hospital policies, but after some time of 'faking' our smile it will definitely make us tired of smiling.

Patient perceptions of a nurse's skill are largely based on their interpersonal skills and caring practices, rather than their technical skills. Nurses should be measured on the compassion they show to patients. Patients sometimes describe nurses as friendly, caring, compassionate, kind, and good listeners as nurses who are very skilled. 'Good bedside manners' is still a very strong indicator by our clients which best describe nursing skills and qualities of the ideal nurse.

Compassion may be present and smiling is not necessarily a way of displaying it. No-one can smile all the time; nurses are humans too, they are not robots and being friendly doesn't always require a smile. Some nurses and midwives do not think of themselves as 'smilers' and this does not indicate that they are unhappy or that they dislike smiling. Are we expected to put a smiling face all time without variation? It is okay to cry with the patient, feel the anger and annoyance and definitely okay to laugh with them, however, to insist that a nurse be smiling and sweet all the time to "cheer up" the patients, especially depressed ones, is just a silly argument.

On the other hand we have to acknowledge the benefits of smiling too, as this has been known to reduce stress, alter our mood and make us feel better. Smiles are also contagious; when you smile at people more often, you will receive a smile back. According to Denis Waitley, 'A smile is the light in your window that tells others that there is a caring, sharing person inside.'

Being genuine and kind facilitates the healing process and not only the expression on our faces. A genuine smile here and there will make them trust us. Are we smiling enough?

Kelmtejn mis-Segretarju Ġenerali

Il-Kunsill il-ġdid irranka sew. L-għaxar membri li jiffurmaw il-Kunsill qed ikunu involuti fil-laqgħat li jkollha l-Union, kulhadd skond ir-responsabbiltà tal-kariga li jġorr. L-istess jista' jingħad għaċ-Chairpersons tal-Group Committee li bi ħġarhom qabdu l-mazz f'idejhom u qed ikunu involuti huma wkoll f'kull laqgħa li jkun hemm li tikkonċerna ir-rwol tagħhom.

L-Amministrazzjoni tal-Union iddeċidiet li toħloq tlett Group Committees ġodda li ser ikunu responsabbli mill-ITU, Casualty u Theatres. Dawn it-tlett areas hemm fihom jaħdmu numru sostanzjali ta' membri u għalhekk sabiex l-MUMN tagħti servizz kif jixraq li jkun wieħed viċin il-membru u fl-istess waqt tisma' dak li jridu jgħidu n-nurses, ġew stabbiliti dawn il-tlett kumitati.

Dan ix-xahar organizzajna seminar għall-attivisti fejn prinċipalment ddiskutejna il-mod kif timxi internament l-MUMN u kif dan jista' jkun aħjar, u l-proposti għall-Ftehim Settorali ġdid. Saru bosta suġġerimenti interessanti li ser ikunu l-bażi ta' dan il-Ftehim. Nistieden lill-membri kollha li jekk iridu jibgħatu il-proposti tagħhom jistgħu jgħamlu dan fuq l-email address tal-Union. L-MUMN minn dejjem kienet miftuħa għall-membri u hekk ser tibqa' tkun anzi trid tinfetaħ aktar. Infatti din ser tkun l-ewwel darba li l-Kunsill tal-Union ser ikun qed jilqa' propsti għall-Ftehim Kollettiv mingħand il-membri stess biex hekk l-MUMN tkun veru il-Union tal-membri tagħha.

Għalkemm qed isiru laqgħat dwar l-investiment il-ġdid fil-qasam tas-saħħa, kemm dak f'Malta kif ukoll f'Għawdex xorta l-membru jibqa ' jaħseb fuq dak li jista' jkun ġej għalih. Dan huwa aġir normali għal min ikun qiegħed jistenna xi ħaġa ġejja. Għalhekk l-MUMN hija kontra li tinħoloq anzjeta żejda għaliex il-membru jsofri dan kollu fuq il-post tax-xogħol u ħadd aktar. Din il-Union qed tagħmel l-almu kollu tagħha sabiex tnaqqas din l-anzjeta fost il-membri.

L-MUMN qegħda wkoll taħdem mall-Gvern sabiex ikun hawn f'pajjiżna aktar nurses, kemm Maltin kif ukoll barranin. Fejn huma kkonċernati nurses Maltin din il-Union qed tkun involuta f'ħidma sħiħa sabiex ikun hawn f'pajjiżna universita Ingliża ta' profil għoli u b'hekk iż-żagħżagħ Maltin ikollhom l-opportunità li jgħażlu liema università iridu jattendu. B'hekk tikber il-flessibilita' ta' l-universita Maltija billi jinħolqu aktar pathways mingħajt ma jiġi kkompromess il-livell. Nistennew u naraw….

Is-sena d-dieħla l-MUMN tgħalaq għoxrin sena anniversarju, eżatt fid-19 ta' Settembru. Ġie organizzat kumitat apposta sabiex iħejji sew għal dan l-aveniment speċjali kif inhu xieraq. Kull min hu interessat li jgħamel parti minn dan il-kumitat għandu jikkuntatja lil Alex Lautier fuq sanderlau@hotmail.com li huwa c-Chairperson tal-Kumitat Eżekuttiv b'Relazzjonijiet Soċjali u Kulturali.

Tagħrif ieħor important li nħoss li għandi naqsam miegħek huwa l-fatt li ntlaħaq ftehim bejn il-Bord tan-Nurses u l-Midwives u l-MUMN dwar l-Specialisation Framework fejn il-professjonijiet tan-nursing u l-midwifery ser jingħataw spinta l-fuq dwar l-ispeċjalizzazjonijiet.

L-MUMN ser tibqa viġilanti fuq tlett oqsma li huma l-aspett trejdunjonistiku, dak edukattiv u dak soċjali. Dawn huma t-tlett pilastri li fuqhom hija msejsa din il-Union. Huwa strumentali li l-MUMN ittejjeb il-kundizzjonijiet tax-xogħol tal-membri tagħha u tagħmel l-għalmu kollu tagħha biex iżied il-pakkett finanzjarju u fl-istess waqt tindokkra il-qasam edukattiv sabiex i-professjonijiet jitilgħu tarġa oħra l-fuq. Ma dan kollu din il-union trid tkompli tħares l-aspett soċjali anki permezz tal-Forence Nightingale Benevolent Fund.

Colin Galea
Segretarju Ġenerali

President's message

Dear colleagues,
It is my pleasure to present the Malta Union of Midwives and Nurses' (MUMN) June 2015 journal 'Il-Musbieh', the second one during my Presidency. I hope everyone has plans for the summer and hopefully, it will be nice and warm for all to enjoy. Even though the summer will be on us soon, we at the MUMN will continue to work hard for our members. I'd like to take just a few minutes of your time to share some highlights of what's been occurring since our last edition in March.

We can all agree that we live in fast-changing times, with innovation in practices within the health care system occurring all around us. There are of course many questions to be answered regarding how these innovations and practices will be implemented. One of the things that holds a lot of people back when something new is to be implemented is that they feel overwhelmed by the massive changes they think they have to make right away. And those entire giant, looming changes become oppressive, leading to a sort of paralysis that prevents the person from attempting the new goal. Planned change in the health care system is the calculated and collaborative effort to bring about improvements within the system. It is necessary for a wide range of reasons, but it can be challenging to implement. An unstructured approach to implementation can lead to failure. Any questions and problems need to be solved, as it is vital to create the conditions for the wide-ranging exploitation of these innovations for the benefit of all employees, patients and organisations. On this regard the MUMN Council together with the members of the Group Committees are constantly on the forefront to work in the best interests of the members the MUMN represent. Quite frankly I can say that the MUMN has a busy year ahead – the coming months' promises to be just as busy as the last ones. We are working hard, at times even behind the scenes to ensure that your voice is heard about important issues such as the working conditions, training and education, staffing levels, and supporting staff. Together with Council members and Group Committee members, I visited some of you at your workplace and was able to see and feel the fantastic work that you do. I recently visited a mental health unit, the mental health outreach team, the crisis intervention team, some wards at SVPR, two homes for the elderly, the Gozo General hospital, and the Accident and Emergency department at Mater Dei Hospital. On a particular evening, I also spent some time with the staff working at the extensions (corridors) at Mater Dei Hospital. My aim is to continue this practice, during the coming weeks, to foster clearer communication, while soliciting feedback from members to improve processes or take care of problems.

