IL-MUSBIEH

MALTA NURSING AND MIDWIFERY JOURNAL

Malta Union of Midwives and Nurses

No.65 - Diċembru 2014

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Diċembru 2014

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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.

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Ritratt tal-faċċata: Stephen Gatt

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editorial

Foreign Nurses working in Maltese hospitals

The Nursing and Midwifery Council's decision to recruit new foreign nurses is most welcomed, but what are the criteria's of employment? Are we in line with other countries with regards implementing tougher entry requirements for international nurses wishing to bring their skills to our shores? Is induction strong enough and is ongoing support for overseas nurses offered? Are we addressing their social and cultural issues?

On the face of it, the requirements do not look too tough. It is of no use to Skype nurses or visit them abroad as part of the interview process. Foreign nurses' clinical skills must be tested and assessed before being employed. At present this is not done with our foreign nurses. Supervising nurses or mentoring nurses on the job for a set period of time is not enough.

Of course there is no perfect method to protect the public (our patients) and ensure nurses are safe to care for patients. Our employer must take responsibility for ensuring that their nursing staff are competent and display the right values. It is not about just checking they can pass a few tests. Employers need to hire people with the right skills and behaviours, and then continue to train and enthuse them to care for patients in the right and safe way. Scrutinising their abilities is a priority. For too long our employer has simply passed nurses at the end of their supervision.

At present more than 200 foreign nurses are registered as working in Malta. Approximately 60 nurses are registered each year. We have no objection to the recruitment of foreign nurses in the short term but the issue needs to be tackled from an educational point of view. On the other hand the employment of foreign nurses as a long-term solution poses a number of problems.

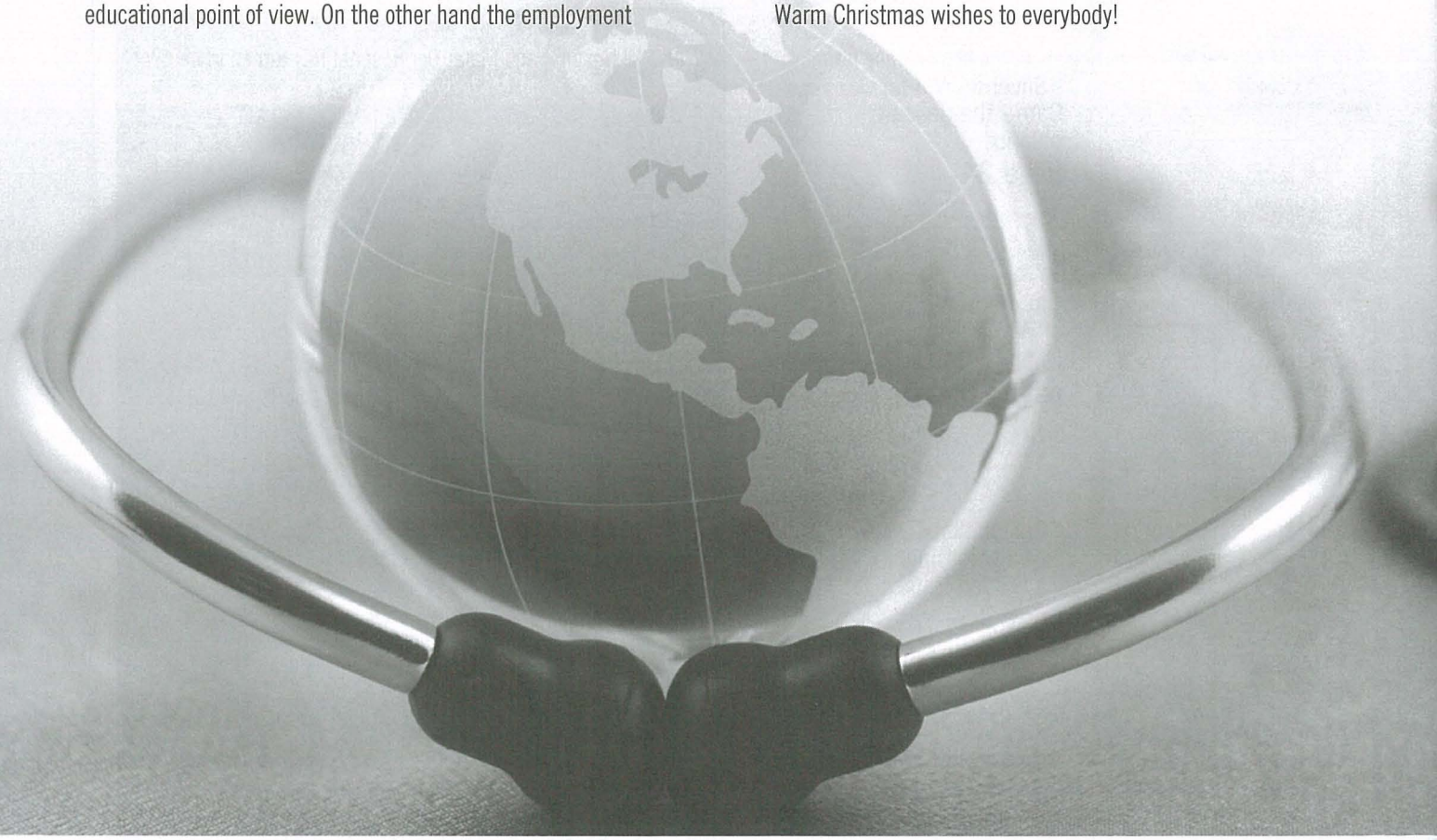
Some countries, especially developing ones, do not have training standards as required by the EU. The language issue is a headache: Apart that not all patients speak English some of the English spoken is terrible. Nurses arriving from the European Union to take up jobs in Malta admit they may not have the "right" language skills to work effectively, and often have difficulty slotting into the healthcare system. Being generally competent in English does not mean one has the 'right' language skills. Job contracts are another problem. Foreign nurses can just leave their job overnight, leaving a vacuum or havoc at a clinical level.

We have great respect for our foreign colleagues, but most of them sustain a whole family abroad; that means that they work almost 80 to 100 hours per week. Obviously, working 30 hours of overtime per week is at their own free will, but no one can perform such hours in nursing without being drained or burned out.

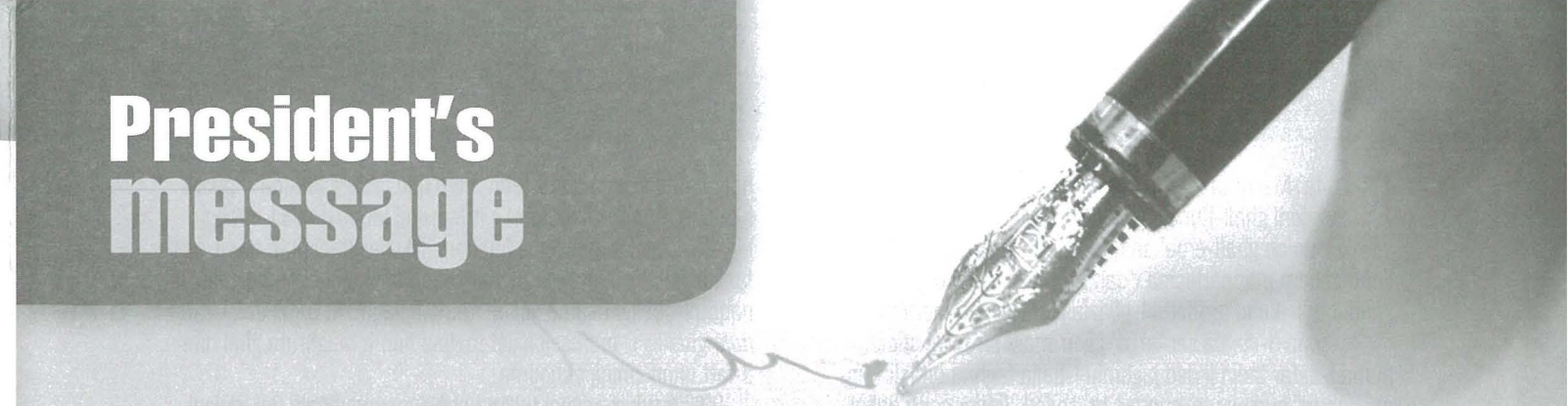
Unless Government acts to address the root causes of the shortage of staff, there will be a growing demand for nurses from abroad. With Malta's ageing population likely to increase, demand for foreigners to work in our hospitals and residential homes will surely increase.

Eventually, will one day foreign nurses working in our hospitals outnumber Maltese nurses?

Warm Christmas wishes to everybody!



President's message



A year has passed and 2014 turned out to be an challenging year for MUMN ...but in a positive aspect. A year were a new Health Minister and Parliamentary Secretary were appointed with the changes in the managements of various entities that this brought about. Not to mention that in the elderly ministry, changes also took place. A new Minister and a new Parliamentary Secretary were also appointed. MUMN had to adopt to such changes not just by assessing to the changes in policies and political directions but also to the method of operandi every minister and parliamentary secretary brings about.

Transfers, lack of compliment, lack of supporting staff, issuing of calls according to the new sectorial collective agreement are some of the challenges which MUMN officials had to face in the name of its members. Not to mention the unexpected news which were brought to light in the 2014 budget.

Next year , there are developments which MUMN is aware about but surely there will be unexpected developments which nurses and midwives and all other MUMN members will be taken by surprise. The migration of the new onocolgy hospital, the opening of new wards in Mater Dei Hospitals, the new wards in SVPR, the new Health Centre in Hal Kirkop and new services in Gozo General Hospital...are some of the "known" developments.

Next year will also bring about the competence framework which was finalized in the 2013 agreement. In simple terms, such competence framework will be a "checklist" which will be filled by the nurses/midwives and counter signed by the Charge Nurse/Midwife and assisted by the Practice Nurses/Midwives. But further details will be issued at a later stage. Such competence framework will replace the portofolio and once the competence framework is done those nurses and midwives with the sufficient number of years of experience and in the rightful grade can move to scale 8 without the need of waiting for the issue of a call for application.

A further application which will be issued by the Nursing and Midwifery Council is the opportunity for nurses and midwives to apply to the registers through the Specialization Accreditation Committee. Nurses and Midwives will apply through a established criteria which still needs to be issued.

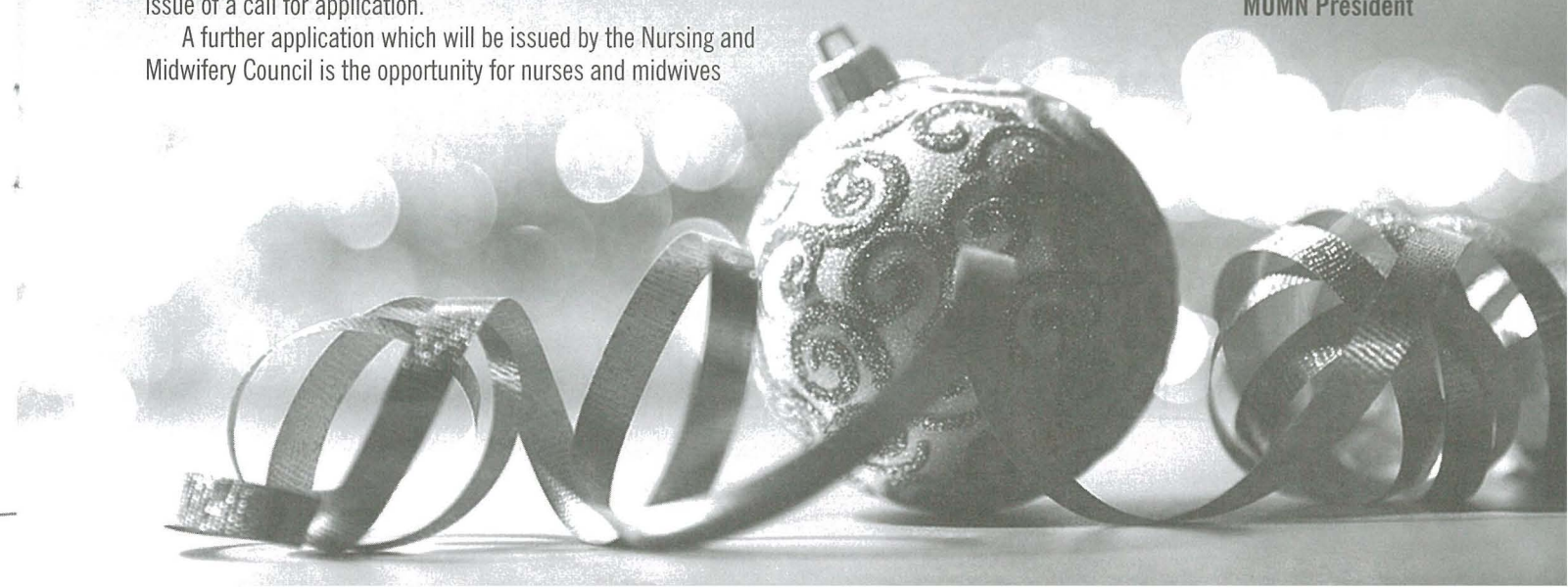
Next year will be also be an election year for a new MUMN Council. This year we are moving away from the ballot boxes and all members of MUMN will be receiving their respective voting document with a self addressed envelope according to the address which will be given to MUMN. Emails will be send on this regard but please inform MUMN and update your home address by sending an email on administrator@mumn.org

The situation developing in this country is that although the number of nurses is increasing, the new services and the extensions being planned will allow the shortage of nurses to persist. As every nurse is already aware the number of foreign nurses in this country is on a steep increase with a record number of recruitment of foreign nurses being present in every ward and in every hospital. Every hospital has a threshold on how many foreign nurses it can take without jeopardizing patient safety. Certain hospitals such as Mt. Carmel, such threshold has already been reached.

At least, MUMN managed to resolves three ongoing persistent issues this year besides other issues. The issue of the Covering letter and the issue of lack of carers in Gozo general Hospital and Mater Dei Hospital has turned to be a success story. The success of MUMN always depends on you as members and that is the secret of MUMN's success.... because of your trust in your union .

