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Crack Down Violence

Threats and acts of violence against public officials will be punished more severely following amendments to the Criminal Code that came into force last March 2014. The minimum sentence has gone from four months in jail to a year, and a fine of at least D4,000 can be imposed. The maximum penalty for such an offence is a seven-year jail term and a D25,000 fine. The victims included members of the police force, teachers, nurses and doctors in public hospitals. Staff working in A&E, lone workers who work in the community and mental health settings are especially prone to these attacks. It is unacceptable that caring staff are rewarded with intimidation and violence. Threats and violence should never be viewed as 'part of the job'.

A Zero Tolerance campaign to put an end to violence against hospital staff must be urgently launched so that nurses, midwives and other health care professionals will have a safer place to work. A publicity drive to educate the public about the unacceptability of violence or aggression towards healthcare staff, guidance for staff on dealing with the problem and policies on when to withhold treatment from violent patients should be urgently dealt with. Violence against staff must be fought with tough legal action. Health authorities should have systems in place for reducing incidents of violence and aggression by at least 20%. Police Officers on duty at A&E should never be reduced or removed. Actually a police station should be permanently established in our general hospital. A system of police reporting should be efficient, user-friendly and fool-proof. Police Officers themselves must be sensitive, polite and helpful towards staff that are already stressed out.

The cost of violence against staff is not a joke. Victims can suffer physical and psychological pain. Confidence can be irrevocably dented and stress levels rise. All health care professionals should be encouraged to report incidents, irrelevant of the level of the incident. Even verbal abuse is violence. A standard definition of abuse and a robust process for collecting data should be in place. Security Management is another issue which is not clear enough how it functions in our hospitals. Security personnel should not be abruptly removed after 24h from potentially volatile areas and situations. There are too many grey areas of what is self-defence, restraint measures and patient’s rights. Conflict resolution training is a must especially if de-escalation techniques are meant to be used. The approach to actual violence and aggression has to be prevention. Potentially violent situations must be envisioned, and identified.

Although it is unlikely that the risk of violence for healthcare staff will ever completely be eradicated, initiatives to clamp down violence must be seen and felt. Zero tolerance to violence in hospitals is a must.

The Editor
The drive for the recruitment of nurses and midwives and psychiatric nurses is always a challenging aspect for any Government and MUMN. Although, as a union we market the nursing and midwifery profession, our success is constrained by the other courses which the University of Malta offers to our young generation. Recruitment of foreign nurses is not a new aspect since I recall, even when Prof. Rizzo Naudi was a Health Minister (way back in the late eighties) eighty Albanian nurses were brought to Malta to work as nurses. Very few, if any, remained from those nurses. But definitely with the numerous vacancies across the Health Division, from Gozo General Hospital to SVPR to RKGH to MDH such vacancies will not be all addressed.

This year, with the opening of the new oncology centre, new vacancies will emerge complied with the existing vacancies. Not to mention the expansion of the Emergency Department, this will need an additional of at least fifty nurses from the new graduates coming from the University.

Besides all the various issues in nursing and midwifery such recruitment is vital since it will have a big effect on the existing nurses and midwifery work force. Workloads and stress are mostly related to nursing compliment on the wards and departments. The Government has its own pressures... pressures of always needing to deliver more. More operations to reduce the waiting list, more beds in the elderly care and in the acute areas and more nurses in casualty to address the waiting lists... are some of the pressures on the Health Division and on the Government. As you can see, for the Health Division to address such issues, a numerous number of nurses are needed.

Recently, an added service has started by the midwives in post natal care. MUMN supported this service which was needed on both sides of the spectrum. On one side it was the enhancement of the midwifery profession in the community, giving post natal care which although such service existed before, has now developed into a better service. On the other hand all new mothers when discharged from Mater Dei Hospital are getting a better service.

MUMN is also gradually growing with many other professions joining MUMN. It is encouraging to see that MUMN is becoming stronger and we are proud to be of service to other health professionals which after all are all important in the health service of the country.