Capitalizing on the theme of "MUMN Leading the Way" MUMN can offer strategies to advance professional status of its members and health care systems. I can say that this is indeed the most impressive honour in my entire career. I look forward to working to serve nurses, midwives and other health care professionals' members of the MUMN to improve the quality and safety of care for our patients, and continue to transform our nation's health. During these past 3 months the MUMN Council worked closely with the Group Committee members, so that their industrial relation input is more visible at their respective workplaces. As a matter of fact, I take the opportunity to thank each Council member, Group Committee members and Office Administrators for their extraordinary work they are doing. I also thank you, for your valuable work you are doing. Through the input of all, the MUMN is leading itself proactively rather than retrospectively, by eliminating some of the potential problems, and address and act on others. MUMN officials together with Group Committee members actively worked on different avenues. Some of our work include: regular meetings at departmental and hospital level, meetings with staff at ward level, launching of the nurses' marketing campaign, exploring avenues to conduct research based studies at hospital level with the aim to identify the required skill mix, discussions at Ministry level on the possibility of having other universities providing Degree in Nursing, meetings with social workers and ECG technicians in view of their career progressions, meeting with physiotherapists, set up of new group committees which include also the addition of 3 committees representing Intensive Therapy Unit, Main Operating Theatre, and Accident and Emergency Department. We have continued to lobby decision makers to ensure that adequate resources are available to support investment in staff development and good working conditions. The MUMN is also in dialogue with the Attorney General, the Hon. Owen Bonnici, Minister for Justice, Culture and Local Government, Director of Court and the Health Department to find a way forward in view of Magistrate Inquiries and the way our members are being summoned.

I hope you will agree that this address highlights the challenges we are facing as a profession and our robust responses to them and the sheer range and depth of the work we are doing. Without you, our members, we would not be the organisation we are and could not support our colleagues in the way we do. My personal priority continues to be to improve member engagement. I hope you have started to see that the new consultation process is making a difference; that I have been listening carefully to your views, concerns and ideas and am taking every opportunity to speak about the issues of greatest concern to you. As a Council we are determined to defend your pay, terms and conditions; demand respect for the amazing work you do and to get the public to understand why things go wrong when staffing levels and skill mix are not right.

I look forward to continuing to work with you over the coming months.

Maria Cutajar
MUMN President

Compression bandaging in Venous Leg Ulcer Treatment

Compression Therapy is a strong therapy which can promote venous leg ulcer healing, and enhance a person's quality of life[1], [2]. Persons suffering from chronic venous insufficiency are predisposed to develop venous leg ulcers, due to impairment of the blood return circulation system, to the heart[3]. The squeezing effect of compression onto the leg, results in reduced oedema and improved venous blood flow towards the heart[1]. Although hosiery or intermittent pneumatic compression devices are available to induce compression, bandages are most often used to achieve this effect[1].

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 frail1. Sub-bandage pressures, vary according to posture, movement of patient and also bandage application techniques[2]. 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[2]. This effect, improves the actions of the calf muscle pump, to pump blood back, from the leg towards the heart[4].

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[2].

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[2], [5]. Long-stretch bandages, sustain high pressure for long periods of time, even whilst the patient is resting[5].

Short-Stretch cotton bandages are able to create high working pressures during exercise, and low resting pressures[2]. 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 also 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[5].

Multi-layer compression systems have been found to be more effective than single layer compression systems[5]. The concept of multi-layering is that compression is applied in layers, thus achieving an accumulation of pressure[5]. 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[2].

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[5].

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[1]

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[1], [5]. 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[5].

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[6]. Budgetary constrains, stress the importance of presenting evidence of cost-effectiveness, prior to approval of re-imbursement 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[6]. 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[5]

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 bi-elastic 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[5]. 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[4]. 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[1]. 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[5].

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

Our Metabolism, Our Diet and Our Weight

Everyone has heard of the word "metabolism". We all think we know what it means but in reality, do we know how it works and how we can make it work better? Wikipedia (2014)[1] defines it as "the set of life-sustaining chemical transformations within the cells of living organisms. These enzyme-catalyzed reactions allow organisms to grow and reproduce, maintain their structures, and respond to their environments. The word metabolism can also refer to all chemical reactions that occur in living organisms, including digestion and the transport of substances into and between different cells." In simple terms, metabolism refers to the rate at which our body functions. This means that if our metabolism works slowly we would tend to put on weight and on the contrary, if it is fast, we would lose weight easily. Keeping this in mind, therefore, the way we eat would determine how our metabolism would function.

Our body breaks down food when it is sure that the intake of food is regular and sufficient for our body to function properly without the risk of us collapsing and dying. If it feels that we are not taking in sufficient nutrients and risk ending up without energy, rather than using up our energy stores it would conserve energy by storing rather than breaking them down. This is what we would call a slow metabolism, which ends up in a person gaining weight rather than losing it, because his fat and energy stores are being conserved rather than used up. It happens when we, either do not eat enough food or our meals are too far apart. These would make our body think we are in 'starvation mode' and would lead to us gaining weight. Eating lots of proteins, which places greater energy demands on the body, would also slow down one's metabolism. Another important factor which affects metabolism is when someone is allergic to wheat (or some other food). When he eats it this would make him bloated and tired and would also slow down his metabolism. A final factor which affects our metabolic processes is our thyroid function. A fast-working thyroid makes our metabolism faster and a slow-working thyroid gland would make us burn less calories and put on weight.

The secret to make our metabolism work faster is to eat regularly. The 'famous' small, frequent meals which all nutritionists who promote a healthy diet so often talk about. Eating regularly would show the body that food is available and therefore the metabolism would work regularly also and make fat and energy store-breakdown faster. In order to do this one would need to plan a healthy diet, starting with a healthy breakfast in the morning, a small meal at lunchtime and the main meal in the evening. In between these meals one would need to take healthy snacks. These would shorten the gap between the meals and make one's metabolism work regularly, helping him to lose weight. Obviously, it is important that the snacks and meals – plus the portion sizes – are healthy and small enough to be metabolised within 2-3 hours, until the next larger meal is ingested. Otherwise rather than losing weight one would put on weight as he would not have metabolised all his food before eating another batch of food, thus storing all the extra supply of food still in his stomach. The secret is therefore finding the correct portion sizes which one metabolises within a few hours and learning how to eat as much as your body can cope with.

In order to control our weight we must control our diet, in order to ultimately control our metabolism and make it work efficiently. We are what we eat. If we eat healthily we maintain a healthy weight and live a healthy life. This is what we should learn and teach others, our friends, our family and our children.

Geoffrey Axiak M.Sc. Nursing (Manchester), B.Sc. Nursing, P.G. Dip. (Nutrition & Dietetics)
Clinical Nutrition Practice Nurse - Elderly Care
geoffrey.axiak@gov.mt

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EFN Press Release

The 102nd EFN General Assembly approves key policy documents linked to Education, Workforce and Quality & Safety

Meeting in Brussels on 16-17 April 2015 for the 102nd EFN General Assembly, the EFN members approved policy documents that will support the EFN and its members to set the scene at national and European levels.

The EFN Competency Framework, will be used by the National Nurses Associations to encourage the nursing schools at national level to deploy the guidelines for implementing the competences listed under Article 31 of Directive 2005/36/EC, amended by Directive 2013/55/EU, on the Mutual Recognition of Professional Qualifications. Furthermore, recognising the importance of Continuous Professional Development (CPD) to deliver high quality and safe care, the new EFN Policy Statement and Position Paper on CPD are calling on the European Commission, national governments, regulators, professional organisations and employers to take actions and guarantee that nurses all over the EU & Europe have access to CPD, supported by appropriate structures and resources.

Moreover, the new EFN Matrix 3 +1, including three categories of nurses (General Care Nurse, Specialist Nurse, and Advanced Nurse Practitioner) + the principles of the Healthcare Assistant (HCA) will provide clarity when collecting comparable data for workforce planning and forecasting in the EU Member States. An EFN working group has been established to look at the HCA profile.