Festive season has arrived. How quick time is passing. It is a family time and festive season. The Council of MUMN with all the Group Committee wish you a Merry Christmas and a Happy New Year and are looking forward to continue serving you next year.

Paul Pace
MUMN President



Kelmtejn mis-Segretarju Ġenerali

Fl-20 ta' Marzu tas-sena d-dieħla jitħabbar ir-riżultat ta' l-elezzjoni għall-Kunsill ġdid tal-MUMN li jkollu mandat biex imexxi l-union għall-erba' snin ta' wara. Huwa importanti li inti tieħu sehem u tipparteċipa f'dan il-proċess sabiex jiġu eletti kandidati li jkunu jirriflettu l-għażla ġenwina tal-membri.

Is-sena d-dieħla ser terġa' ġġorr magħha żewġ sfidi li huma l-aktar tnejn li qed jagħmlu l-ħajja tagħna diffiċli – in-nuqqas ta' nurses u n-nuqqas ta' sodod. Jidher ċar li qabel ma jissolvew dan iż-żewġ sfidi, numru ta' sptarijiet u postijiet oħra tax-xogħol mhux ser jieħdu ruħ għaliex direttament jew indirettament kulħadd milqut minn problema waħda jew l-oħra u anki hemm sptarijiet li huma milquta' miż-żewġ problemi.

L-MUMN għandha pjanijiet konkreti sabiex dawn l-isfidi jiġu ndirizzati u nista' nħabbar li l-Gvern irid jiltaqa' magħna fil-bidu tas-sena l-ġdida sabiex nippruvaw insibu soluzzjonijiet dejjiema għal dawn iż-żewġ sfidi li issa ilhom magħna għal snin twal.

Bħal ma taf l-MUMN qegħda hemm għalik sabiex tiddefendi d-drittijiet tiegħek però fostna hemm min qiegħed jinsa li ma' dawn id-drittijiet hemm ukoll l-obbligi tagħna li huma importanti daqs id-drittijiet. Meta l-MUMN tiddefendi l-membri tagħha f'każijiet ta' dixxiplina jew minħabba nuqqasijiet fil-kundizzjonijiet tax-xogħol jew dwar materja oħra li l-membru jħoss li jkun sarlu nuqqas fil-konfront tiegħu, aħna jkollna f'moħħna li dak il-membru qed jaqdi l-obbligi tiegħu u għalhekk ħaqqu difiża soda u effiċjenti. Però qed jaslu għandna rapporti li hemm numru ta' membri li mhux qed jaqdu dawn l-obbligi lejn il-pazjent u anki lejn sħabhom il-kollegi tagħhom fuq il-post tax-xogħol. Irridu niftakru li mingħandna jistennew mhux biss li naqdu l-obbligi tagħna kollha imma li nagħmlu wkoll dak l-*extra mile* għaliex il-professjonijiet tagħna huma magħrufa għal dan il-fatt minn żminijiet qodma.

Għalhekk ix-xogħol tagħna huwa meqjus bħala vokazzjoni għaliex aħna mhux talli huwa mistenni minna li naqdu d-doveri tagħna imma wkoll dik in-naqra aktar li kull pazjent u l-qraba tiegħu jkunu qed jistennew mingħandna. Jien konvintissimu li l-maġġoranza assoluta tal-membri tagħna mhux talli jaqdu d-doveri tagħhom iżda wkoll jissalbu biex jaraw li l-pazjent huwa moqdi f'kull ma jkollu bżonn. Però naf ukoll b'ammont żgħir ta' membri li per eżempju għadhom jilgħabu bil-mobile waqt li jkunu qed jaqdu d-doveri taghhom! Jew numru żgħir ieħor li hekk kif jirrispondu t-telephone u jxommu li hemm problema, jaraw kif jagħmlu u jfarfru fuq il-kollegi tagħhom! Dawn in-nies jitfgħu l-professjonijiet lura u jtebbaw l-isem ta' kull wieħed u waħda minna.

Għal-lum ħa nieqaf hawn. Nieħu din l-opportunità sabiex minn qalbi nawgura lilek u l-familja kollha tiegħek l-isbaħ xewqat għall-Milied Hieni u Sena Mimlija Saħħa, Risq u Barka.

Colin Galea
Segretarju Ġenerali

EFN & ICN Press Release
28 November 2014

Nurses Caring for Ebola Patients - Zero Tolerance

Brussels, Belgium; Geneva, Switzerland, 28 November 2014 - The European Federation of Nurses Associations (EFN) and the International Council of Nurses (ICN) call for full protection of the nursing workforce and zero tolerance towards circumstances that result in staff infection.

The International Summit on "Nursing and Ebola Virus" (27-28 October), along with DG Sanco* meetings with the National Coordinators for Ebola (7 November) and with the health professionals (13 November), expressed the need for different levels of preparedness - general preparation, dealing with suspected cases and caring for known cases – in which "zero tolerance" of staff infection is key for concrete actions. Such preparedness should also include an escalating response scenario should a wider breakout occur in Europe.

In order to ensure health services providers are well organised and prepared for Ebola, the EFN and ICN call on the European Health Council, the Health Security Committee and the European Ministers of Health to take concrete actions by:

• Identifying an EU list of reference centres for Ebola and making sure a cost-effective network supports patients and staff safety.

• Setting out an agreed team composition related to patient needs but balancing the risks of burnout with the risks of exposing an unnecessarily high number of staff. It is important to look at patient-nurse ratios and outcomes.

• Making ECDC** protocols "fit for practice" by bringing the nurses working with Ebola patients together with DG Sanco/ECDC to exchange practical experience in the operability of the ECDC protocols so that nurses throughout the EU can deploy adequate material to care for Ebola patients.

• Adopting, implementing and monitoring Ebola guidelines at national level, in close cooperation with the ECDC. The training for donning (putting on) and doffing (taking off) of personal protective equipment is a priority which DG Sanco/ ECDC should organise.

• Investing in the education and training of health professionals to deliver safe and high quality care. Continuous professional development is key for patient and staff safety, along with the appropriate and sufficient time and resources to access it.

• Combatting "stigmatisation" of those who care for Ebola patients. A Commission working group with the people concerned should develop a roadmap to immediately combat stigma in care, including provision for psychological support for healthcare workers and their families. We need to take care of those who care for Ebola patients.

• Transposing existing EU legislation on Biological Safety and Safety at Work into the daily practice of frontline staff and therefore using the available social cohesion funds (2014-2020) for skilling-up the nursing workforce.

The ECDC and DG Sanco should plan concrete actions throughout and with the nursing community to prepare nurses for the safe and adequate care of Ebola patients. Without appropriate resources and investments, and without a highly qualified, motivated and competent nursing workforce in the right numbers, no protective measures can sufficiently safeguard those who provide care for those who need care.

10.11.2014 - inewsmalta

Premju għal żewġ infermiera Maltin

Żewġ infermiera Maltin li ħadu inizjattiva biex jiffaċilitaw il-ħajja tal-pazjenti tal-kanċer tal-isptar Boffa ġew ippremjati għal din l-iizjattiva mir-Royal Marsden School tal-Ingilterra.

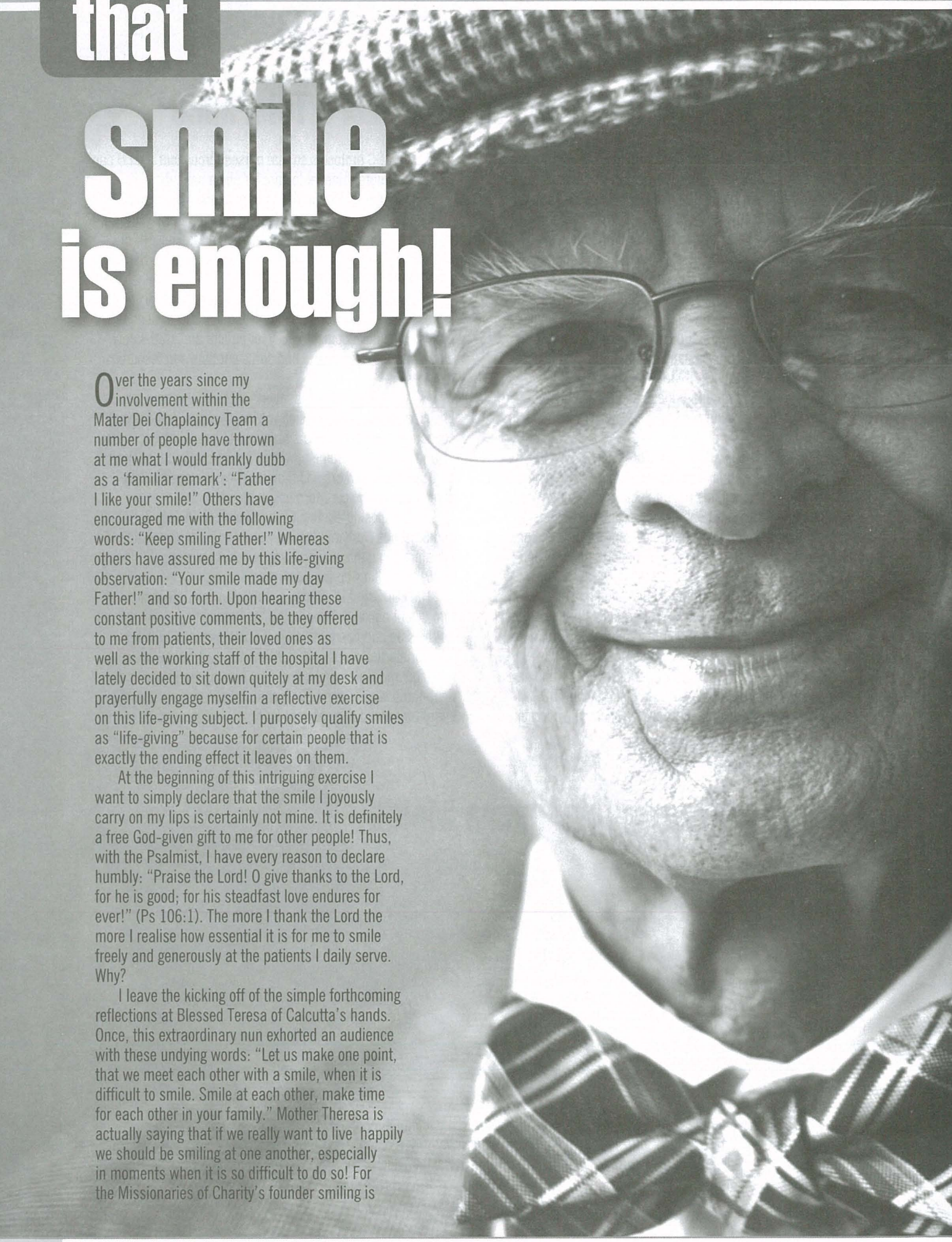
L-infermiera huma Elysia Mercieca u Abigail Camenzuli, li lejn l-aħħar tas-sena li għaddiet nedew l-Aurora Support Service – servizz li jingħata fl-Isptar Sir Paul Boffa biex joffri appoġġ u edukazzjoni lill-pazjenti tal-onkoloġija.

Dan is-servizz jinkludi tagħrif lill-pazjenti dwar it-terapija li jkunu se jirċievu, laqgħat biex il-pazjenti jagħmlu kuraġġ b'xulxin, appoġġ lill-qraba tal-pazjenti, kif ukoll servizzi ta' sbuħija għall-pazjenti nfushom.

F'kumment lil inewsmalta.com, iż-żewġ infermiera esprimew sodisfazzjon li bil-premju mirbuħ huma taw promozzjoni lill-Isptar Boffa lil hinn minn xtutna.

Ritratt: Ian Noel Pace

that smile is enough!



Over the years since my involvement within the Mater Dei Chaplaincy Team a number of people have thrown at me what I would frankly dubb as a 'familiar remark': "Father I like your smile!" Others have encouraged me with the following words: "Keep smiling Father!" Whereas others have assured me by this life-giving observation: "Your smile made my day Father!" and so forth. Upon hearing these constant positive comments, be they offered to me from patients, their loved ones as well as the working staff of the hospital I have lately decided to sit down quitely at my desk and prayerfully engage myselfin a reflective exercise on this life-giving subject. I purposely qualify smiles as "life-giving" because for certain people that is exactly the ending effect it leaves on them.

At the beginning of this intriguing exercise I want to simply declare that the smile I joyously carry on my lips is certainly not mine. It is definitely a free God-given gift to me for other people! Thus, with the Psalmist, I have every reason to declare humbly: "Praise the Lord! O give thanks to the Lord, for he is good; for his steadfast love endures for ever!" (Ps 106:1). The more I thank the Lord the more I realise how essential it is for me to smile freely and generously at the patients I daily serve. Why?

I leave the kicking off of the simple forthcoming reflections at Blessed Teresa of Calcutta's hands. Once, this extraordinary nun exhorted an audience with these undying words: "Let us make one point, that we meet each other with a smile, when it is difficult to smile. Smile at each other, make time for each other in your family." Mother Theresa is actually saying that if we really want to live happily we should be smiling at one another, especially in moments when it is so difficult to do so! For the Missionaries of Charity's founder smiling is

tantamount to creating a family spirit by making time to get to know one another.

Is this not a solid basis on which effective pastoral care within a hospital setting should be built? Is this not one of the most significant ways a chaplain ought to address his/her way of providing spiritual care for those in need? Time and experience have been persistenty demonstrating that creating a sacred space in which the patient can vent out his/her concerns, fears but also hopes is foundational for a fruitful his/her fruitful accompaniment together of course with that of his/her family and friends.