Well, summer will soon be with us. It is time for holidays, feasts and family outings. Hope you all enjoy the summer and that all members of MUMN will enjoy this season, since after all, not just our working environment is important.

Paul Pace
MUMN President

A number of midwives and nurses donating not just their energy but also their blood to give life another chance. The initiative was undertaken yesterday as a mass blood drive amongst them was held.
Female Genital Mutilation

The Challenges It Brings

by Maria Cutajar, MUMN Vice-President
(continued from last edition)

CONSEQUENCES OF FGM

FGM puts children at risk of life threatening complications at the time of the procedure as well as health problems that remain with her for life. They may suffer bleeding at the time of the procedure leading to haemorrhagic shock, neurogenic shock as a result of pain and trauma, or develop severe infection, all of which can lead to death if not treated promptly. Other immediate consequences of FGM include severe pain and bleeding, shock, psychological trauma, urine retention, damage to the urethra and anus, and infection. Risks and complications increase according to the type of FGM, and are more severe and prevalent with infibulations.

The procedure also permits the transmission of viral infections such as hepatitis and HIV. The women may suffer complications such as recurrent infections, pain and obstruction associated with urination and they are at higher risk of painful menstruation and intercourse, pelvic infection and difficulties in becoming pregnant. Retention of urine and recurrent infections often require repeated hospital admissions and some women carry a risk of developing nephritis. The development of cysts and keloids at the site of the scar are very common, often causing embarrassment and marital problems, and usually require surgery for removal.

During pregnancy there are many further complications that may occur as a direct result of the FGM. Labour may become obstructed and if early medical intervention is not provided this may lead to the death of both baby and mother. The WHO estimates that many women giving birth die in the process, simply as a result of FGM. If the mother and baby survive there is the risk of damage to the vagina leading to the formation of fistulas into the bladder or bowel, which cause constant incontinence as a result of a vescico-vaginal fistula or recto-vaginal fistula. Women in this condition are often rejected by their family and become social outcasts. Apart from the many physical complications, the girls and women experience considerable psychological problems including depression, anxiety and post-traumatic stress disorder. These psychological problems are exacerbated at the time of marriage and often lead to increased distress and fear of intercourse. If de-infibulation is performed the woman is again exposed to the life threatening complications of sepsis, bleeding and the transmission of chronic infections such as HIV and Hepatitis and also damage to the urethra.

When giving birth the scar tissue might tear, or the opening needs to be cut to allow the baby to come out. Such
cutting and re-stitching of a woman’s genitalia results in painful scar tissue. FGM survivors also face significantly increased risks during childbirth, including the possibility of losing the child during or immediately after birth. Studies indicate that these risks are greater the more extensive the type of FGM. A major WHO (2006) organisation study found a significant increase in adverse obstetric outcomes for women who had undergone FGM (WHO, 2006. Female Genital Mutilation and Obstetric Outcome: WHO Collaborative Prospective Study in Six African Countries. Geneva). The study involved 28,393 women at 28 obstetric centres in six African countries (Burkina Faso, Ghana, Kenya, Nigeria, Senegal and Sudan). Deliveries are more likely to be complicated by Caesarean section, post-partum haemorrhage, episiotomy, an extended stay in maternity hospital, resuscitation of the infant, and inpatient perinatal death.

SUPPORTING FGM-AFFECTED GIRLS AND WOMEN

1. Be Aware and Informed:
   Healthcare professionals need to be aware that a significant number of women who have undergone FGM now reside in Western countries. Women and girls may present in various settings/circumstances, including general practitioner visits, obstetric/gynaecological or psychological consultations, or in the context of seeking asylum, domestic violence and rape/sexual assault. It is important that health care professionals are aware that most women who have undergone FGM are unlikely to refer to the subject during a consultation with a healthcare professional. In most cases, a woman who has undergone FGM will access health services with a complaint that is not, or that she does not perceive to be, related to FGM. The healthcare professional must therefore be alert to the possibility that a woman or girl may have undergone FGM, or may be at risk.