Looking closely into the necessary move from hospitals towards Primary and Community care, the EFN Policy Statement and Position paper on "Moving Care to the Community" are calling on the EU key decision-makers to ensure that the frontline workforce is supported with sufficient EU funding, in order to make integrated care a success. Furthermore, to engage the nursing profession in the deployment of the European Digital Agenda to make EU policies "fit for practice".

Moreover, the EFN Members noted the results of the Ebola questionnaire that will be taken forward during the Luxembourg Presidency. It is important to build the capacity for being prepared. Lessons learned are always positive!

Finally, the EFN members approved a new revised Constitution of the European Nursing Research Foundation (ENRF). This was done bearing in mind, that it is important to strengthen the nursing research at EU level, in order to deliver evidence-based policy-making and ensure that political decisions are taken to improve the daily realities of the European nurses and to bring in appropriate measures to improve the access to high quality healthcare services.

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Reference:

Slavin. J., N. A. Greenberg. (2003). Partially Hydrolyzed Guar Gum: Clinical Nutrition Uses.

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Spiritual care in terms of hospitality

The 4th European Conference on Religion, Spirituality and Health, which was hosted by the Faculty of Health Sciences of the University of Malta from 22 till 24 May 2014, focused on the integration of religion and spirituality in the field of clinical practice, hence on health care professionals. Among the inspiring lectures who enriched the conference programme, which programme was mainly composed of keynote lectures, symposia, free communications and posters that were skilfully organized, I would like to mention an interesting Powerpoint lecture delivered by Rev. Prof. John Swinton. John is currently a Professor in Practical Theology and Pastoral Care in the School of Divinity, Religious Studies and Philosophy at King's College University of Aberdeen as well as an honorary Professor of Nursing at the University's Centre for Advanced Studies in Nursing. John's lecture dealt with Re-imagining Mental Illness: Creating Communities That Care.

This presentation tried to explore different ways where we can re-think mental illness. Its starting point was that of departing from the claim that mental illness is merely a problem to be addressed towards a new and healing comprehension which regards it principally as a way of living in the world. Obviously such living needs to be understood and related to more than just annihilated. Mental illness happens in real people before they are rendered as simple diagnoses.

These personal experiences should never be sidelined. Thus, John's presentation examined ways that can aid to reacquire an authentic holistic approach to people who undergo psychological difficulties.

A powerful assertion John made during his intriguing, simple, clear and intellectually engaging presentation was that mental illness is a disruption of our life stories. He continued to explain that mental illnesses are a rupture in the stories we tell about ourselves and those that are told about us. As care givers we are called to give people back their stories and help them embrace their narratives. John said that spirituality is a way of looking and listening carefully to the stories of people we daily minister to. Consequently, to provide spiritual care, particularly with people with mental health, essentially means being hospitable to them. In every pastoral encounter there is an interesting dynamic within the pastoral relationship which is taking place, namely from guesting to hosting.

The chaplain is the guest whereas the patient is the host. This pastoral movement is not simply restricted to the spiritual care of mental patients. My pastoral experience in Mater Dei Hospital informs me that this happens in every pastoral encounter I am engaged in as a chaplain.

In order to better appreciate the working concept of guesting in pastoral care it would be wise if we take a multicultural approach. To begin with, hospitality is about the relationship that occurs between the guest and the host. This, of course, involves the reception and entertainment of guests, visitors, or strangers. Etymologically the word hospitality comes from the Latin word hospes which means "host", "guest" or "stranger". Hospes is made up from the word hostis which means "stranger" or "enemy". In fact that is where the term "hostile" is used.

For the ancient Greeks hospitality was a divine right. The host was duty-bound to make sure that his guests' needs are met. In Greek society a person's nobility and social standing heavily depended on his/her ability to conform to the laws of hospitality. On the other hand Celtic societies regarded the concept of hospitality as protection. A host who satisfied a person's plea for refuge was expected from him not only to provide food and shelter to his/her guest but also to see to it that they are not harmed whilst under their care. The Indian perspective on hospitality is utterly based on the fundamental principle of Atithi Devo Bhava. In other words "the guest is God". This maxim is illustrated in many stories that show how a guest is precisely a god who rewards the hospitality provider. From here one can easily trace the Indian attitude of graciousness towards guests at home as well as in all social situations. Lastly, and not the least, the Jewish belief of Hachnasat Orchim, or "welcoming guests," is modelled on the example of Abraham in the Book of Genesis.

Hosts are the ones who provide food and drink for their guests together with caring for their general comfort and entertainment.

Moreover, many adopt the ritual of offering their guests an opportunity to either cool down or warm up. Others cared so much for their guests to the extent of offering them air conditioners, both for free or for an insignificant fee. When the visit is concluded hosts usually would accompany their guests out of their home while wishing them a safe journey.

Obviously, as pastoral carers, we are always invited by those whom we care for to accompany them throughout their distressing journeys. It is they who welcome us. Certainly they do so because in us they behold God's presence who is "finding them in a desert land, and in the howling waste of the wilderness, and is encircling them. God's presence is caring for them and keeping them as the apple of (God's) eyes" (see Deut 32:10). Invasive as it might initially appear, God's presence is always liberating, provided of course that the caregiver thoroughly understands that within the pastoral relationship s/he is the guest and never the host. However the irony is that the pastoral giver himself/herself is to exercise his/her pastoral guesting role by taking on board some of the hosting attitudes! The effective pastoral giver should see in the person who is serving God's presence too. That is why s/he needs to protect the patient from any harm s/he might encouter as s/he recounts his/her story. By listening attentively and non-judgmentally to what the patient wants to say the pastoral caregiver is providing a securing existential comfort, a safe place where the person in distress can attain that necessary hope to make him/her carry on with his/her life challenges. Finally, when the pastoral visit is over the patient would happily entertain the healing reassurance that no matter the obstacles that would be met s/he knows that another caring person is accompanying him/her.

Is being a spiritual caregiver not a divine privilege indeed?

Fr Mario Attard OFM Cap

from our diary...

Two separate groups of Staff Nurses received their certificate after completing with success the EN-SN Conversion Course.

FNBF Group Com
on behalf of the

The members forming the MUMN FNBF Gr

The Florence Nightingale MUMN Benevolent Fund organised its annual ceremony where those nurses and midwives, members of this fund, celebrate their retirement age. For the first time in these last 14 years this ceremony was organised at the Presidential Palace as H.E. President of Malta is the Patron of this Fund.

The members forming the MUMN Pensioners Group Co

mittee presented a donation to H.E. President of Malta Community Chest Fund.

The MUMN SVPR Group Committee organised a well structured conference to celebrate this year's International Nurses Day. During this conference the Group Committee presented a microphone to be utilised by all at the SVPR Theatre, mattresses and other equipment to the CEO of this Elderly Residence.

oup Committee.

The Directorate Nursing Services in collaboration with MUMN organised a conference to celebrate the success of 800 Enrolled Nurses who converted to Staff Nurses through a specific course.

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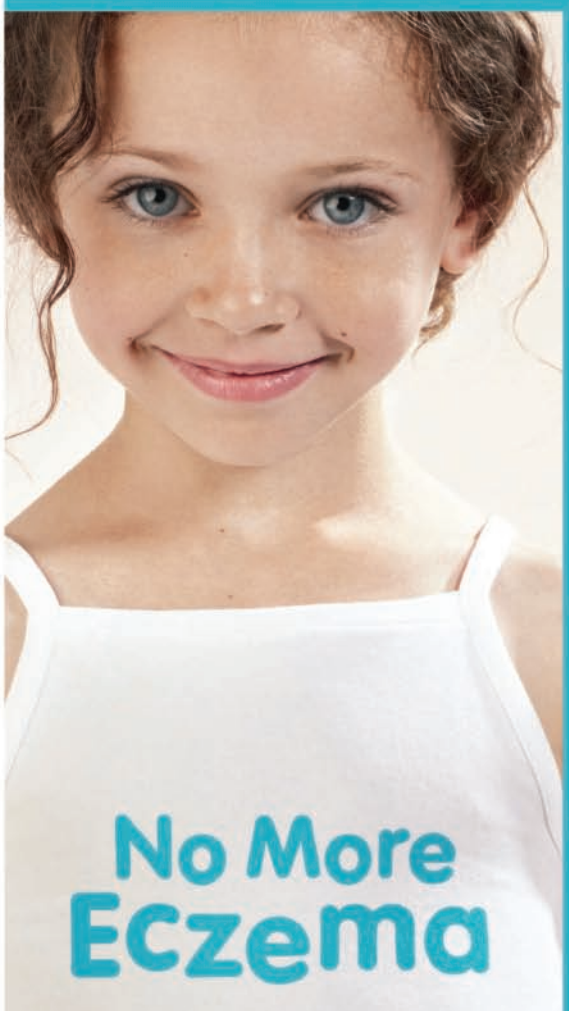