However there isn't such a thing as a meaningless smile. It plainly does not exist. And, lo and Otherwise if this occurs because that surely means that one is seriously bridging the pathological! Hence, for every smile there must be a meaning. The famous Vietnamese Zen Buddhist monk, teacher, author, poet and peace activist, Thích NhĐt HĐnh, corroborates this thought when he wisely says: "Sometimes your joy is the source of your smile, but sometimes your smile can be the source of your joy." Joy and smile cause each other. They are intmately interrelated for the simple reason that they sustain one another reciprocally.

Thích NhĐt HĐnh's comment triggers me to ask another pivotal question as a chaplain: Since I am a Christian what is the bedrock of my Christian joy? What singles the latter out from other types of happiness that are to be detected both in the secular world as well as in the different kinds of religions that are around us? The best person to answer this fascinating query is noneother than the current charismatic Pope Francis.

When the Holy Father addressed the crowds in St. Peter's Square on December 15, 2013, prior the recitation of the Marian prayer of the Angelus, he told them that the Church is a house of joy. Francis also said that the Gospel message is "an announcement of joy for the whole people. Those who are sad find joy in her (Church), they find true joy in her." When he referred to the first reading of that Third Sunday of Advent taken from the prophet Isaiah (Is 35:1-6a, 10), Pope Francis said to those present that God comes to encourage those who are fearful of heart, or rather, when our life becomes dry and arid.

"And when does our life become arid?" he pertintely asked. "This happens when it lacks the water of the Word of God and his Spirit of love. However, great are our limits and our dismay, we are not permitted to be downhearted and vacillating in the face of our infirmities. On the contrary, we are invited to get a grip and straighten our weak knees, to have courage and not be afraid because our God always shows us the greatness of his mercy." In this empowering Angelus address the Pope lovingly encouraged those who feel that they can't have a fresh start in life due to their sins by assuring them that God awaits all with mercy and love, ready to forgive. This greatly aids us to conquer sadness and provides us with that much need and true joy when those ferocious troubling waters come upon us.

The Holy Father said that Christian joy, like hope, is essentially founded on God's fidelity, in the assurance that he always keeps his promises. Futhermore the Pope also said that "the prophet Isaiah exhorts those who have lost their way and are in trouble to trust in the Lord's fidelity because his salvation will not delay in breaking into their life." The Argentinian Pontiff joyfully shouted "Jesus Christ is our joy! His faithful love is inexhaustible!" That is why the Holy Father appropriately emphasized the urgent need of praying for those who are sad and make them "feel the warmth of the community."

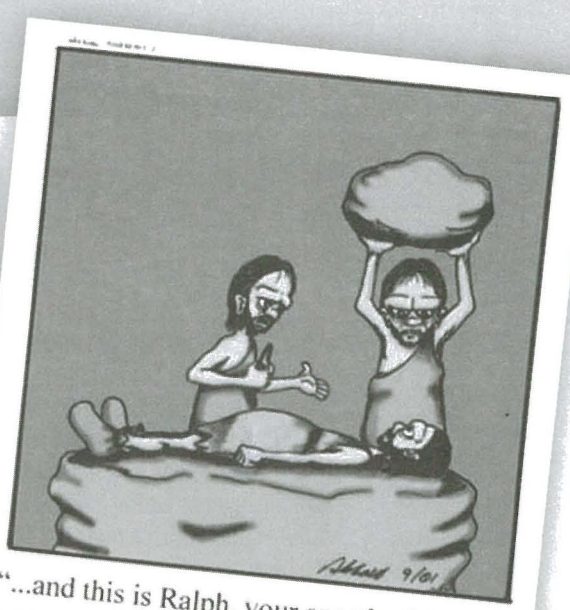
And, just seconds before praying the Angelus with that huge crowd, the Pope appealed to all the faithful to look at the example of Mary during the Advent season, who obtains for all of us the joy of the Gospel. He said: "It is an intimate joy, made of wonder and tenderness. It is what a mother experiences when she looks at her newborn child, and feels that he is a gift of God, a miracle that she can only be grateful for!"

How can I not be grateful when God, in his infinite mercy, overshadows me with his loving mercy? How can I not exclaim with joy at the reality that God forgives my personal sins every time I a proach Him with a childlike trust? How can I not be exuberantly happy when God heals my spiritual and phyisical infirmites just because he is a faithful God that keeps his promises from generation to generation? How can I not radiate his joy when I personally experience his motherly care for me each and every time I entrust myself into his hands? Finally, how can I not lavishly offer to Mater Dei's patients, relatives and staff his redeeming smile as well as that fabulous prayer that entirely changes one' perspective on life, the Chaplet of the Divine Mercy?

This is precisely what is hidden in that smile, which for many it seems to be enough for them to believe that God's loving presence is warming them up to offer their lives to him, to submit their entire being to his redeeming guidance especially and starting from that time of their great need!

Fr Mario Attard OFM Cap

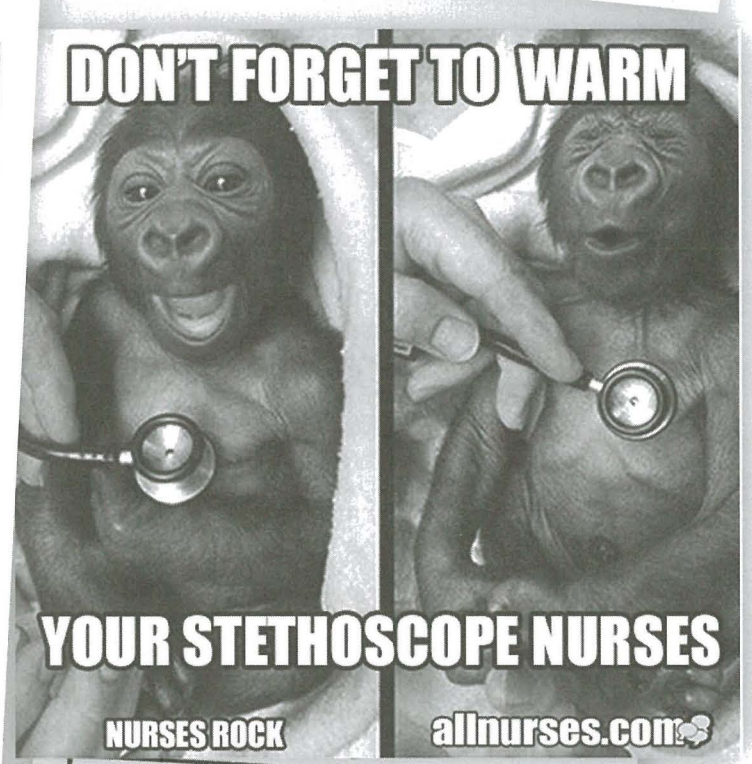
Humour Page



"...and this is Ralph, your anesthesiologist."

About a Nursing Student

"You're afraid of snakes? I start nursing school next week. Now, that's scary."



"Sorry I'm late, I had great nurses."

"Why do blood tests always have to be by shots? Can't I take a written test?"

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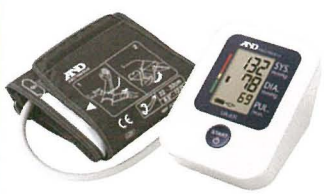

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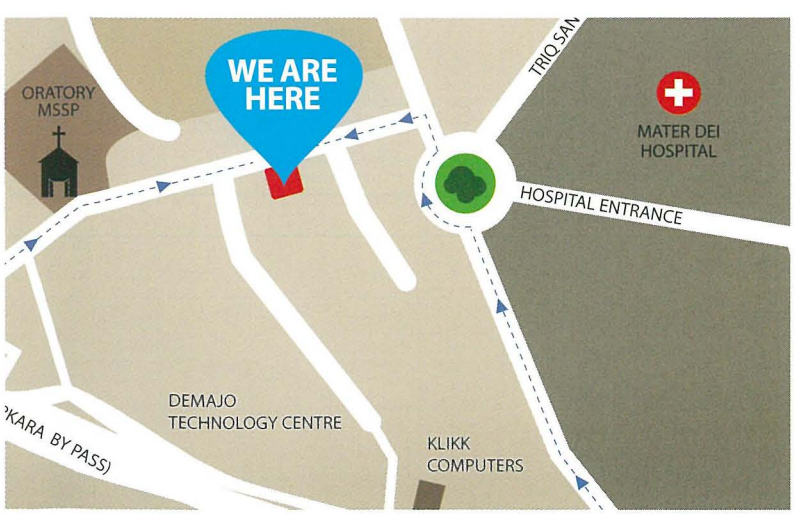

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Resource OptiFibre® helps maintain normal bowel functions in patients suffering from constipation, diarrhoea and irritable bowel syndrome. Besides a regulatory effect on gastrointestinal function, Resource Optifibre® has shown positive effects on lipid metabolism and mineral absorption. The main clinical benefits of Resource Optifibre® are listed below:

Prevents constipation and increases transit time.
Increases Calcium and Iron absorption.
Prevents and treats acute diarrhoea.
Improves glucose and insulin response.
Helps in preventing hyperlipidemia.

Resource OptiFibre® has the advantage of improving patient compliance, given that it does not alter taste, texture or colour when added to food. Unlike other dietary fibres, Resource OptiFibre® mixes easily into hot and cold meals and beverages without impacting texture or flavour, thus assuring maximum acceptance by patients. Consequently, Resource OptiFibre® may be added to both hot and cold meals such as soups, pasta and other hot dishes or to liquids such as tea, coffee or juices. Resource OptiFibre® is non gelling, making the product also suitable for patients that use a PEG tube and require a fibre rich diet. This product may be recommended for both short and long term use.

Resource Optifibre® should be introduced gradually by simply adding 1 scoop (equivalent to 1/2 a sachet) to foods or liquids for the first 3 days. This dose may be gradually incremented by adding another scoop every 3 day interval until the desired effect is achieved. The maximum amount administered should not exceed 4 sachets/8 scoops per day.

Reference:

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

Risk-reducing mastectomy for women with an increased risk of developing breast cancer: awareness and choice

PART 1

The French surgeon Broca, who lived in the 19th century, had hypothesised over 140 years ago that some cases of breast cancer may be due to a genetic susceptibility[1]. Since then, it has become known that some women carry a high-risk predisposition gene, namely BRCA1 and/or BRCA2.

It is a fact that breast cancer is the most commonly occurring cancer in women. More than one million women are diagnosed with breast cancer every year worldwide[2]. As stated by Mr G Caruana Dingli, Consultant Surgeon at Mater Dei Hospital, Malta, the incidence of breast cancer in Malta is on the increase, although fortunately, mortality has declined[3].

For women with a BRCA1 or BRCA2 mutation, or a strong family history of breast cancer, prophylactic mastectomy offers the greatest protection against the development of breast cancer.

In this regard, the aim of this study is to determine whether prophylactic mastectomy would be considered as an option by women to reduce their risk of developing breast cancer. To this end, questionnaires were handed out to female health care workers at Mater Dei Hospital in an attempt to find out what they think about the surgery.

It is also intended to raise awareness about the fact that, so far, only prophylactic mastectomy can significantly reduce the risk of developing breast cancer[4].

WHO IS MORE LIKELY TO DEVELOP BREAST CANCER?

All cancer is genetic. However, not all cancer is inherited. Breast cancer develops because of mutations in certain genes. Some women, and men, inherit these mutations.

A woman is likely to develop breast cancer if her mother, sister or offspring has had breast cancer. However, for this woman the lifetime risk of developing breast cancer is 7% to 49%. This depends upon which relative is involved and the age at which breast cancer developed. On the other hand, if a woman tests positive in genetic screening for BRCA1 her lifetime risk for developing breast cancer is 85% to 90%[5].

Table 1 – Major markers of increased breast cancer risk in women[1]

Relative risk increased more than 4 times
- Evidence of susceptibility gene BRCA1
- Pre-menopausal breast cancer in mother and sister
- Atypical hyperplasia in breast biopsy or aspirate
- Insitu cancer – ductal or lobular

Relative risk increased 2 to 4 times
- Pre-menopausal breast cancer in mother or sister
- Hyperplasia without atypia in breast biopsy or aspirate
- History of previous cancer in one breast
- Aging Caucasian women

Table 2 – Minor markers of increased breast cancer risk associated with up to 2-fold increase[2]

General markers
- Post-menopausal breast cancer in first degree relative
- Previous cancer of the ovary or endometrium
- Nodular densities in mammogram are predominant
- Obesity in women over 50
- Tallness in adult life
- Excess ionizing radiation to chest wall or breasts
- Increased alcohol consumption
- High socio-economic status

Hormone-related markers
- Non childbearing (in women under 40)
- Delayed first child
- Short duration of breast-feeding
- Onset of menstruation before age 12
- Prolonged use of oral contraceptives
- Prolonged HRT

In recent years, knowledge about inherited and/or familial breast cancer has increased considerably. However, management options have remained relatively the same; namely surveillance with mammography and MRI scans, risk-reducing mastectomy, and a "wait and see" approach. In the case of two of these options there is no possibility of cancer prevention; only to start full cancer treatment once cancer has been diagnosed.[6] It is important to point out that screening for breast cancer at the current stage of knowledge serves only to detect breast cancer and reduce the risk of mortality; it does not reduce the risk of developing breast cancer[7].

1 *Broca P: Traite de Tumeurs. Asselin Paris 1866*

2 *D G R Evans, A Howell: High risk breast cancer predisposition genes. Advances in Breast Cancer- March 2009 vol 6 issue 1 pg 2*

3 *Mr. G Caruana Dingli: Neoplasia Mammaria: Esperienze Maltesi - Conference Europa Donna 2010*

4 *Andrew D Bailam: Risk-reducing mastectomy for women at high personal risk of breast cancer. Advances in Breast Cancer- March 2009 vol 6 issue 1 pg 7*

5 *Basil A. Stoll, Risk from Family History, chapter 2, 11-18*

6 *Andrew D. Baildam, Risk-reducing mastectomy for women at high personal risk of breast cancer. Advances in Breast Cancer March 2009 vol 6 issue 1*

7 *Anthony B. Miller MB FRCP, Director National Breast Screening Study, University of Toronto, Canada, Role and Limitation of Mammography in Screening - Chp 24 : 217-221*

BREAST CANCER SUSCEPTIBILITY GENES

The last decade of the twentieth century saw a major breakthrough in understanding breast cancer. Extensive studies led to a search for high-risk genes that predispose to the development of breast cancer. Scientists have identified three classes of breast cancer susceptibility genes. For the purpose of this paper, only two will be mentioned, since it is these two that confer a risk that is greater than 40%, hence considered as high-risk susceptibility genes.[8]

The identification of BRCA1 in 1994 and BRCA2 in 1995 led to a greater understanding of the development of the disease. BRCA1 is found on the long arm of chromosome 17 and BRCA2 is found on the long arm of chromosome 13. Mutations in these genes are rare. This phenotype is inherited in an autosomal dominant manner. This means that a mutated gene from one parent can cause the disease even though the matching gene from the other parent is normal.

BRCA1 and BRCA2 belong to a class of genes known as tumour suppressor genes. This means that one of their functions is to prevent cells from growing and dividing too rapidly and/or in an uncontrolled way. Mutations to these genes would cause the gene to "malfunction" thus allowing cells to grow and divide uncontrollably and form a tumour.[9]

Genetic testing for BRCA mutations is expanding worldwide. It is a medical test that identifies carriers of the mutated gene so that more accurate risk quantification can be given. In this respect, the test can help doctors in the management of women who are at high risk of developing breast cancer. Genetic testing is offered to women with a strong family history of breast cancer. Genetic testing is voluntary. The decision to be tested is a personal and complex one. Counselling is very important both before the test and after the test if it results to be positive.

RISK-REDUCING MASTECTOMY: THE EARLY DAYS

Just over a decade ago, risk-reducing mastectomy was highly controversial. Since there was no evidence base, the efficacy of the surgery was unknown and it was regarded as an extreme and drastic option. Pioneering women who wanted to do something about their increased risk enrolled in research studies that showed the effectiveness of prophylactic mastectomy in preventing breast cancer. Early studies conducted by Hartmann and his team at the Mayo Clinic in 1999[10] and again in 2001[11] estimated that the risk of breast cancer was reduced by 90% - 95% with bilateral prophylactic mastectomy.

Another study published in 2001 in the Netherlands[12] followed up 139 women with BRCA1 or BRCA2 mutations who had had bilateral prophylactic mastectomy. After about 3 years of follow-up none of these women had developed breast cancer. Although the follow-up period was short, an updated study published in 2004[13] confirmed the preliminary results.

In a historic study[14], the results of which were also published in 2004, 483 women who were identified as BRCA1 and BRCA2 mutation carriers were followed up. Of the 483 women, 105 underwent prophylactic mastectomy and 378 were the control group whose breasts were intact. This study showed that prophylactic mastectomy reduces the risk of developing breast cancer by about 95%.

Although these studies showed a dramatic reduction in the incidence of breast cancer after prophylactic mastectomy, the real question is whether women would consider it to reduce their risk.

8 *Evans D.G.R., Howell A., High-risk breast cancer predisposition genes. Advances in Breast Cancer March 2009 vol 6 issue 1*

9 *Genetics Home Reference: ghr.nim.nih.gov (accessed on 24/08/2013)*

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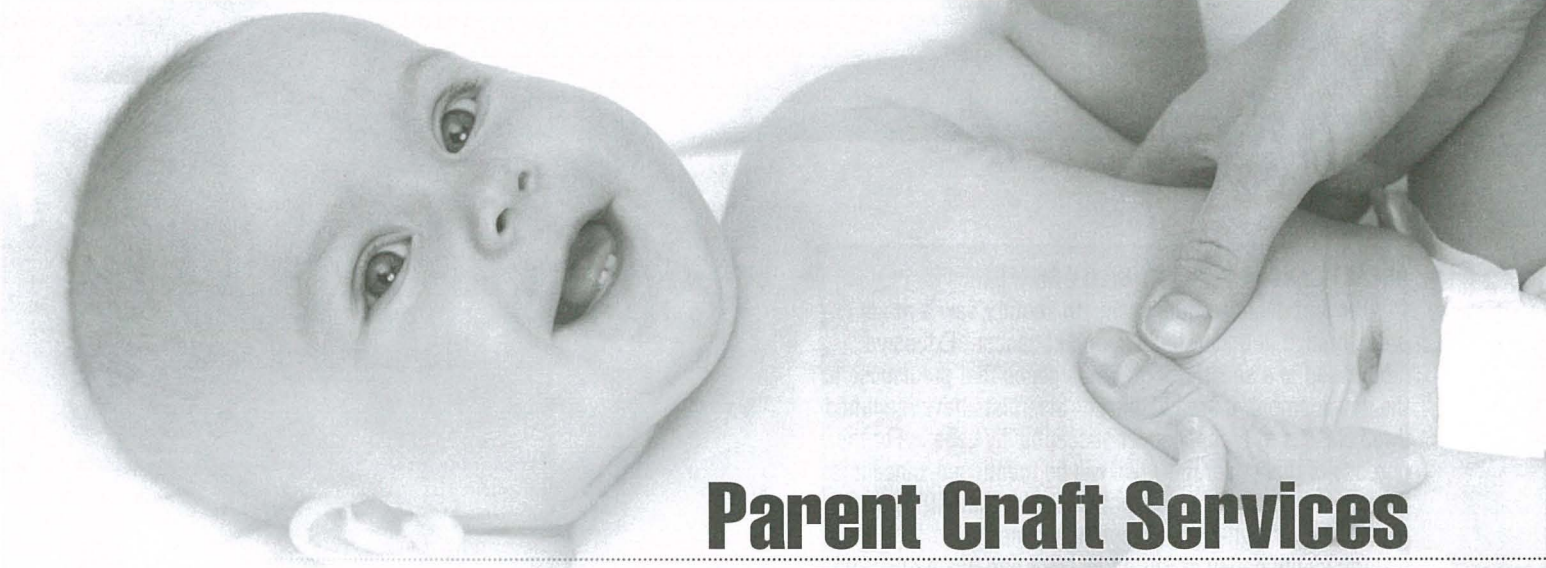

Parent Craft Services

Education & Support

Parentcraft Services is a free-standing Unit, forming part of the Obstetric Department and situated at Mater Dei Hospital.

The Mission of Parentcraft Services is "***Education and Support***". Therefore, every effort is made to keep up to date, and to present the latest knowledge and research to the clients, whose feedback has always been very favourable.

Education is mainly carried out through courses offered to expectant clients/couples, but also to new parents, as Baby Groups (aka Reunions). The latter serve both as a social and an educational tool, as many queries are answered and information straightened out during these meetings. Sessions about Childcare Centres are also offered postnatally, as is dental support and information regarding nutrition.

In late 2011, were also introduced the *sessions for Grandparents,* which are in great demand, and ever-increasing in popularity. Furthermore, a number of *ad hoc sessions* are also offered, while Education also includes sessions for student nurses/ student midwives, secondary, post-secondary, and even tertiary students.

Parentcraft Courses include: Early Pregnancy Courses (starting from 10 weeks pregnancy) and Childbirth Courses (usually starting from 28 – 30 weeks pregnancy). Specific Childbirth Courses cater for C*lients expecting multiples, Parents with other children (Refresher), English Speaking Clients.* Sessions are also now being offered *to Pre-adoptive parents*

Parentcraft Services works closely with GHOZZA (formerly School Girl Mothers' Unit) to offer pertinent information to School-age and Teenage clients, regarding pregnancy, childbirth and child rearing. Parentcraft Services is further reaching out to these young mothers-to-be by offering *a complete childbirth course on Sundays, where the partner, and both sets of grandparents can also attend.* This, in order to provide more Understanding, Support, and Attachment.

Childbirth Courses are offered in the morning, afternoon and evening. This includes weekdays, Saturdays, Sundays and even Public Holidays. Most times, 2 or more concurrent sessions are held. As can be expected, the most popular lectures are those held in the evenings, weekends, and on Sunday mornings, with the latter having 4 or even 5 concurrent sessions. Evening, weekend, and Sunday groups are considerably large, with an average of 18-22 couples per group.

Furthermore, there has been a considerable increase in one-to-one sessions. These include *clients with special needs, including physical, psychological or social needs.*

Other sessions are also held regularly, in response to client-demand, and to the perceived client-need, and in liaison with other Units/Departments. These include *sessions about Dental Care, Standards of Childcare Centres, Stem Cell Collection, Speech and Language Development, Healthy Eating Habits in Infants/Toddlers,* etc

Although hospital-based, Parentcraft Services is clearly very much oriented towards Primary Health Care, although it is also a bridge to hospital care should a client present with any complaint or health problem. Close liaison is continuously maintained with hospital practices and policies, to ensure that accurate and updated information is passed on to our clients.

Besides lectures at MDH, Parentcraft Education is also offered extensively through the *Media,* by participating in various TV and radio programmes. Parentcraft Services will also be having *its own programme **"Familji ta' Ghada"** on Radju Malta 2, every Tuesday at 11.30am, repeated on Saturdays at 10am*

Other information is offered, through *various professional handouts and booklets,* sometimes in collaboration with other Departments, such as Department of Social Welfare Standards (DSWS), Health Promotion and Disease Prevention Unit, Commissioner of Children, Occupational Health and Safety Authority, Department for Industrial and Employment Relations etc.

Furthermore, Parentcraft Services is further deeply involved in public and professional education through *active participation and organization of various Conferences.*

Furthermore, a successful project is the "Mother and Child module" being presently offered to MCAST Students, undergoing the BTEC Diploma in Health and Social Care

Various talks are also being held with the Education Department, mainly the Heads of Schools, and with the iLearn Centre, in Parentcraft's quest to *eliminate contradictory advice, and to provide pre-conceptual education.*
Further talks are being held with other Departments and Organisations, further optimizing the already sterling service being provided to the Maltese Public.

• continued on page 23

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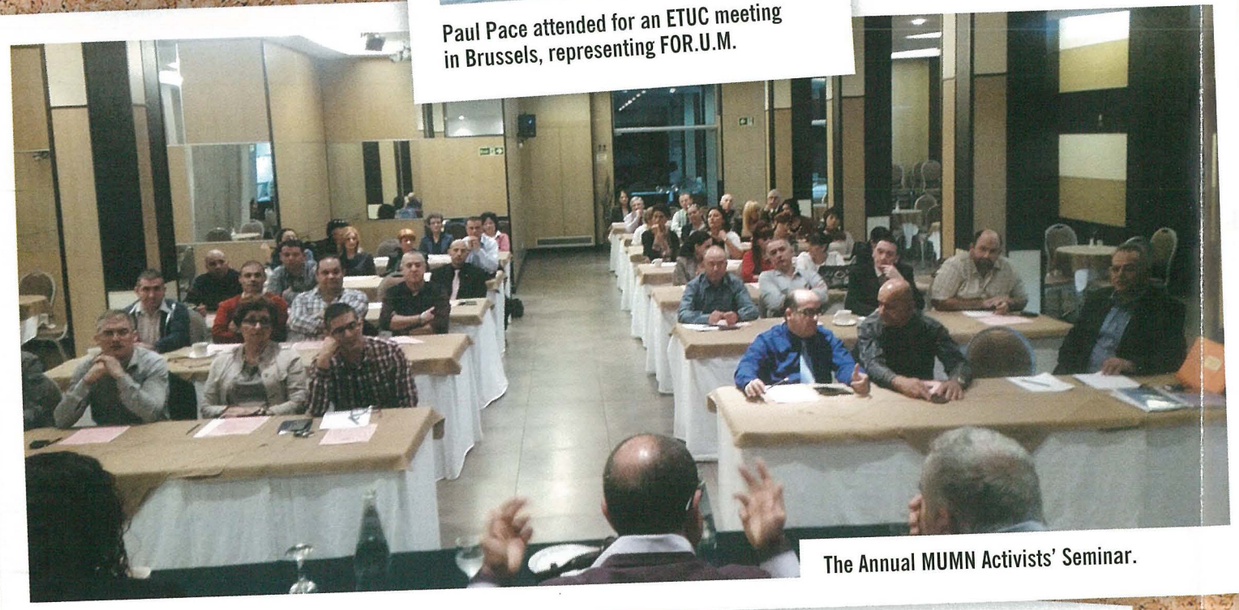
from our diary...

MUMN 1996
Malta Union of Midwives and Nurses

Paul Pace attended for an ETUC meeting in Brussels, representing FOR.U.M.

MUMN Council would like to congratulate Bernardette for her achievement as the Worker of the Year in Gozo General Hospital.

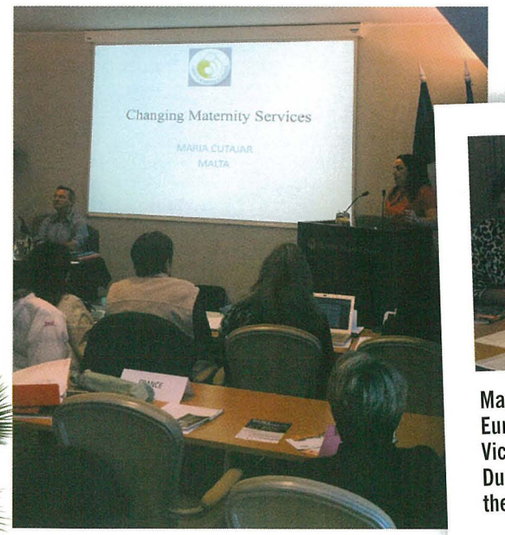
The Pensioner's Group Committee organised a brilliant outing for their members.



The Annual MUMN Activists' Seminar.

Nurses working at the Admitting & Emergency Department assisting illegal immigrants and their children on their arrival in Malta. (photo from the Times of Malta).

The Delegates from Malta who attended the CNF Conference in London.



Maria Cutajar and Antoinette Saliba representing MUMN at the European Midwives Association (EMA) Annual Meeting. MUMN's Vice-President is addressing the delegates at the same meeting. During this meeting Maria Cutajar was elected as a member on the EMA's Executive Council.