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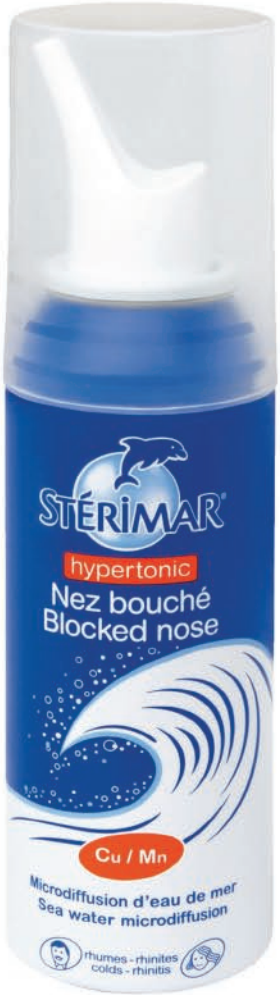

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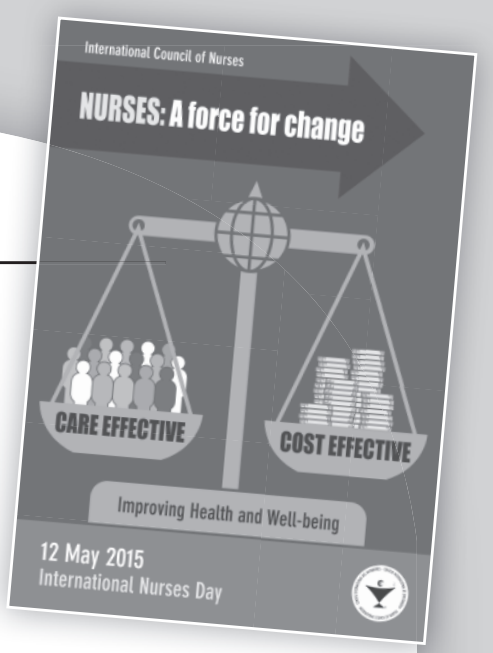

International Nurses Day celebrates cost effectiveness of nurses

Geneva, Switzerland, 11 May 2015 – The International Council of Nurses has chosen the theme Nurses: A Force for Change: Care Effective, Cost Effective as the theme for International Nurses Day 12 May 2015.

The theme reinforces the fact that global health cannot be achieved without nurses' participation at all levels of the healthcare system.

"Nurses and policy makers must focus on the nursing role as a key priority and determinant for achieving equity, delivering universal health coverage and ultimately improving health outcomes globally," stated David Benton, ICN Chief Executive Officer. "Nurses are well positioned to drive improvements in efficiency and effectiveness".

As the single largest group of health professionals, and those closest to people in all settings, nurses can have an enormous impact on reducing health costs and increasing quality of care. Nurses understand the landscape of healthcare delivery including financing, cost effectiveness and resource management, and access to care. The decisions that every practicing nurse makes multiple times each day can make a significant difference in the efficiency and effectiveness of the entire system.

Drawing upon examples from around the world, the ICN's toolkit for International Nurses Day examines the current issues around health system financing and the value of nursing. It provides guidance for nurses and policy makers on how to best achieve equitable access to effective and affordable healthcare services. The tools, information and ideas for action contained in the kit will assist and encourage nurses and national nurses associations (NNAs) to become engaged in and knowledgeable about health system financing as a means to achieving quality of care and patient safety in a cost effective way. Examples from around the world demonstrate what is possible when nurses bring their creativity and professional perspective to the transformation agenda.

ICN offers the IND kit to national nurses associations, health ministries and health institutions worldwide. Materials in the kit, including the poster image, can be downloaded from www.icn.ch/publications/2015-nurses-a-force-for-change-care-effective-cost-effective/2015.

Celebrated around the world on the anniversary of Florence Nightingale's birth, International Nurses Day is an excellent occasion for nurses and their associations to inform and remind the public and policy makers about the role they play in promoting the health of communities and nations.

The role of the midwife during pregnancy, birth and after birth between 1900 and 1990

Since the beginning of humanity, humans gave birth to their offspring with or without the assistance of other skilled individuals, usually another woman. I was always fond of the art of midwifery especially of those midwives who used to provide their service in the community between the 1900 and 1990, who had limited resources but were very skilful.

Documentation and information regarding homebirths and midwifery practices between 1900 and 1990 is very scarce and there is no information about what used to happen in the birth room during homebirth within those mentioned dates. Hence, I decided to conduct the research myself and look further into the subject.

The aims of this research were to explore the perceptions of the mothers and midwives about their homebirths which occurred between 1900 and 1990. The objectives included exploring the roles of the midwife during pregnancy, the actual birth as well as after birth and to exploring the personal stories and experiences which occurred, from the mothers' and the midwives' point of view.

Since no similar research was conducted before, an exploratory design was used and information was gathered using a semi-structured interview using open ended questions to guide the participants. Till this time of writing twenty four mothers were interviewed whom between them delivered 95 babies at home including one set of twins, two unassisted births, three still born and one maternal death. A total of three midwives were interviewed counting one from Gozo and information about three other midwives who passes away was gathered.

This study made use of three different sets of open ended questions which were asked to the participants during semi structured interviews and which differed according to the participants' role. One set were used to interview mothers who had experienced a home birth between the 1900 and 1900, another set was used to interview the midwives who had assisted them and the final set were used to interview the relatives of the midwives in cases where the latter had passed away. Questions to the mothers included information about themselves; information about their homebirth experience, care provided during child birth, pregnancy and after the baby was born. They were also asked about their midwife and her role, and about other relatives or attendees present on the day.

The midwives, or their relatives, where the latter had passed away, were asked questions regarding their profile, qualifications, studies and place practice, work experience, management of the mother and baby care, during and after pregnancy. They were also questioned with regards to their actual practices during home delivery, infection control measures, documentation, payment and time management. They were also asked to recount personal experience and particular cases which they could still recall. All participants were very generous and allowed me to go through all the tools, books, registers, notes and other things which the midwife used to possess. I personally visited several birth rooms (alcove / 'arkova') in houses and went in various World War II underground shelters some of which had specific rooms which were used by women to give birth or receive medical attention.

The environment and resources available were not always favourable, however everyone used to make his or her utmost to ensure the best possible environment with the limited resources they had. Midwives worked in all sorts of unpleasant environments including damp underground shelters and risked their own lives to help woman in labour during air raids. They had to work for long hours, always available 24 / 7 to address the needs of the mothers.

Having a homebirth sometimes was the only option for the mother. Although the great majority of births were straight forward and without complications, there were a number of challenges which the mothers had to go through such as lack of support from the husband. Since analgesia was often unavailable, mothers had to endure labour pains and feel the needle coming through their skin during suturing.

During my research my perceptions change, a lot of questions were answered and a lot of misconceptions were cleared. The role of the midwife during homebirth between 1900 and 1990 had until today been a mystery, however through this research I managed to expose what used to happen in the birth room, behind closed doors.

Janice Cassar
Staff Nurse
E & A Department
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HUMOUR PAGE

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Nurse Marge *in Charge*

About a Nursing Student

"How refreshing."

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MUMN APPEALS AUTHORITIES TO SEEK AN IMMEDIATE SOLUTION FOR THE SERIOUS PROBLEM REGARDING PARKING AT MDH

Hon. Dr. Konrad Mizzi
Minister for Energy and Health

Hon. Mr. Chris Fearne
Parliamentary Secretary for Health

Mater Dei Hospital comprises a long standing issue regarding staff parking. Our members are continuously informing us with the serious problems they are facing every time they need to park their car to resume duty. MUMN cannot bear this situation any more.

Most of our members leave quite early in the morning then necessary so that they would not face a havoc before they start their shift. This situation creates also serious family problems on those parents who need to attend to a child care centre or at their parents to leave their children under their care. It is not right for the children who needs to wake up more early then needed because of this parking problem. Our members will be already stressed even before they start their daily shift.

This situation is creating a chaos even for those who have shorter shifts as on their way out they find their car blocked by someone who was desperate to find a parking space and park the car in front someone else's car.

Some months ago, during a meeting at the Ministry, MUMN was informed that there are plans so that a 400 space car park would be created in the area where today there is the helicopter pad. We were also informed that by the end of this year this new car park would be completed. This new car park would surely alleviate the problems our members are facing on a daily basis.

In this scenario MUMN would like to strongly appeal to you to speed the process for this new car park to materialise. Apart from the shortage of staff our members cannot also face shortage of parking space.

MUMN requests a meeting so that you inform us in what stage is the process of the new car park and how they can it be ready before the opening date.

Regards,

Maria Cutajar
MUMN President

MUMN protests with government for deductions in salaries without employees' consent

The Malta Union of Midwives & Nurses said it cannot tolerate more the fact that the Health Department is authorising deductions without consent on the salaries of its members every time the same department does a mistake and overpays its employees. Accomplice with the Health Department is the Treasury Office in Valletta.

The last case occurred this week when a single mother raising a seven month baby was overpaid by the Health Department with the amount of Đ1215. This nurse asked for a breakdown as was not convinced that this amount was correct. The Department objected to hand a breakdown and instead did not give any salary to this nurse, leaving her literally stranded with her seven month baby to care.

This was not the first case that occurred and so MUMN seeked legal advice who in turn sent a letter to the Permanent Secretary at the Health Department.

MUMN will not accept the fact that the Treasury Office in Valletta continues to shift the Health Department's mistakes on our members and more grievous are the situations where deductions are occurring without our member's consent.

MUMN is ready to meet the Finance and Health Ministries in order to discuss and find an acceptable solution for this scenario. On the other hand if another member complains due to a similar situation, MUMN will not have any other option but to register an industrial dispute with the Health Department.

An exploratory study of Maltese patients' perceptions of their preparation for total joint replacement at the pre-admission clinic

Patient education is an integral part of the pre-operative preparation for elective patients. Various studies show that patient education provided at Pre-Admission Clinics (PACs) leads to a reduction in anxiety and fear levels (Johansson, et al. 2002), increased knowledge about care and rehabilitation (Lin et al., 1997) and increased adherence to the prescribed postoperative activities (Santavirta 1996). However, knowledge related to the patient's perceptions about these clinics is limited.

This study reports the findings of a qualitative study using semi-structured interviews carried out with a purposive sample of 30 patients following joint replacement surgery in Malta. Approval for this study was obtained from the local University Ethics Board and participant informed consent was ensured. Qualitative data was collected using in-depth semi-structured interviews with seven open-ended questions. The data obtained was analysed thematically following the stages expounded by Burnard (1991).

Two main themes emerged from the patient interviews from which four sub-categories were identified (Box 1).

Theme 1: Managing a complex situation

The information given at the PAC assisted the majority of patients in managing their pre-operative anxieties and addressing their practical needs. However, it is also evident that information giving is a complex affair that entails skilled intervention by the health care professionals since the perceptions of some patients reflected an internal struggle between the need to know and the apprehension of knowing too much.

Clarifying the unknown

Most of the patients stated that the information they received helped them to clarify the process they would be going through and reduced 'fear of the unknown'. The importance of small details that might normally be overlooked by health care workers were considered as essential by a number of patients in helping them to ease their anxiety. The information was also found to be of practical application in preparing the patients' home environment.

Conflicting knowledge needs

Although the majority of patients verbalised positive feelings about receiving information, eight patients reported apprehension of varying degrees on receiving the details related to potential complications, even if they appreciated the need of information.

Theme 2: Experiencing the clinic

The second theme was related to the patients' experience of the organisation of the clinic.

Complementary educational strategies

The use of complementary educational strategies using both verbal and written information during the PAC helped patients to retain knowledge. Verbal information helped in 'humanising' the experience of receiving information as well as clarifying personal queries while the booklet served as a reminder and a source of reference.

Organisation of care

The structure and organisation of the clinic itself was viewed positively by most of the patients. They had a positive view of the individualised attention and the feelings of encouragement as well as confidence that were projected by the PAC team. It was stated that the attitudes of the PAC team also assisted the patients to feel respected as an individual person and a human being.

The knowledge obtained in this study can be summarized as the 7 'D's of patient education in the PAC setting:

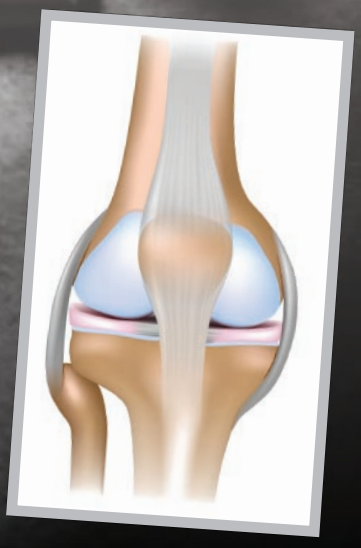
1. **Direction:** Patients should be provided with details about their hospital experience and practical information about e.g. home adaptations.
2. **Depth:** It is important to gauge the knowledge of patients and how much they would like to know. While information on potential complications is a requisite, the emphasis should be on preventive and active measures that the patient can do.
3. **Detail:** Nurses should provide the details relevant to the patient and the space to ask questions and clarify uncertainties or anxieties. Use of verbal, written and picture materials ensure that retention of knowledge.
4. **Damage control:** Patients may have predetermined ideas and unwarranted worry. Identifying these worries is very important to be able to control any unnecessary fear.
5. **Discharge planning:** Good problem solving skills are required to ensure a smooth discharge plan. When challenges

are identified, the nurse should be able to assist the patient and relatives in breaking down the challenge into action steps.

6. **Dignity and respect:** Giving information in a respectful way without being directive, acknowledging the patient's specific needs, involving the patients in decision making and treating patients with dignity will assist them to feel secure and cared for.
7. **Drive and motivation:** PAC nurses should provide an 'energising interaction' during the session to help motivate and empower patients. The relatives can also motivate, coach and remind the patients about the education covered during the PAC.

References can be obtained from the author himself at the below email address.

Reginald Aquilina
Practice Nurse (Orthopaedic)
reggie.aquilina@gmail.com



03 ta' Gunju 2015.

L-MUMN TIKKUNDANNA LIL MIN HU RESPONSABBLI GHAN-NUQQASIJIET KOLLHA MARBUTA MALL-KWISTJONI TAL-LIVELL BAXX TA' KONKOS FL-ISPTAR MATER DEI.

Il-Malta Union of Midwives & Nurses ma tistax toqgħod lura milli tikkundanna li min hu responsabbli għan-nuqqasijiet kollha li rriżultaw f'konkos ta' livell baxx fil-bini ta' l-Isptar Mater Dei.

Mingħajr ma tidħol fil-kontroversja politika, l-MUMN tistqarr li din il-kwistjoni qed toħloq problemi bla bżonn lill-membri tal-union li jaħdmu f'dan l-isptar. Eżempju ċar huma n-nurses li jaħdmu fid-Dipartiment ta' l-Emergenza fejn minbarra li jiffaċċjaw numru sostanzjali ta' pazjenti li qiegħed dejjem jiżdied, issa jridu jaħdmu f'kundizzjonijiet tax-xogħol mhux feliċi minħabba l-fatt li qed isiru xogħlijiet ta' kostruzzjoni minħabba l-irresponsabbilita' ta' persuni li xogħlhom kien suppost li jaraw li l-livell ta' konkos użat kien wieħed ta' livell għoli u li l-poplu Malti ħallas għalih.