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LABORATOIRES
FUMOUZE

• continued from page 18

Parentcraft Services is also working with various NGOs *regarding asylum seekers*, mainly KOPIN, INTEGRA, JRS and AWAS. An initial seminar was organized whereby information was clarified to managers and staff of the obstetric units. Presently, KOPIN has been approved funds for *a project regarding Sexual and Reproductive health* under the Julia Taft Fund which is managed by the US State department. Parentcraft Services will be actively involved in this project.

New projects include: *Sessions for Dads only* while Parentcraft Services is presently involved in an innovative and challenging project – *the creation of DVD modules on a large variety of subjects.* This visual material is also intended to be *available online.*

Support is mainly maintained through a very popular ***Support Tel. Helpline - 2545 5124,*** where clients can call in, to ask help for any problem, both during pregnancy or after birth. The telephone helpline is open to all, including those who have never attended, relatives, and anyone wishing to make use of this service. Calls vary from brief ones enquiring about the courses or about their applications, to complicated and intense ones, sometimes requiring referral to other Departments/Units.

In addition, there has also been a significant increase in *one-to-one counselling sessions,* presenting mostly with pregnancy-related, emotional, or social issues. If need be, referral will be done to other Units/Departments, such as *Department of Social Welfare Standards (DSWS), Social Work Unit, Ghozza, Richmond Foundation, Institute of Family Therapy (IFT),* etc.

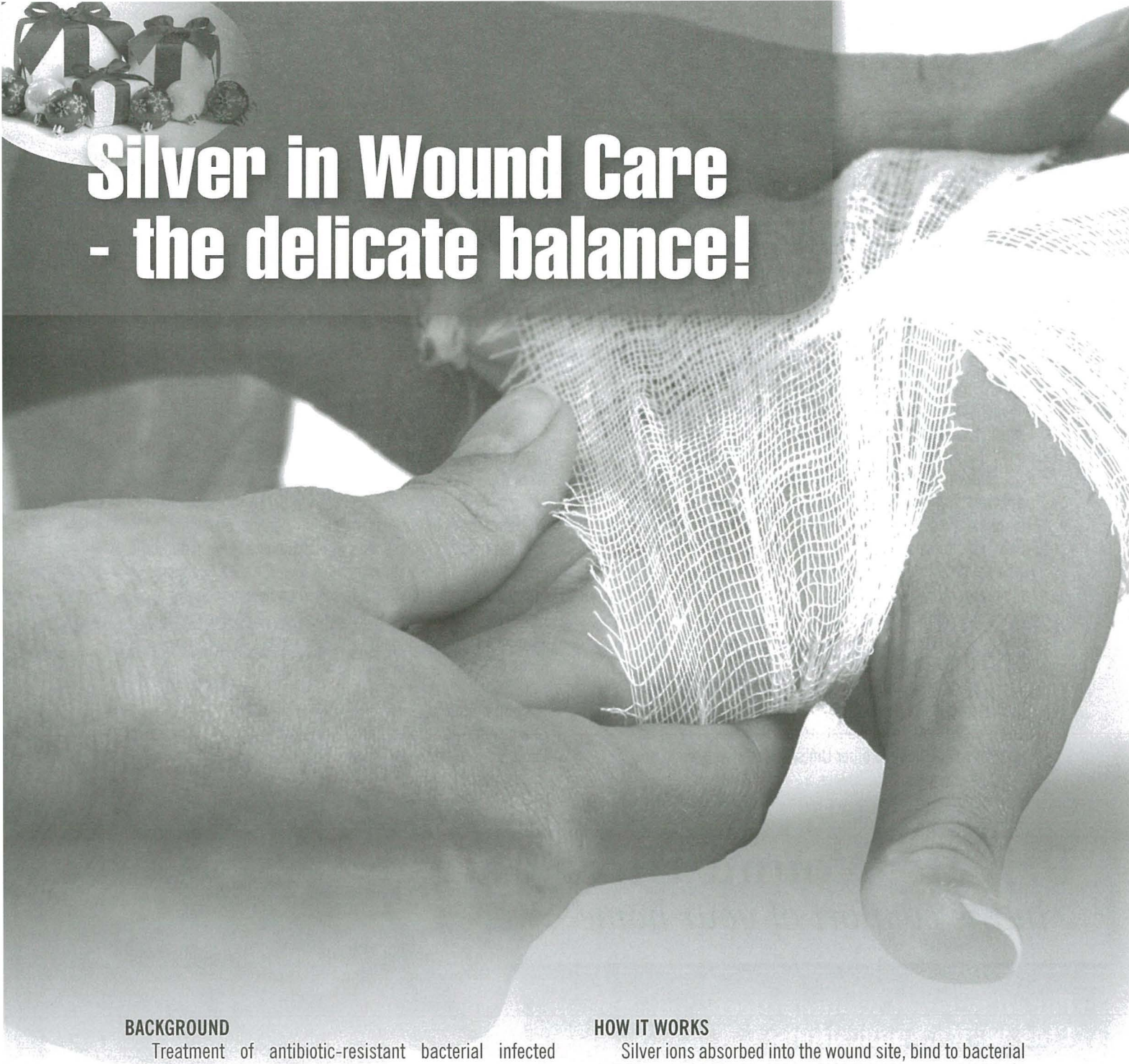
Parentcraft Services is a dynamic service, ever-changing with the needs of its clients. Besides being very Customer Friendly, Parentcraft Services aims towards the "Positive Parenting Policy", offering a family-friendly environment where clients feel safe to visit over and over again, and to share their worries and joys with the midwives they have learnt to trust.

M'Louise Bugeja
Charge Midwife - Parentcraft Co-ordinator
Parentcraft Services (Mater Dei Hospital)

Parent Craft Services

Mater Dei Hospital
Tel: 2545 5123, 2545 5124/2545 5127
Tel/Fax: 2545 5125 Helpline: 2545 5124
Email: parentcraft@gov.mt

Silver in Wound Care - the delicate balance!



BACKGROUND

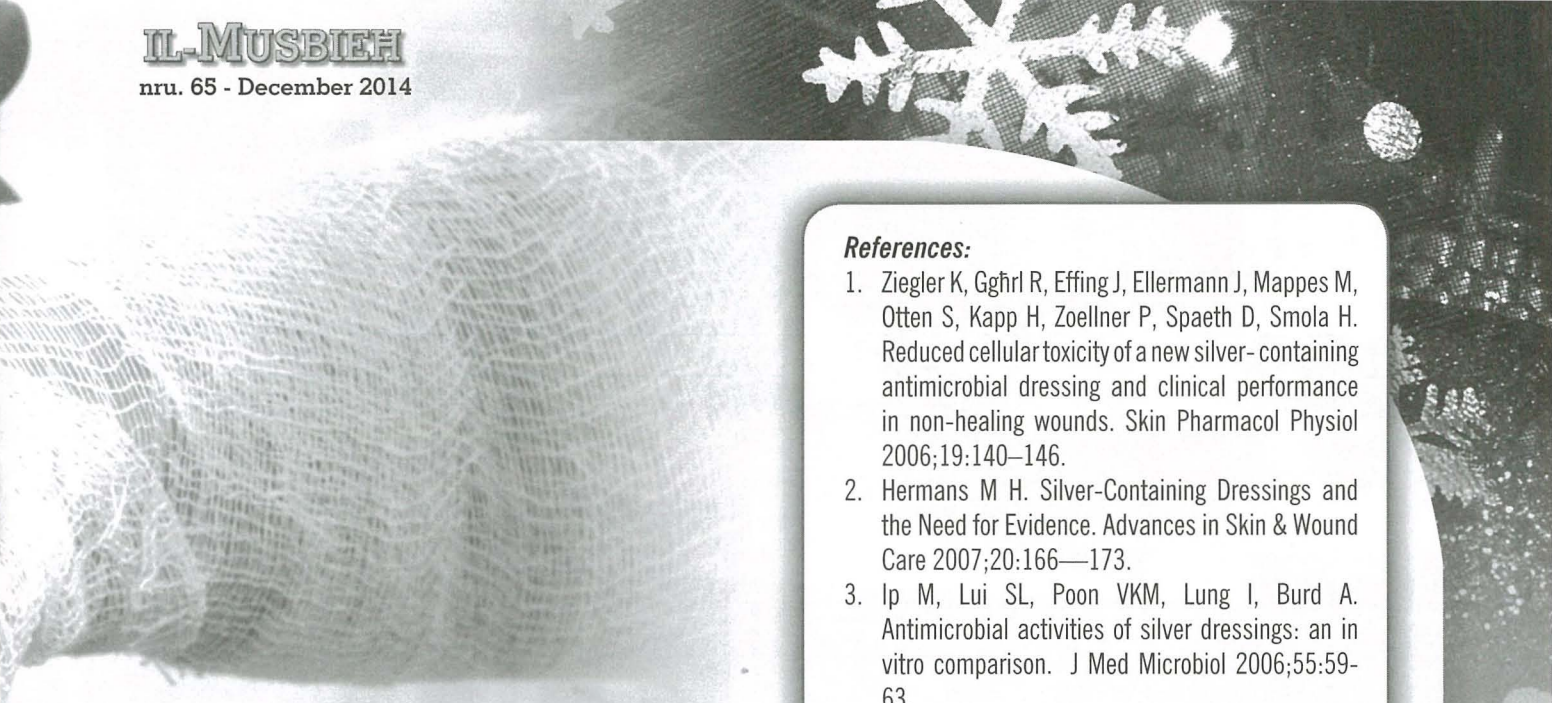
Treatment of antibiotic-resistant bacterial infected wounds poses a major problem in wound care. The development of silver-containing wound dressings has improved the local management of critically colonised and infected wounds. Silver is a broad-spectrum agent effective against a large number of Gram-positive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

HOW IT WORKS

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

PHYSICAL AND CHEMICAL PROPERTIES

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



ANTIMICROBIAL EFFECTS AND TOXICITY

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

THE WAY FORWARD

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

CONCLUSION

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

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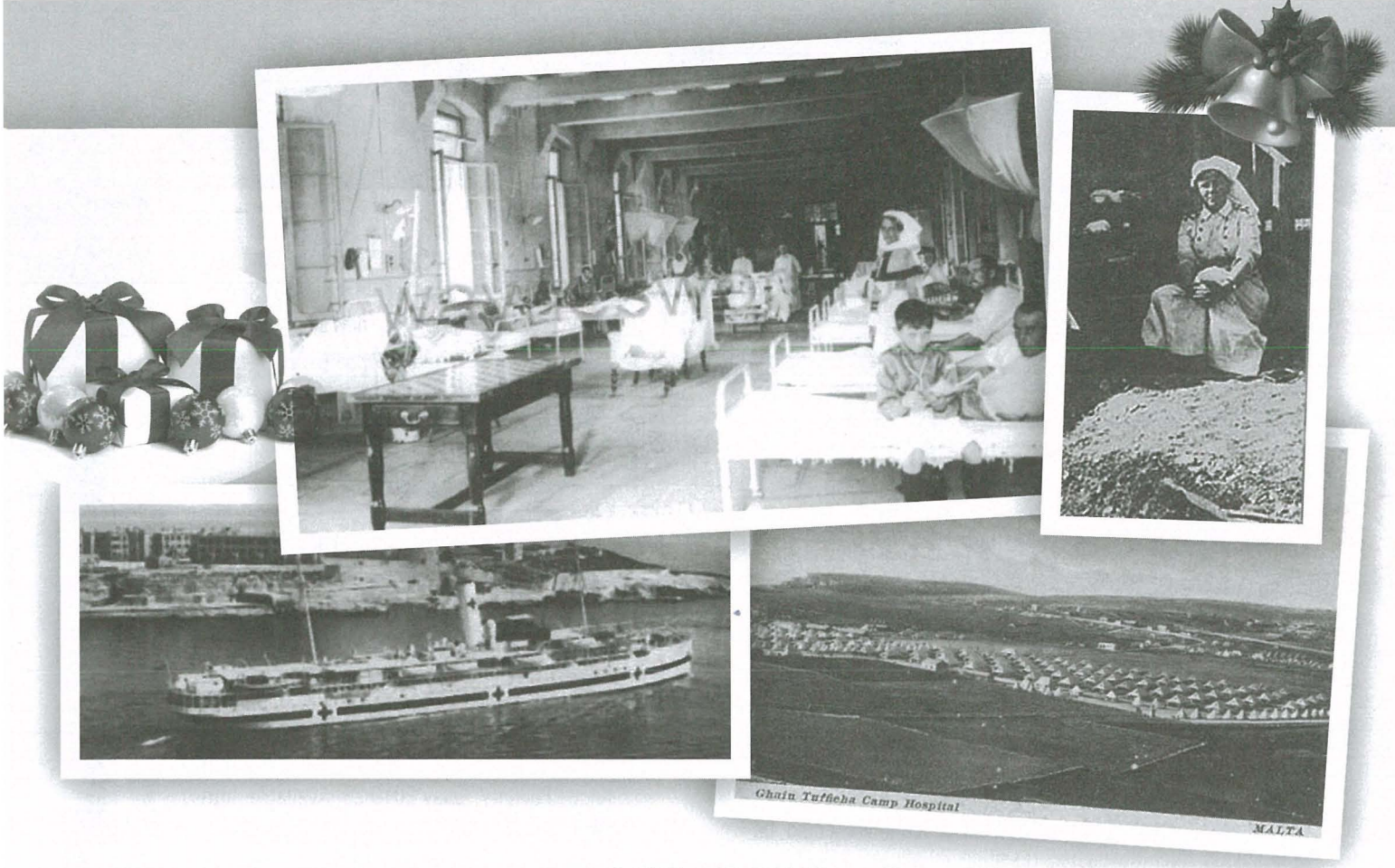
Tanya Carabott, P.Q.Dip.HSc (Mgmt)



In memory of World War One Nurses

Whilst the World is commemorating a grim anniversary since the start of WW1 we cannot forget the exhausting and often dangerous work of nurses who worked in the horrors of war. Obviously Malta is no exception, although not at the home front, local and foreign nurses who working on the island were almost the busiest in Europe. These great events of courage in Malta dubbed our nation as the 'Nurse of the Mediterranean'.