Minbarra n-nurses li jaħdmu fid-Dipartiment ta' l-Emergenza, fil-futur qarib ser ikollna lin-nurses, midwives u professjonisti oħra li ser jgħaddu mill-istess żgombru meta ser isiru xogħlijiet fi block D li wkoll huwa milqut mill-istess nuqqasijiet ta' konkos ħażin. Dan huwa fatt inaċċettabli fejn minħabba numru ta' persuni li xaħħmu butthom minn fuq il-poplu Malti, ser ikollna ngħadu minn sagrifiċji żejda u kapriċċużi waqt li jkun għaddej ix-xogħol ta' rinfurzar tal-bini.

Barra minn hekk l-MUMN tinnota b'dispjaċir l-ammont konsiderevoli ta' miljuni ta' ewros li ser jintefqu sabiex jiġi nfurzat il-bini. Kien ikun aħjar li dawn il-fondi ser jintefqu fi sforzi sabiex jiżdied in-numru ta' nurses f'pajjiżna kemm mill-att edukattiv kif ukoll mill-att ta' titjieb fil-kundizzjonijiet tax-xogħol biex b'hekk ikun hawn ammont ta' nurses biżejjed kemm għall-esiġenzi ta' llum kif ukoll dawk tal-futur qarib. Kien ikun ahjar li dawn il-fondi intefqu sabiex in-nurses u l-midwives ikollhom supporting staff kif inhu xieraq sabiex il-pazjenti jingħataw kura aħjar. Din il-Union tħeġġeġ lill-Gvern biex ikompli għaddej bl-isforzi tiegħu sabiex dawn il-miljuni jiġu irkuprati.

L-MUMN tixtieq tieħu din l-opportunità sabiex tirringrazzja lill-membri tagħha kollha li barra li qed iħabtu wiċċhom ma' sfidi kbar sabiex joffru l-awqa kura possibli lill-pazjenti qed ikollhom ukoll jaffrontaw sitwazzjonijiet ta' żgombru minħabba dan l-infurzar fil-kostruzzjoni.

Colin Galea
Segretarju Ġenerali
MUMN

Investing in the future

Mervi Jokinen

Joeri Vermeulen

Healthy mothers and children are building blocks for a strong future in Europe. While infant and maternal mortality continue to decline, the burden of mortality and morbidity in the perinatal period – pregnancy, childbirth, and the postpartum – remains a major concern. Optimal maternal and infant health are critical to societal wellbeing. Achieving optimal perinatal health thus involves a balance between intervening to manage and prevent complications while minimising interventions that have negative side effects on health and induce anxiety among pregnant women and their families. Unnecessary medical interventions also contribute to the costs of providing healthcare without achieving gains in health (EURO-PERISTAT 2012). European midwives are concerned about the variation in, and inequality of, care in Europe, and these inequalities continue to persist in 2015.

It is essential that the importance of women's health and newborn care to the overall public health of nations is recognised. Strategies for public health and chronic conditions should reflect this. There are many socioeconomic factors that contribute to the health of women, newborns and families across Europe (EURO-PERISTAT 2012, WHO European Region). Factors such as poverty, the availability of healthcare, economic and political forces, and gender issues all impact on the health of women and children. Reduction of the inequality of care provision within the EU is an essential goal.

In a recent EU health policy meeting Commissioner Vytenis Andriukaitis (Directorate of European Health and Food Safety) presented his vision of developing and securing an optimum public health strategy across the EU. This included a realisation that the funding is largely focused on healthcare not public health; his envisioned strategy therefore includes four P's: prevention, protection, promotion and participation.

In The Lancet's recent 'Series on Midwifery' (2014), one of the key messages stated that effective coverage of reproductive, maternal and newborn health requires three actions: facilitating women's use of midwifery services, doing more to meet their needs and expectations, and improving the quality of care they and newborn infants receive. Though this was a global approach to providing a framework for quality maternal and newborn care, it is easily recognised as equally applicable for European women's healthcare.

Services

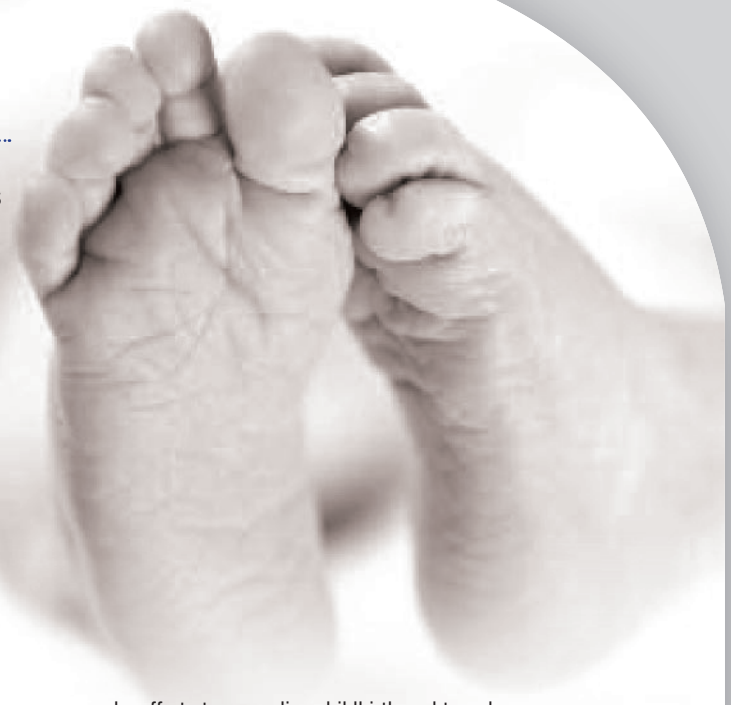
Designing and delivering maternity services in which women's choice, control and continuity of care are not only desirable but essential, too, should be recognised as a key indicator for safe and quality care. In general, these women are healthy and younger than the majority of the healthcare-receiving population; therefore the usual hospital-based, highly interventional clinical care patterns are not cost effective nor do they recognise the social determinants that influence the optimum outcome of the woman's pregnancy.

The variations in birth outcomes are well documented, and the rising caesarean rate is of concern and can be between 12 and 55% in Europe (Macfarlane et al., 2015). This has a considerable financial and long term health burden for both the woman and the baby. There is increasing evidence on how the mode of birth impacts on the wellbeing of the newborn as an infant, child and young adult. Involving women in the planning of their care makes it personcentred and builds their confidence. It impacts on preparing them as a family unit seen as a valued part of society.

These variations are often based on economic and political drivers which set the framework of national health systems. The European Midwives Association (EMA) has undertaken surveys in the pattern of maternity care provided, midwifery practices and women's access to midwives; these have highlighted similar concerns. The women are more adept at sourcing information available across borders via the internet and challenging the status quo in their own countries.

Vulnerable mothers

The situation for unregistered women, illegal immigrants, as a group is of great concern because of the barriers or lack of access to healthcare in a number of European countries. We would draw particular attention to the situation of pregnant women, for whom access to healthcare is extremely important. Lack of access negatively affects the health of both these women and their babies. Equally important is the lack of knowledge and information about sexuality and reproduction, as well as the lack of access to contraceptives, good healthcare services, counselling and maternity care. It is of great importance that all women in the EU have the right to a free abortion, free contraceptives and, when necessary, access to interpretation services. Female



genital mutilation (FGM) is recognised in key political declarations and policy documents of the European Parliament, European Commission and European Council. Women who have undergone FGM may have complications in childbirth, and safeguarding newborn babies to prevent the cycle of this practice in the EU by parental education is paramount.

In many countries people live in poverty and the impact on health outcomes is well documented. The financial crisis specifically affects women and children living in poor areas where reductions in budgets more negatively impact on the population compared to people living in better socioeconomic conditions. There is also a direct link between poverty, poor diet and an associated increase in obesity. This adversely impacts on women's pregnancies and births related to either existing or pregnancy-induced medical conditions. These women require more complex care as well as higher levels of health education and promotion to initiate changes in lifestyle behaviours.

In some countries the level of smoking, alcohol and other substance abuse amongst pregnant women is reflective of their challenges in everyday life. Maternal smoking is a well-recognised risk factor for adverse perinatal outcomes: low birth weight, intra-uterine growth restriction, and premature birth with associated long term chronic respiratory conditions (EUROPERISTAT 2012).