Most of the nurses worked voluntary and were also untrained, such as the VAD (Voluntary Aid Detachment). They wore starched and spotless white uniforms and were universally admired for working on most dreadful battlegrounds in an attempt to ease the pain of bereavement. Conspicuous uniforms looked and felt almost romantic but the work itself was exhausting, unending and sometimes disgusting.

Wartime nurses dominated nursing history. Acceptance of nurses as equal contributors with doctors on the front line was no big deal. Apart from them there were thousands of untrained women working as midwives or nurses in civilian life, but they had little or no experience of working with soldier patients and their status in society was little better than that of domestic servants. Thousands of young women from middle-class homes with little experience of domestic work, not much relevant education and total ignorance of male bodies, volunteered and found themselves pitched into military hospitals.

Professional nurses, battling for some kind of recognition and for proper training, feared this large invasion of unqualified volunteers would undermine their efforts. Poorly paid VADs were used mainly as domestic labour, cleaning floors, changing bed linen, swilling out bedpans, but were rarely allowed until later in the war to change dressings or administer drugs. The climate of hospital life was harsh.

Despite the constant threat of Turkish shelling or torpedoes at the front, the exhausted nurses cleaned, bandaged, warmed, and comforted their patients, many of whom had ghastly wounds or were suffering from the effects of gangrene and disease. Others, worked mainly in tent hospitals, and most of their patients were suffering from malaria, dysentery, and black water fever. They toiled through hot, mosquito-infested summers, and then had to endure freezing winters.

By war's end, having faced the dangers and demands of wartime nursing and taken on new responsibilities and practices, nurses had proved to be essential to military medical service. But professional nurses, the backbone of the wartime service, failed to get legal recognition of registered status until 1943. Some drifted into public health and midwifery but nursing remained something of a Cinderella service.

In Malta, 27 hospitals and camps were set up and the first batch of 600 casualties from the Gallipoli landings arrived on 4th May 1915. The number of sick and wounded treated in Malta from May 1915 up to February 1919 was approx 58,000 from the Mediterranean Expeditionary Force, and 78,000, from the Salonika Expeditionary Force. Nursing staff and doctors often died in Malta from diseases while nursing patients.

WW1 Nurses must always be remembered and cherished for their acts of gallantry and devotion to duty under fire. They are an example to all of us.

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Charge Nurse

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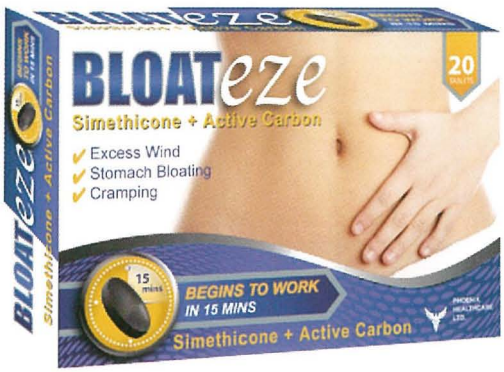

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Reduced protein levels, similar to values found in breastmilk.

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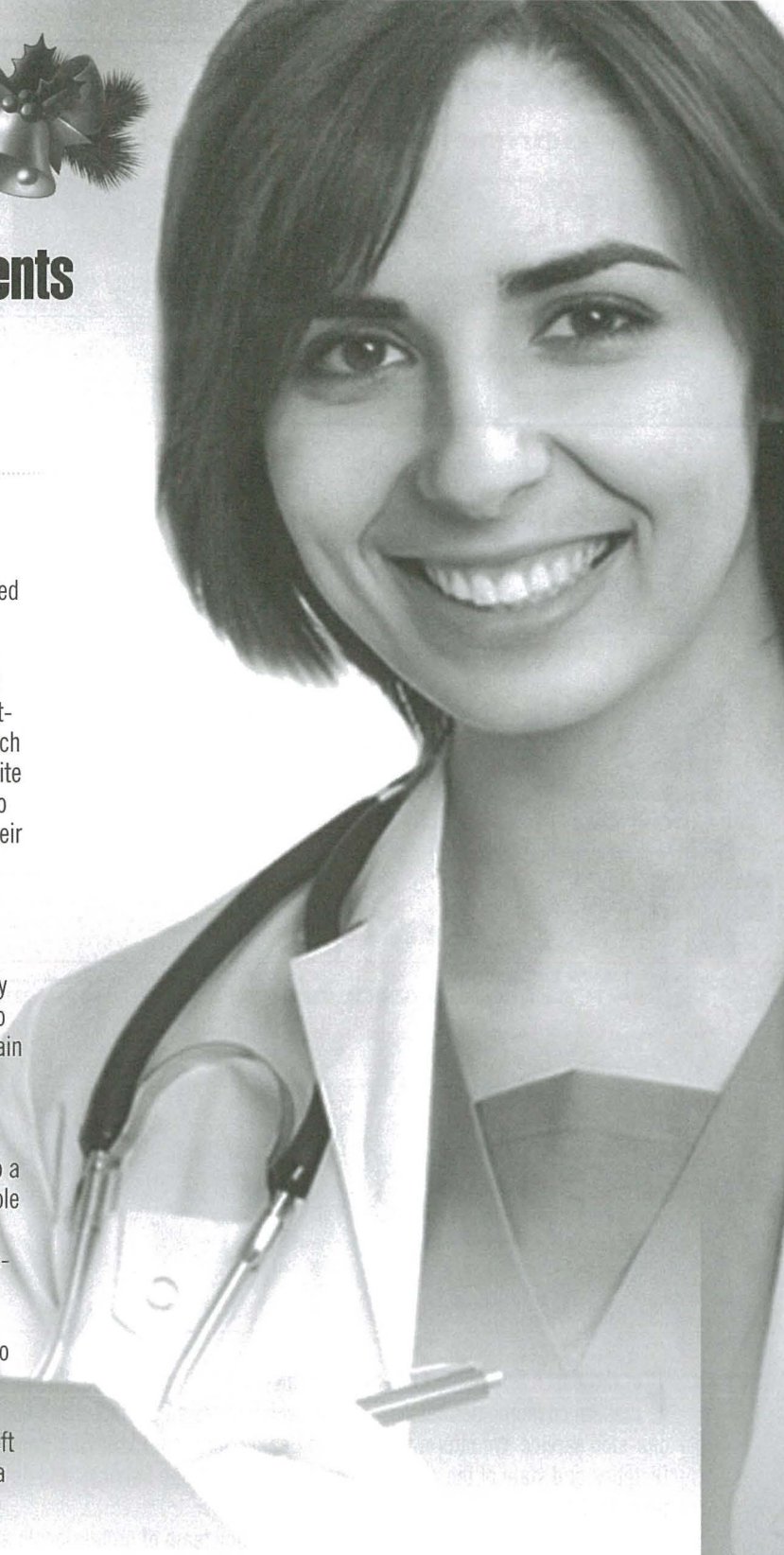
NWH200 13/10/2014

University of Malta discouraging nursing students to study – with a change in the bye-laws!



We have all seen our billboards in our national roads. Billboards sought to encourage individuals to join the nursing community. A campaign that is supposedly intended to help the Maltese people be given the appropriate care when in need in our hospitals. A campaign that was introduced because the health care community claimed that at this very moment we are in great need of nurses. Undoubtedly the job of a nurse is not a particular type of job in which a child would be dreaming of at an early age. A job not quite popular with the masses, and so the small percentage who do pursue this career should be encouraged to continue their studies. After all these people will be caring for us: The Maltese population.

What exactly is this new change in the bye-laws? Diploma Nursing students need to complete 3 years of studies, and it has been this way for a few years now. Like any other exam in the University of Malta students will undergo exams at the end of their first semester in January and again in June in the end of the second semester. Like any other course in the University of Malta, if a student will fail to receive sufficient marks in any of these exams conducted either in January or June, the student is entitled to undergo a re-sit in September. This is also what the majority of people think is fair.

In 2013 the University of Malta decided that in the second year of this course, students are to sit for their exams in January, but if they fail from any of these, they will not be allowed to continue their studies. They will then have to wait until September to sit for their resit exam and if they pass they will have to wait until next January so they can continue their second year of studies exactly where they left off (starting the second semester). This basically means a student will lose an entire year of studies because of this change in the bye-laws.

Numerous complaints emerged as soon as students enrolled in this course heard of this change in the bye-laws, and most of the nurses, doctors, midwives and other health care professionals as well as other health science students were concerned. If this change in the bye-laws is practiced, most of the hospital staff fears that this will drastically decrease the number of new nurses appointed as staff nurses each year, as well as discourage potential applicants to apply for the course. This will ultimately mean that Malta's problem in the shortage of nurses will only get worse. The Diploma Nursing course employs approximately 90 new nurses each year (which are still not enough to meet the needs of our hospitals and clinics). The Degree Nursing course is also another course intended to qualify individuals with a nursing degree. It employs about 45 new nurses each year, a number which, when combined with that of the diploma course is still insufficient to serve the Maltese Health Care Community. So why introduce these changes?

We should be improving our educational courses in such a manner to improve our country as a whole. This should not be the solution if we ought to encourage more people to enter the nursing community. This should not be the way to improve Health Care in our country. However it may be the solution to increase the constant stress our doctors, nurses, specialists and other health care professionals already suffer from in an average day of work.

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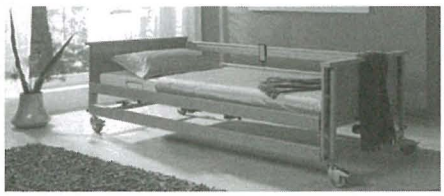

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Being assertive benefits everyone

by Maria Cutajar, MUMN Vice-President

INTRODUCTION

Being assertive is a core communication skill, where needs or wishes are stated clearly with respect for oneself and the other person in the interaction. Assertive communication is distinguished from passive communication (in which needs or wishes go unstated) and aggressive communication (in which needs or wishes are stated in a hostile or demanding manner) (Dorland's Medical Dictionary, 2012). Being assertive means that an individual can effectively express himself/herself stand up for his/her point of view, while also respecting the rights and beliefs of others.

Being assertive can also help boost an individual self-esteem and earn others' respect. This can help with stress management, especially if a person tends to take on too many responsibilities because s/he has a hard time saying no. In some workplaces, saying "no" is frowned upon. Assertiveness skills are essential, as they will enable each employee to look after himself/herself and thus, work more effectively. Sometimes, it involves finding ways of saying no without having to use the "n" word.

Some people seem to be naturally assertive, while others might not, however they can still learn to be more assertive.

WHY ASSERTIVE COMMUNICATION MAKES SENSE

Assertiveness is based on mutual respect and it's an effective and diplomatic communication style. When an individual act in an assertive manner, show that s/he respect himself/herself because s/he is willing to stand up for his/her interests and express his/her thoughts and feelings. It also demonstrates that the individual is aware of the rights of others and is willing to work on resolving conflicts.

Of course, it's not just what a person says — his/her message — but also how s/he say it that's important. Assertive communication is direct and respectful. Being assertive gives an individual the best chance of successfully delivering his/her message. If an individual communicate in a way that's too passive or too aggressive, his/her message may get lost because people are too busy reacting to his/her delivery.

ASSERTIVE VS. PASSIVE BEHAVIOUR

If an individual's communication style is passive, s/he may seem to be shy or overly easygoing. An individual with a passive communication style may routinely say things such as, "I'll just go with whatever the group decides." S/he tends to avoid conflict. Why is that a problem? Because the message this individual send is that his/her thoughts and feelings aren't as important as those of other people. In essence, when an individual is too passive, s/he gives others the license to disregard his/her wants and needs.

Consider this example: An employee says yes when a colleague asks him/her to take over a project, even though his/her plate is full, and the extra work means that s/he has to work overtime and miss his/her daughter's netball game. The employee intention may be to keep the peace. But always saying yes can poison relationships. And worse, it may cause internal conflict because an individual needs will come second.

The internal conflict that can be created by passive behavior can lead to:

- Stress
- Resentment
- Seething anger
- Feelings of victimization
- Desire to exact revenge

ASSERTIVE VS. AGGRESSIVE BEHAVIOUR

Now consider the flip side. If an individual communication style is aggressive, s/he may come across as a bully who disregards the needs, feelings and opinions of others. This individual may appear self-righteous or superior. Very aggressive people humiliate and intimidate others and may even be physically threatening. An individual with an aggressive communication style may think that being aggressive gets him/her what s/he wants. However, it comes at a cost. Aggression undercuts trust and mutual respect. Others may come to resent an aggressive person, leading them to avoidance and/or opposition

ASSERTIVE VS. PASSIVE-AGGRESSIVE BEHAVIOUR

Now consider passive-aggressive behaviour. If an individual communicate in a passive-aggressive manner, s/he may say yes when in actual fact s/he want to say no. An individual may be sarcastic or complain about others behind their backs. Rather than confront an issue directly, an individual with passive-aggressive style of communication may show his/her anger and feelings through his/her actions or negative attitude. An individual may have developed a passive-aggressive style because s/he is uncomfortable being direct about his/her needs and feelings.