Aside from the obvious benefits for individuals, good mental health is increasingly important for economic growth and social development in Europe. All of these are key EU policy goals. Perinatal mental health has historically not been acknowledged as a priority within maternity care. In recent years there has been a concerted effort in the midwifery community – supported by women's groups – to make more support and resources available to women who are affected by mental health issues due to their existing conditions or, more commonly but often hidden, deterioration in mental health during childbirth. Women who develop a perinatal mental illness are missing out on essential and potentially lifesaving care.

Time to change

EMA believes there is in Europe a need for a paradigm shift in maternity services in order to develop a sustainable model of care that is cost effective and more than hospital based. The inadequate utilisation of midwifery personnel, the low level of continuity of midwifery care for women, limited choice for childbearing women, and restricted opportunities for midwives to work indepe dently should be addressed. The development of primary care services requires the full utilisation of midwives as the first choice health professional alongside other healthcare personnel. Achieving normal births for the majority of women – and normalising the process of birth for all women, regardless of the type of labour and birth they will experience – is our focus. Receiving the best care during pregnancy, labour, childbirth and the postnatal period can be linked to short and long term health and social benefits to mothers, children, families and communities. EMA actively supports those European countries that make efforts to normalise childbirth and to reduce unnecessary interventions.

The manner in which society deals with women and their health can be taken as an indicator of the level of social progress. We would therefore urge policy makers within Europe, when deciding and implementing healthcare policies, to be aware of the impact of the inequalities in sexual and reproductive health on women.

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Mervi Jokinen
President

Joeri Vermeulen
Secretary

European Midwives Association
browse www.europeanmidwives.com

EFN Update

June - July 2015

President Message

Dear EFN Members and Colleagues,
eHealth has become high on our political agenda as a driver for health systems reform, in which integrated care and continuity of care have become key priorities in making health systems sustainable and patient centred. As you know, nurses play a key role in this reform, aiming to empower patients and citizens within the process of care. Our efforts in ENS4care to develop eHealth services guidelines in nursing and social care are therefore timely when the Commission keeps "Integrated Care" high on its political agenda.

This was evident during the Riga eHealth Summit in which EFN message was clear: keep mHealth tools as simple as possible enabling nurses to provide more direct patients/citizens care! As the industry starts now designing integrated care models, incorporating big data logarithms for clinical pathways, trying to close the gap between sectors and providers of eHealth services, the Industry will have a bigger return on investment if their products are fit for practice. This means that nurses have a key role to play in the design to make applications "fit for practice". The deployment of these new models which are now massively in pilots needs to support the workforce and lead inevitably to cost-effective services in nursing and social care which are safe and of high quality!

This brings me finally to the concept of "stakeholder engagement", a theme written about and talked about, but not really deployed when products and governance structures are designed. Engaging the frontline staff is a condition for success. If not, recommendations stay at bookshelves and pilots stay pilots or disappear silently.

Therefore, we are at a crossroad, upscaling to real sustainable models of care, where e-health is the enabler for quality and safety. Let's focus on the key challenges of our society, such as dementia, and see how eHealth services can support the carers, the health professionals, and the individual to achieve a high quality of life in the EU.

Looking forward to your support!

Marianne Sipilä
EFN President

News from EFN

EFN 102nd General Assembly, April 2015

The Spring EFN General Assembly agreed on key policies that will support the nursing profession to develop further. The EFN Competency Framework, to be used at national and regional level by the nursing schools to ensure that nursing curriculum are in compliance with the minimum education requirements, including the set of competences listed under Article 31 of Directive 2005/36/EC, amended by Directive 2013/55/EU, on the Mutual Recognition of Professional Qualifications. Furthermore, following the outcome of the DG Santé CPD study, EFN developed a Policy Statement and Position Paper on Continuous Professional Development calling on the national & EU key players to guarantee that nurses all over the EU & Europe have access to CPD. Concerning the Workforce strategy, the EFN members agreed on a Matrix 3+1, including three categories of nurses (General Care Nurse, Specialist Nurse, and Advanced Nurse Practitioner) + the principles of the Healthcare Assistant (HCA) for having more clarity and comparability when collecting data on workforce. The EFN members encourage WHO, EUROSTAT, OECD, ILO and the European Commission (DG Growth) to start deploying these categories to safeguard quality and safety. Finally, the EFN Policy Statement and Position paper on "Moving Care to the Community" becomes an important piece of work for future developments. The next EFN General Assembly will be held in October 2015, in London.

"Trust plays a key role in shaping patients' and health professionals' decisions on whether to adopt and use eHealth.

Nurses are crucial in creating trust in the healthcare system and in the mHealth applications. If it works well for nurses, it will work better for patients and citizens!"

Paul De Raeve, EFN General Secretary, eHealth week, May 2015, Riga

ENS4Care General Assembly
On 15 April, the ENS4Care partners met in Brussels for the 4th General Assembly, to share their views and good practices on the ongoing work and next steps of the project, building on its successes. The partners were briefed by the work packages leaders on the process of validation of the five guidelines (on Prevention, Clinical Practice, Advanced Roles, Integrated Care and ePrescribing), which first version was submitted to the European Commission in February 2015. With the validation results, the guidelines will become final. The ongoing work now mainly focusses on ENS4Care sustainability, leading to the operational design and development of the European Nursing Research Foundation. Policy and evidence are now coming together!

eHealth week Riga - May 2015
Bringing together key health stakeholders as patients, health professionals, health authorities and industry, the eHealth week organised by the Latvian EU Presidency discussed different views on how to implement and regulate mHealth in the EU. Being part of an interesting panel within the "Joint Plenary Green Paper on mHealth", the EFN Secretary General, Paul De Raeve, stressed the key role of mHealth and of the EU nurses in making progress to reform the health systems, and highlighted that mHealth solutions based on certain quality and safety guidelines can facilitate the shift in health care towards a more integrated model with the focus on prevention and continuity of care. Interestingly, a stakeholder event took place and the EU-US Memorandum of Understanding was evaluated on its core topics of which e-skills for the health workforce has become a high priority.

ESCO Reference Group "Healthcare and social work activities"
Being a member of the group, the EFN participated in the last face-to-face ESCO meeting that took place in Brussels on 20-21 April 2015. The chair, David Gorría, informed the participants on the last Maintenance Committee meeting and on ESCO next steps. The SREF group, in which EFN participates, will no longer meet physically and the rest of the occupations that are not yet included in the ESCO platform, will be completed through public consultations and experts called by the Commission. Those occupations that have been already completed will not be modified (including nursing). ESCO will continue working on the database and will be enlarging the number of occupations and sectors.

Joint Action on Health Workforce Planning and Forecasting WP6 Workshop
Being an associated partner of the Joint Action and a member of WP6 (Horizon Scanning), the EFN participated in WP6 Workshop organised in London, on 23 April 2015. The WP leader now designed a deliverable on horizon scanning which needs all attention to read and comment on as the development of the skills and competences of health professionals take into account the changes in the population, different demands in the health services, with a move towards eHealth services, and a redesign of the health workforce, including a major focus on skills needed in community care, primary care and home based care. Furthermore, health promotion needs to become higher on our agenda as preventing citizens becoming sick is key, next to the need for health professionals to be able to provide education for citizens' empowerment and to work within multidisciplinary teams and advanced roles, with the support of eHealth solutions. A final version of the WP6 report "future skills and competencies" is expected to be delivered to the Executive Board of the Joint Action in November 2015.

Med-e-Tel Conference 2015
Invited as keynote speaker at the Med-e-Tel Conference 2015, organised by the International Society for Telemedicine & eHealth (ISfTeH) on 22-23 April 2015, in Luxembourg, Paul De Raeve, EFN General Secretary, expressed that "eHealth has the potential to bring health and social care closer to the community" and explained that healthcare needs more local and global integration. As such education, communication and continuity of care are becoming key for a successful deployment of eHealth services. As such, eSkills of health and social care professionals need to be enhanced and effectively integrated into their education and training at both undergraduate and postgraduate level, as well as through Continuous Professional Development (CPD). Also invited as keynote speaker, the EFN member Dorota Kilanska, from the Polish Nurses' Association, referred to the achievements of the EFN EU project 'ENS4Care', and explained that the guidelines being developed will bring up-to-date information at the fingertips of service users, carers and those professionals supporting them.

European Parliament Interest Group on Carers
Being a member of the European Parliament Interest Group on Carers, the EFN participated in the meeting held on 6 May 2015, in Brussels, to discuss the 'Family vs. state responsibility for long-term care across the EU', and explore how awareness of the crucial role of informal carers can be increased. Germany, Italy, Slovenia, the Netherlands and Ireland, shared their experience and highlighted that Informal carers continue being inappropriately supported. Furthermore, as an informal carer cannot do everything, the governments need to ensure that there are enough formal carers supporting them and their relatives when needed. Frank Goodwin, from Eurocarers and partner in ENS4Care, highlighted the role of carers in empowering patients but also their own responsibility and needed education to be empowered themselves. In the context of the campaign for a dedicated EU-level Carers Strategy 'Enabling Carers to care', the interest group is now looking into potential EU Recommendations on a Reconciliation package that could highlight the role of carers, recognition of the work they do and better support, training and education for formal and informal carers, and solutions to allow people that care for others to stay in the labour market as longer as possible. The meeting was attended by informal carers that came from Ireland. Their experiences and testimonials describing the challenges they face every day made an impressive contribution to the debate.

News from the EU
Legal actions against Member States failing to comply with their obligations under EU law
Aiming to ensure proper application of EU law for the benefit of the citizens, the European Commission undertakes, on a regular basis, legal actions against the EU Member States who do not comply with their EU obligations. In April 2015, Germany has been asked to fully implement into national law EU rules adapting certain directives in the field of right of establishment and freedom to provide services, following the accession of the Republic of Croatia to the EU. This infringement relates to the recognition of professional qualifications, in this particular case for architects and construction engineers, but could apply to the healthcare

• continued on page 38

• from page 37

professionals and in particular to nurses, if the Directive 2005/36/EC, amended by Directive 2013/55/EU is not properly implemented at national level by 18 January 2016. As such, and to help the EFN members' in this process, the EFN developed a Competency Framework, aiming to be a guideline in the implementation of the competences listed under Article 31 of the Directive.

Blueprint for safer healthcare
Keeping in mind that 8 to 12% of patients admitted to hospitals in the EU suffer from adverse events while receiving healthcare, as healthcareassociated infections (HAIs), medication-related events and complications arising during or after surgical operations, and that half of these events could be avoided, MEPs decided to propose some measures to improve patient safety and to ensure that antibiotics are used more responsibly, prohibiting their use without prescription (therefore it is important to have nurses' prescribing), and providing better information, monitoring and infection control. Furthermore, recognising that the current economic crisis has placed increased pressure on national healthcare budgets, and hence has an impact on patient safety, the MEPs are calling on the EU Member States to make sure that healthcare systems are not affected by austerity measures and remain adequately funded.

Online Platform for effective use of EU Structural and Investment Funds in Health
The European Commission launched a new online platform, as part of the project "ESIF for Health" co-financed by the EU Health Programme, to support the EU Member States to use the European Structural and Investment Funds for effective health investments (programme 2014-2020). The platform provides information on funding opportunities for health, through a guide that highlights how to efficiently approach health investment planning and implementation, and a technical toolkit listing the 2014-2020 ESIF instruments and mechanisms, appraisal of investment, calls for proposals, indicators, and new healthcare concepts and models. Time to Deliver the Maternity Leave Directive! Following the vote on 06 May 2015 on the Maternity Leave Directive, the European Women's Lobby invites you to make your voice heard to make sure that the Maternity Directive is back on the European political agenda by signing the petition now! IV therapy user survey for doctors and nurses EU Nurses and doctors are requested to provide their views on Intravenous Therapy. This survey results will be used as background material in nursing studies (namely by Oulu University of Applied Sciences (OAMK), Finland, as thesis work material) and as support material in product development. Deadline: 7 June 2015.

Consumer survey on communication of alcohol associated risks
Taking into account that information on alcohol can be disseminated through various means: producers, public health agencies, health professionals, mass media etc., the European Union Joint Action on Reducing Alcohol Related Harm (RARHA), which brings together expert organisations in public health from 30 EU countries, is now collecting data on communication of alcohol associated risks to map consumers' opinions on the topic. The results will contribute to the discussion on how to communicate information about alcohol-related risks. To complete this survey, click here (Deadline 15 June 2015).

Publications
Building Health Workforce Capacity Through Community-Based Health Professional Education
In May 2014, members of the Institute of Medicine's Global Forum on Innovation in Health Professional Education came together to discuss issues affecting the scale-up and spread of health professionals' education in communities. In presenting a variety of examples from student community service to computer modelling, the workshop aimed to stimulate discussions about how educators might better integrate education with practice in communities. The report of this workshop, that shows that the financial and structural design of health professional education remains in silos and largely focused on academic health centers for training, is now available.

Annual report on gender equality
The European Commission published the 2014 annual report on equality between women and men, presenting the most recent developments and key EU actions on gender equality. It also shows that despite the important progress made over the past years, a lot still remains to be done to close gender gaps!

2015 Ageing Report
The European Commission published a report on Ageing "The 2015 Ageing Report: Economic and budgetary projections for the 28 EU Member States (2013-2060)", based on the new population projections from Eurostat (EUROPOP2013), that highlights the economic, budgetary and societal challenges, including healthcare, long term care and education, that policy makers will have to face in the future, with projections up to 2060. These projections feed into a variety of policy debates at EU level, including the overarching Europe 2020 strategy for smart, sustainable and inclusive growth.

Schuman Report - State of the Union 2015
The 6th Schuman Report on the State of the Union is now available, providing better understanding on: strengthening of the euro zone, growth and employment, immigration, transatlantic issues, etc., and provides a summary of political Europe, electoral balances of power within the Member States and the European Parliament, the state of European public opinion, political and economic representation of women in Europe.

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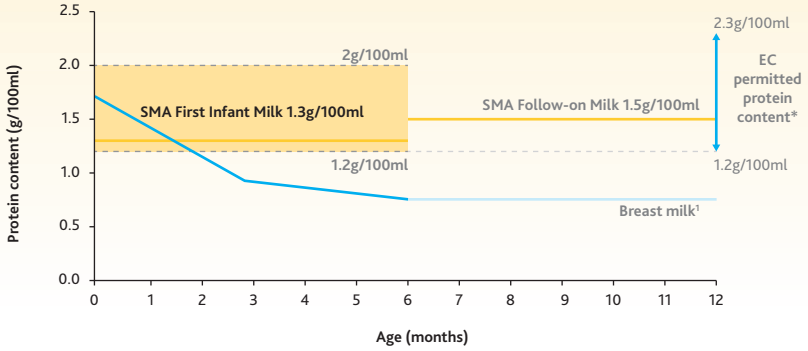
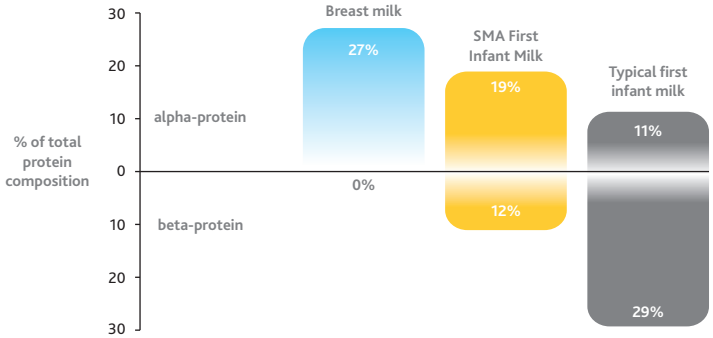


EC (European Commission) (2006). Directive 2006/141/EC on infant formulae and follow-on formulae and amending Directive 1999/21/EC. European Commission.[3]

Furthermore SMA First Infant Milk, has a higher alpha-lactalbumin content compared to other traditional first infant milks.[4]



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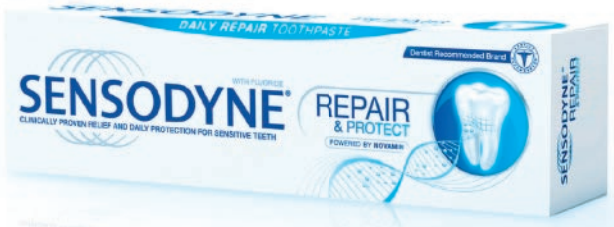

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