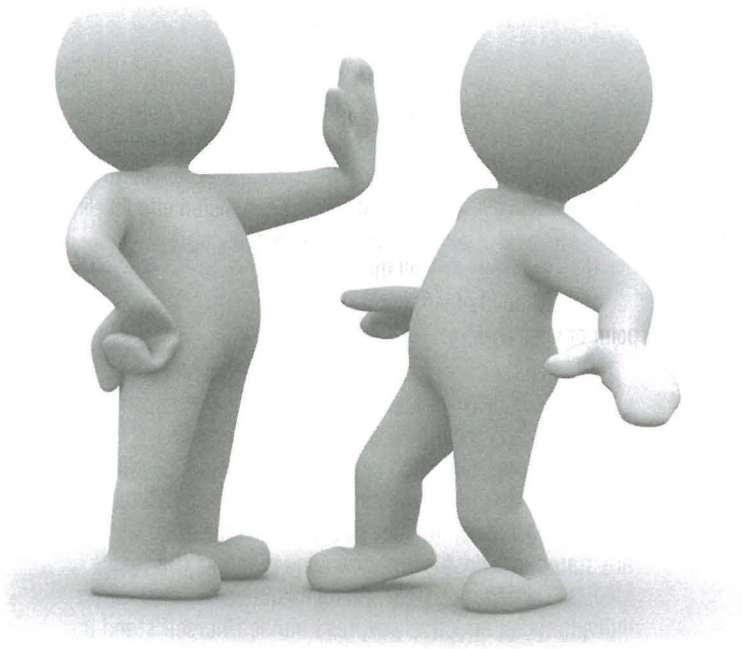
What are the drawbacks of a passive-aggressive communication style? Over time, passive-aggressive behaviour damages relationships and undercuts mutual respect, thus making it difficult for a person to get his/her goals and needs met.

THE BENEFITS OF BEING ASSERTIVE

Being assertive is usually viewed as a healthier communication style, and it offers many benefits. It helps an individual to keep people from walking all over him/her. On the flip side, it can also help an individual from steamrolling others. Assertive communication consists of sharing wants and needs honestly in a safe manner and focuses on the issue, rather than the person. Aggressive and/or passive communication, on the other hand, may mark a relationship's end and reduce self-respect.

BEHAVING ASSERTIVELY CAN HELP YOU:

- Gain self-confidence and self-esteem
- Understand and recognize your feelings
- Earn respect from others
- Improve communication
- Create win-win situations
- Use the 'I' statement, and look forward to reach goals
- Improve your decision-making skills
- Create honest relationships
- Gain more job satisfaction
- Work with integrity, looking after yourself without being selfish
- Learning to be more assertive can also help you effectively express your feelings when communicating with others about issues.



LEARNING TO BE MORE ASSERTIVE

People develop different styles of communication based on their life experiences. An individual communication may be so ingrained that s/he is not even aware of what it is. People tend to stick to the same communication style over time. But if an individual want to change his/her communication style, s/he can learn to communicate in healthier and more effective ways. Assertiveness can help people to be more efficient in their own work, act as role models, showing a way of working that supports others to do the same, and promote a fairer distribution of work.

Tips to help an employee become more assertive:

Assess your style. Do you voice your opinions or remain silent? Do you say yes to additional work even when your plate is full? Are you quick to judge or blame? Do people seem to dread or fear talking to you? Understand your style before you begin making changes.

Use 'I' statements. Using "I" statements lets others know what you're thinking without sounding accusatory. These can be used to voice personal feelings and wishes without expressing a judgement about the other person or blaming them. For instance, say, "I disagree," rather than, "You're wrong."

Be Confident but Not Pushy. When you approach people, you need to have confidence in yourself. Whether it is a relative, client or colleague, you need to have confidence in yourself and your ability to speak your mind. You can't shrink from confrontation. You have to be able to get your opinion across and let the other person know what you want. The problem with this side of assertiveness is when you become a know-it-all bully. When you are constantly pushing your thoughts and opinions on other people, you are more of a steam-roller than a team player. Assertiveness does not mean you dominate. It means you speak your mind

and work with the other person.

Listen, Don't Pretend to Hear. When you are in crisis mode, it's easy to ignore what the other person is saying. You need so much for your opinion to be heard that you don't listen to the opinions or thoughts of others. The problem with this is that you might be wrong. As hard as it is for you to admit, you may not know best. You have to listen effectively to collaboratively make a decision. Again, assertiveness isn't about getting your way all the time and bullying someone into seeing your point of view. It is about striving to understand the point of view the other person has and examining your own thoughts. You have to listen to be assertive because you have to be an active participant in the conversation. You have to listen at the very least to make good return arguments.

Be Clear, Not Confused. In addition to confidence and listening, you need to be able to make yourself understood. Before speaking up, gather your information and have it clear in your head what you want. You need the confidence to clearly state what your needs or views are.

Practice saying no. If you have a hard time turning down requests, try saying, 'Presently, I `m unable to do this task'. Don't hesitate — be direct. If an explanation is appropriate, keep it brief.

Rehearse what you want to say. If it's challenging to say what you want or think, practice typical scenarios you encounter. Say what you want to say out loud. It may help to write it out first, too, so you can practice from a script. Consider role-playing with a friend or colleague and ask for blunt feedback.

Use body language. Communication isn't just verbal. Act confident even if you aren't feeling it. Keep an upright posture, but lean forward a bit. Make regular eye contact. Maintain a neutral or positive facial expression. Don't wring your hands or use dramatic gestures. Practice assertive body language in front of a mirror or with a friend or colleague.

Keep emotions in check. Conflict is hard for most people. Maybe you get angry or frustrated, or maybe you feel like crying. Although these feelings are normal, they can get in the way of resolving conflict. If you feel too emotional going into a situation, wait a bit if possible. Then work on remaining calm. Breathe slowly. Keep your voice even and firm.

Start small. At first, practice your new skills in situations that are low risk. For instance, try out your assertiveness on a partner or friend before tackling a difficult situation at work. Evaluate yourself afterward and tweak your approach as necessary.

Seek for advice or support. Learning to be assertive takes time and practice. If an individual spent years silencing himself/herself, becoming more assertive probably won't happen overnight. Or if anger leads an individual to be too aggressive, an individual may need to learn some anger management techniques. If despite best efforts an individual is not making progress toward becoming more assertive, formal assertiveness training or help from a professional may be considered. The payoff will be worth it. By becoming more assertive, an individual can begin to express his/her true feelings and needs more easily, and achieve personal goals.

CONCLUSION

Communication is an important component of assertiveness. It can help employees become better leaders; able to articulate exactly what it is they need without being intimidated and in a respectful way. Assertiveness is about believing you're entitled to be somewhere, that you have basic rights as a human being and as an individual employee, and that as much as you give respect to others you deserve the same in return. Becoming more assertive can lead to increased respect and recognition as a person and as an employee. Becoming more assertive is a process, and it's not something that happens overnight, however, small changes can move individuals in the right direction. Acting in a more assertive manner actually will make individuals feel more assertive and lead to increased confidence.

Maria Cutajar
Vice-President, MUMN

Personalised elderly clothing - a hidden issue

In 1998, the Maltese population included 63,000 persons aged 60 and over, an increase of 27.4% over the 1985 census figures. In 2012 persons aged over 60 amounted to 102026 or 24.2% of the total population. The planned projections for 2020 were that the number of elderly people will increase to around 95,000, or 24.2% of the population, (Troisi 2003). The projected 95,000 that was supposed to be reached by 2020 was already reached and over by 7,000 in 2012.

This increase could be attributed mostly to improved sanitation, greater availability of food and shelter, and other public health measures that primarily reduced infant and childhood mortality. The advent of antibiotics in the mid-twentieth century reduced mortality among younger individuals.

THE ART OF DRESSING

This elderly cohort of Maltese society needs to be helped so that it can live to its utmost level of independence. In their declining years elderly people may have an increasing difficulty to manage some of the physical activities of daily living, even with dressing. The much under-rated activity offers the opportunity to the individual of making decisions, which, in turn, helps develop and maintain a feeling of self-direction. This, in itself, is an important part of self-fulfillment.

Clothes are the medium of non-verbal communications. The person's mood is shown according to what types of clothes are worn and also how they are worn. When in a good mood, the person tents to keep his clothes tidy. When dejected; however, he frequently does not seem to notice things like stains on his clothes and down-to-heel shoes (Roper et al, 1996).

It is important to understand that physical changes that occur during the normal process of aging can influence either directly or indirectly, the ways in which the dressing activity is carried out. Dressing can be found to be even more difficult when the person has to cope with some illness or disabling condition.

Everyday tasks such as buttoning, zipping, snapping or tying may be difficult or require assistance. Normal dressing skills can pose difficulties owing to arthritis, Parkinson's disease, stroke, Alzheimer's disease and multiple sclerosis just to name a few. Failing eyesight and shaking hands may also make it increasingly difficult for elderly person to retain his independence when it comes to dealing with complicated clothing. Complications such as incontinence, edema or fragile skin can make the traditional clothing impracticable and difficult to put on.

Problems that can make independent dressing difficult can include:

- Inadequate function of the nervous system, which not only controls movements of the body, but also the rationale of the skill involved in dressing.
- Limited mobility – crippled hands cannot hold or fasten small buttons or zips.
- Involuntary movements of the limbs. As the person ages, involuntary movements caused by neurological conditions, such as Parkinson's disease, are more common. The person may experience increasingly uncontrollable hand movements that will make simple tasks difficult.
- Blindness caused by disease prevalent in old age can cause problems in dressing – although many people achieve the necessary skills to attend to all aspects of their personal dressing, while others would require some help.
- Arthritis and stroke are the most common conditions that can cause difficulty in dressing. Arthritis is a disease that affects many, both young and old. Typically, arthritis affects the primary joint in the hands, feet, knees, hips and shoulders.

Thus the process of dressing needs to be considered when selecting clothes to help overcome dressing difficulties caused by these problems. However, with the help of the instruction from the health carers the dressing activity needs, as much as possible, be carried out independently by the person who has been affected by any form of disability.

CHANGE OF STATUS

Elderly people and their carers need to be advised, through appropriate information, about what is available to make assisted dressing easier. Modified clothing could be designed to help independent dressing possible again to elderly people in rehabilitation programs or to those who are finding this task difficult simply through the normal change of old age.

The use of Velcro tapes on garments can eliminate the use of small buttons and hooks which the elderly people find

so difficult to manage often owing to failing eyesight or loss of fine hand movement. Footwear must be given its proper importance. It is essential for footwear to be lightweight. Fastening must be adequate to hold feet well back in the shoes. All footwear provided should allow toes to move normally, without undue pressure of friction.

Occupational therapy needs to be involved when finger movements are limited and clothing and fastenings need further adaptations.

INSTITUTIONS AND NURSING HOMES

Certain authors prefer to remain anonymous when writing on such a delicate issue as that of clothing worn by elderly clients in institutional setting. These include authors with a number of practical experience in elderly care. One (anonymous) author (1994) argues that it has not become universal practice for such clients to possess personal clothing in these residence.

Goodwin (1994) states that caring for people's clothes while they are in hospital or any care setting is fundamental to ensure his needs are met. A sense of 'depersonalisation' is created as a result of depriving a person of his own clothes (Roper et. al. 1996). In this respect, a 1972 document by the UK Department of Health and Social Security lays down the basic requirements of clothing services, including the provision for laundry, ironing, labeling and repair services.

Allowing elderly clients in nursing homes/institution to wear their own clothes provides the opportunity for people in the long-term care to preserve their autonomy and exercise decision-making skills. Besides, it gives these clients yet another possibility of preserving their self-esteem, dignity, helps to prevent boredom, lack of motivation and 'institutionalisation' (Nursing Standard, 1990).

The concept of personal clothing for long-term clients has been given attention at the Gozo General Hospital. For this purpose a launderette had been included in two particular wards, namely the Male Geriatric Ward and the Long Stay (Mental) Ward opened in 1991 as an extension of the main hospital. The aim was that personalised clothing to be washed in the same unit. Unfortunately, this service was discontinued owing to lack of staff.

This problem does not seem to be particular to Gozo. Goodwin (1994) states that the role of the laundry assistant, indeed, the whole function of personalised clothing rarely seems to arouse much interest or attention.

Saliba (2000) who investigated the dependency level in dressing as an activity of daily living, found that positive results in the level of independence could be achieved if elderly clients are provided with suitable clothes related to their abilities.

In 2001 Saliba analysed the dressing activity in a local institution and found that 47% of the clients ranged within the dependency level while 32% clients ranged within the semi dependency level. Only 21% were found to be independent.

To enhance the activity of dressing, clients need to be motivated by a provision of a reason to dress. This can be done by organising and involving clients in social activities related to their backgrounds. In an institutional setting, this can include attending Day Centers as that in Ghajnsielem and other social activities, so that they can be integrated with their counterparts in the community.

RECOMMENDATIONS

The elderly person who loses the use of a limb is helped to use alternative techniques according to disability. In the first stages, there may be increased risk of accidents should the person, even momentarily, forgets the limb deficiency.

1. Skin care, especially hand and feet, is important and this should be kept soft and supple.
2. The person needs to be given enough time to dress.
3. Praising their efforts are a means of providing psychological support which enables the person to retain optimal independence.
4. Assessing the client with sensory deficit is essential as he may require modified aids.

Nurses, together with the physiotherapist and the occupational therapist, can enable the frail elderly to continue dressing independently or with as little help as possible. This can be made easier by modified clothing, which includes:

- Stretch fabrics and wide sleeves and trouser legs, whether in fashion or not, for easier management.
- Zips and Velcro tapes are easier to manage than small buttons or hooks and eyes.
- Simple fastening garments (large buttons etc.)
- Suitable stockings.
- Easy-to-wear underwear, especially when finger movements are limited and fastening needs further adaptation.
- Velcro fastening on footwear.

Empathy is necessary so that any person who has to wear modified clothing can be helped to regain confidence and continue to use dressing as a source of self-esteem and a mean of communication (Roper et al., 1996).

Until the day comes that any older person can go into hospital, secure in the knowledge that he will not be sharing underwear, we must acknowledge that we are providing an unacceptable level of care (Anonymous 1994).

Note: This article is part of my work done during the EN to SN Conversion Course first intake 1998 – 2000. After fourteen years some changes were done. Others, in my opinion, needs to be introduced so that the concept of the fundamental care setting of clothing will be met to help elderly to live a dignified life.

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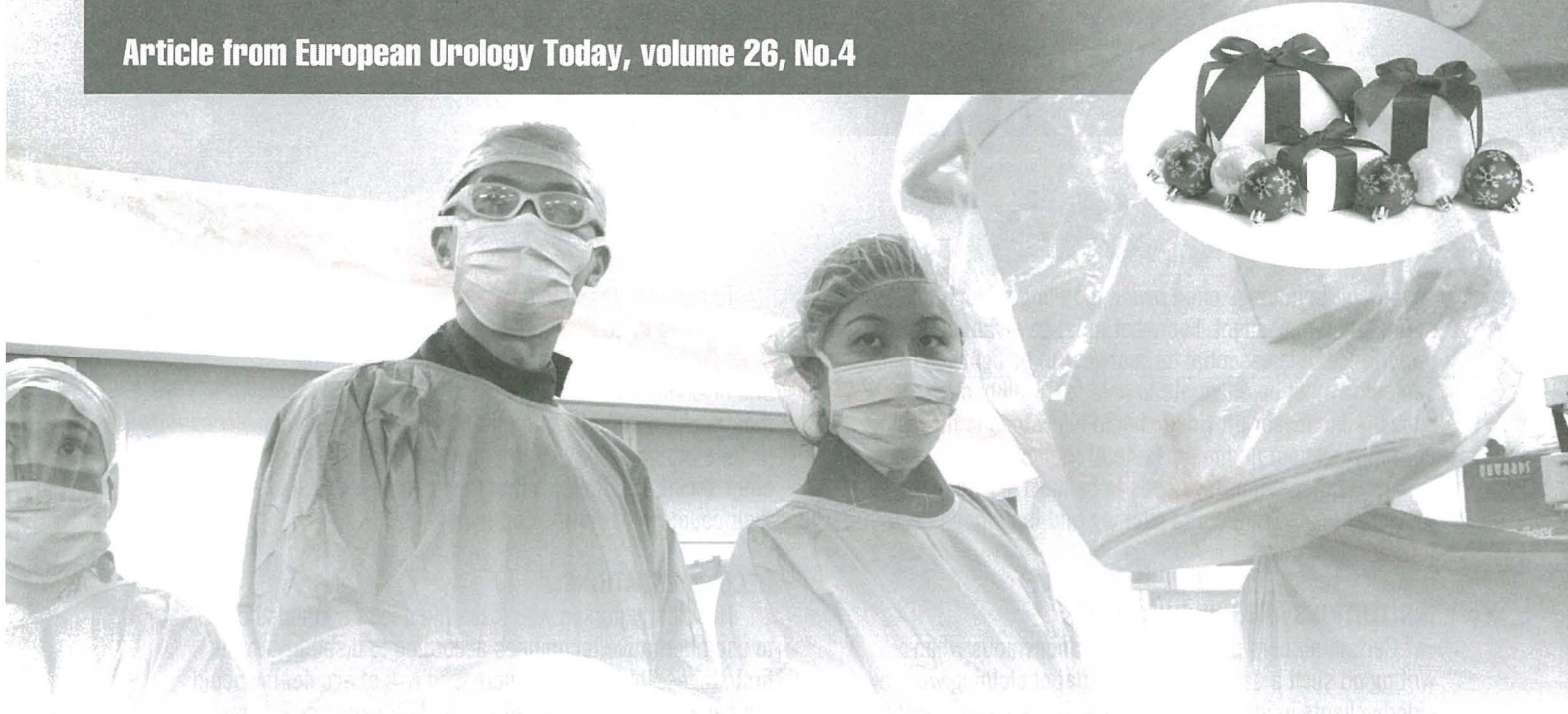
Editor – who is interested in the references of this article please contact Mr. Saliba on carmelsaliba@yahoo.co.uk



Urology nursing: the road map ahead

Every healthcare professional knows the reality of having "to know more about less." With the rapid developments in technology, treatment options and outcome results, healthcare professionals are expected to acquire a wide range of competencies, and urology nursing is not exempted from these challenges.

Recent experience and studies have shown that, where nursing specialisations have been accepted and nurtured to grow, the service provided has improved considerably. This has not gone unnoticed and in the EU Directive 2013/55 we find the following statement:

"The nursing profession has significantly evolved in the last three decades: community-based healthcare, the use of more complex therapies and constantly developing technology presuppose a capacity for higher responsibilities for nurses..."

Nursing specialisations have now gained some ground and are well-established in a number of European Union (EU) states. Yet, unfortunately, there is still no harmonious formal EU-wide regulation or standard. The situation is such that when the above-mentioned EU directive 2013/55 was published, it omitted to directly address these specialisations. In other words, unless work has started in earnest, by the time the directive comes into force nursing specialisation cannot be automatically recognised based on the goal of the proposed European Professional Card (EPC). This EPC project, under the updated Professional Qualifications Directive, is meant to facilitate the free movement of professionals in the EU. This new system should, in theory, simplify, administratively, the recognition procedure within the competent authorities of EU Member States.

In a way, the omission of nursing specialisation in the EU Directive 2013/55 came as no surprise, since we have no common training and testing framework. The European Specialist Nurse Organisation (ESNO) was quick to recognise this and addressed the issue with the EU Directorate as soon as it was published. A reply from Brussels came shortly afterwards and basically paved the way with the following statement:

"...The modernised Professional Qualifications Directive introduces the possibility to set up "common training framework" and "common training tests," aimed at offering a new avenue for automatic recognition. A common training framework or test could be set up if the profession concerned or the education and training leading to that profession is regulated in at least one third of Member States. Qualifications obtained under such common training frameworks should automatically be recognised in the other participating Member States. These new principles might be relevant for specialties of sectorial professions, such as nurses."

The above statement says it all. In short, we must have at least "one third of Member States" that follow the same pathway of common training and testing framework in order to have such nursing specialisation recognised across the EU automatically. It is by all means a straightforward statement but it is not an easy task by any standard. Contrary to other nursing specialisations that are confined to a specific unit or service, urology nursing is spread over a large spectrum of services, thus making our task somewhat harder to reach within the established timeframe of less than two years.

The EAUN Board is now fully engaged in this quest and we also have good representation in the ESNO board as well. The goal ahead is not unreachable but it can only be surpassed through a collective effort from clinicians, hand in hand with members of the academe. This bumpy road to reach our set objectives cannot be made overnight nor can we accomplish them all by ourselves. We will get there, one small step at a time.

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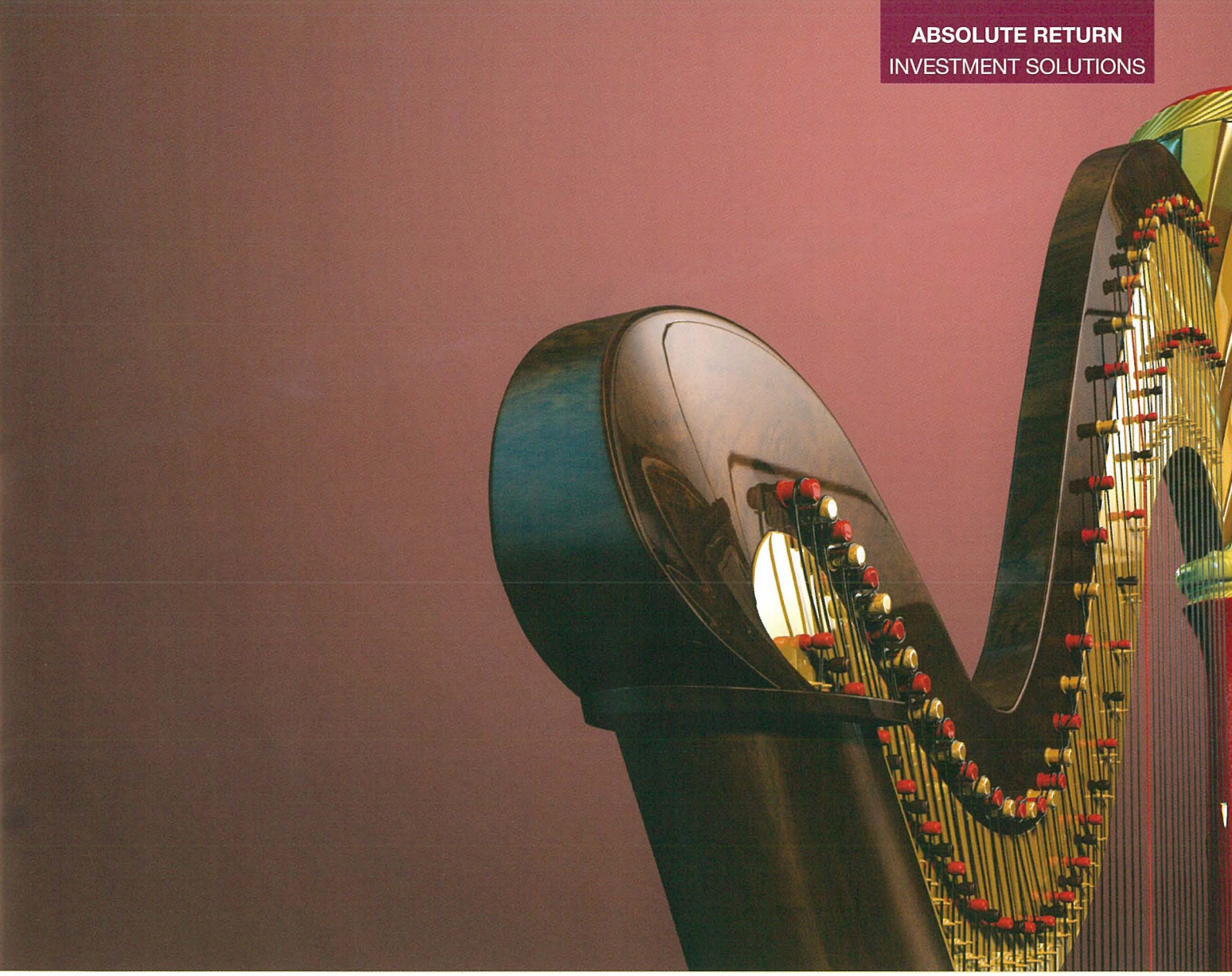

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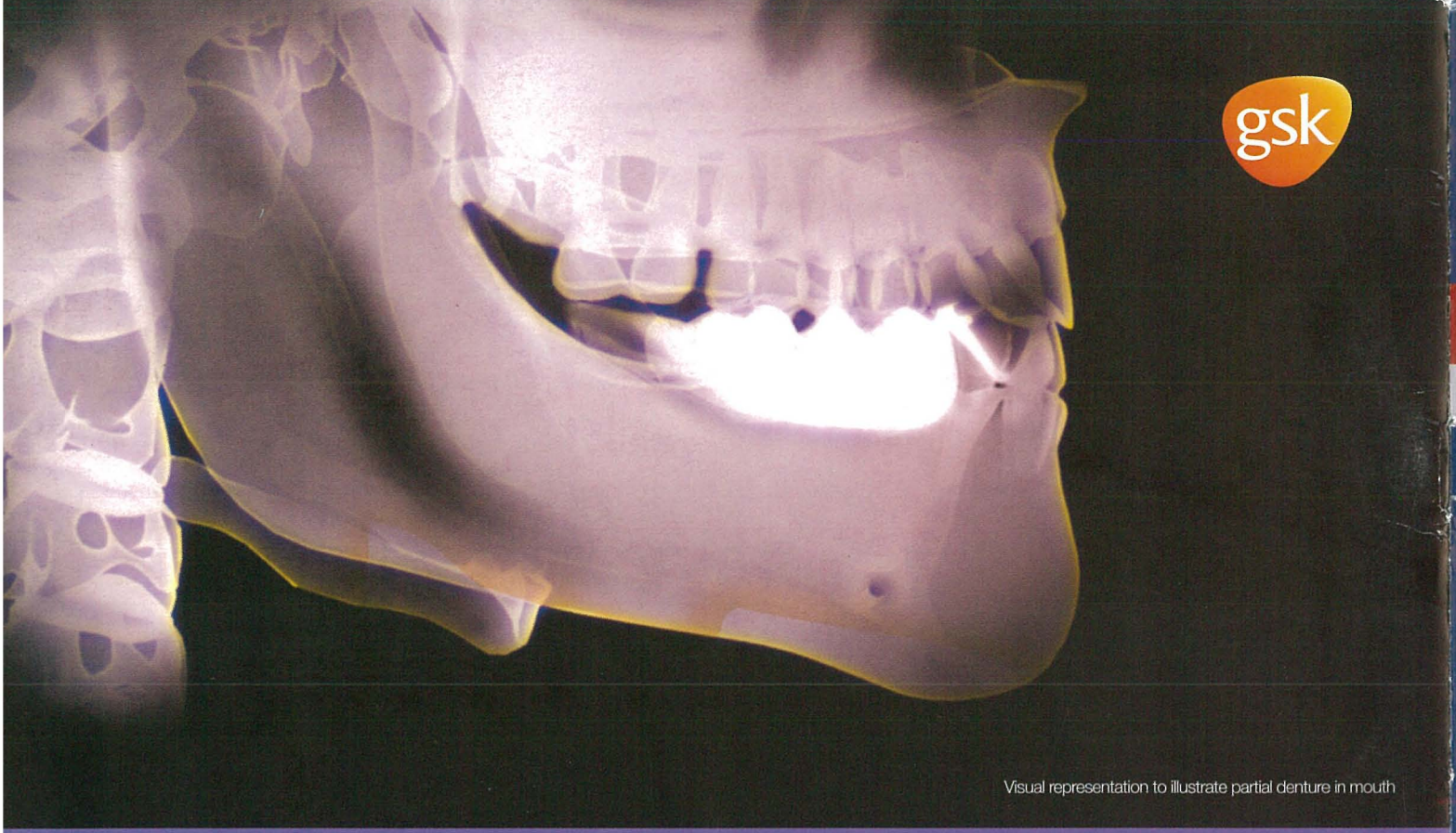

Visual representation to illustrate partial denture in mouth

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*Activity on *in vitro* bacterial biofilms after 5-minute soak. †When used as directed.

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