   Health professionals are ideally placed to inform and educate girls/women, partner/husbands and families about FGM, and to provide care and treatment of its consequences. Counselling can be an important means of discussing, for example, deinfibulation procedures and psychosocial or sexual problems, and to empower women to explore their bodies and reproductive health needs. When offering care to a woman with FGM, service providers must be conscious of the background, values and belief systems of the woman and her family. However, it is imperative that those factors do not influence the care or counselling provided to women and/or families.

2. Assess Individual Needs:
   Don’t assume that all women will be aware that they have undergone FGM. Women and girls who have undergone FGM may have vivid, vague or no memories of the procedure. They may also be unaware that other girls and women are different from them or may not have undergone the same experience. They may have no understanding of the type of FGM performed on them, and may not be aware of any links to subsequent health complications. It is important to spend time explaining how and why there may be a physical problem because of the FGM. Explain all options available to the woman. However, bear in mind that she may not be in a position to make decisions there and then, and may need to consult with family members.

   to be continued....
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Dear Colleague,

MUMN would like to inform you that during the last week we have reached an agreement with the Health Department over some issues that have been pending for quite some time. These are mainly three:

1. Those Nurses and Midwives who work their duties on a part-time basis, now are entitled to receive the amount of €700 through their Continuous Professional Development Allowance (CPD Allowance) each year.

2. Those Nurses and Midwives who will continue to perform their duties after their retirement age and whose grade, before retirement, was from Deputy Charge Nurse/Midwives above to the grade of Chief Nursing/Midwifery Manager will now be receiving the basic pay amount on the higher step of scale 8. Before this agreement these professionals were receiving an amount pegged to scale 10 plus two extensions.

3. Another point in this agreement is that all the casual/temporary period worked before receiving the appointment will now be calculated for bridging purposes.

This means that if a nurse/midwife resigns from work and after a period of time she will return back to work, the casual/temporary period will be added to the actual amount of years worked.

Whilst I take this opportunity to thank you all for your support and cooperation,

Best regards,

Colin Galea, General Secretary - MUMN
The Adoption of Family Friendly Measures at the Maltese Work Place - Part 1

Gone are the days when the majority of families had only one breadwinner per household wherein the men work and in turn their wives look after their children and perform all the domestic chores. With today’s lifestyle of both men and women struggling to cope in creating the ideal balance between job and family responsibilities, the European Union felt the need to boost and raise awareness of the so-called “Family Friendly Measures” for an improved way of life and better working conditions of its citizens. This matter had been given considerable importance at European Union level in order to enhance participation in the labour market and iron out the rising quandary of low birth rates in a number of European Union Member States. In this respect, the Government of Malta is following suit by promoting the adoption of family friendly measures by bringing into force various Maltese Subsidiary Legislations and affecting a number of amendments to employment legislation. This move has been deemed by many as being essential due to the fact that according to statistics published by EUROSTAT, Malta is one of the EU28 with the lowest rate of working females. However, on a more positive note, the above mentioned rate has increased to 49.8% in 2013 compared to 32.1% in the year 2001. For the aforesaid reasons, the Government of Malta as an employer has, in the past, and still is, setting an example to the private sector by granting a variety of family friendly measures to the public sector and service which include:

- Adoption leave;
- Birth leave;
- Maternity leave;
- Parental leave;
- Paternity leave;
- Responsibility leave;
- Tele working;
- Urgent Family leave;
- Work flexible hours;
- Work on a reduced-hours basis.

As part of the initiative in promoting family friendly measures, the Public Administration HR Office has published, on 16th August, 2012, the "Family - Friendly Measures Handbook" in line with the policy of the Government of Malta which manual is applicable to all public employees. Nevertheless, in instances where the family friendly measures do not form an integral part of Maltese Legislation, such as working flexible hours and working on reduced hours, any requests made by employees, may only be acceded to following evaluations and discussions between the Director (in the case of public service) or Employer (in the case of private sector) and the employee concerned and on condition that the exigencies of the service or company are not deterred. Notwithstanding the above, the key scope of this manual is to act as a management tool for Human Resources Managers and Directors alike in assisting the implementing the above mentioned family friendly measures whilst motivating and supporting employees in reaching the perfect equilibrium between work and family. Therefore, by setting an example to the private sector, the Government of Malta is striving in reminding all Maltese employers that ‘family’ is the core of our small nation. In relation to the family friendly measures applicable to employees working within the public service, such measures are regulated by the Public Service Management Code which code is binding and enforceable on public officers. On the other hand, the following family friendly measures which are applicable to workers engaged in the private sector are regulated by national legislation as explained here below:

Adoption Leave

This family friendly measure is regulated by Regulations 4, 5 and 5A of Subsidiary Legislation 452.78 of the Laws of Malta which was brought into force by means of Legal Notice 225 of 20003 on 2nd September, 2003. These Regulations apply to all employees whether working on fulltime or part-time basis and irrespective of whether such are employed for a definite or indefinite term however, provided that the employee making such a request has been in employment with the same employer for a continuous period of a minimum of twelve months. As per Regulation 4(1) of the aforementioned subsidiary legislation, adoption leave is granted in the form of parental leave whereby employees of both gender share an individual right to be granted unpaid parental leave on the basis of adoption, fostering or legal custody of a child in order to enable such employee to look after the said child. Nevertheless, in order for an employee to avail of such a right, the child who is to be adopted or fostered must fall within the age bracket of 4 months up to the age of eight years. The employee concerned is also obliged to notify, in writing, his employer of the former’s intention to apply for parental leave at least three weeks in advance.

Birth Leave

This family friendly measure is defined in article 2(1) of the Minimum Special Leave Entitlement Regulations (Subsidiary Legislation 452.101 of the Laws of Malta) as meaning "leave without loss of wages granted to a father on the occasion of the birth of his child". In accordance with article 1(2) of the afore mentioned legislation, such leave is granted to employees who have just become fathers and who work on a full-time basis. The scope of the said legislation is to create minimum standards which may be altered so long as these are more favourable than the minimum standards established by law. Regulation 4(1)(b) provides that employees are entitled to a minimum of "one working day of birth leave". This regulation further provides that such leave "...shall be availed of on the next working day after the occurrence of the relevant event". Such condition may, however, be varied so long as the employee requests a postponement of up to two weeks following the event due to compelling circumstances. However, employees working within certain sectors for instance the laundries industry, the construction industry and the private security industry, such are entitled to two days birth leave with full pay. Moreover, Regulation 6(1)(a) of Subsidiary Legislation 452.79 also provides that part-time employees are entitled to pro-rata birth leave. Due to the extensive provisions regulating the remaining family friendly measures, such will be dealt with in detail in the next issue of I Review.

Dr Lynn Spiteri Dalmas
- Legal Officer (I Review Publication)
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Washing of weakened noses and treatment of allergic rhinitis

Allergic rhinitis is an international Public Health problem. In most western countries, it affects 10 to 25% of the population and its prevalence is constantly increasing. It is characterised by inflammation of the nasal mucosa and a group of symptoms (sneezing, obstruction and a watery nasal discharge) due to an excessive immunological reaction in the presence of an allergen. Owing to its impact on social life and productivity at work, allergic rhinitis gives rise to considerable indirect costs. Furthermore, following work by many researchers, the WHO considers it a major risk factor for asthma owing to the continuity between the nasosinusal and bronchial mucosae. It is therefore necessary to treat allergic rhinitis by preventive and curative measures, among which washing the patients' noses occupies a paramount position.

Seasonal allergic rhinitis

Easily identifiable, since it occurs at the same period each year, "hay fever" is the result of an allergy to graminacea pollen. It appears almost everywhere in Europe from April to July and may be severely incapacitating in subjects who must preserve their alertness.

Perennial allergic rhinitis

It persists throughout the year and essentially results from contacts with various different allergens (dust and acarids, animal hair, moulds and occupational allergens). Family histories are often observed.

Whether seasonal or perennial, allergic rhinitis is considered severe if accompanied by at least one of the following symptoms: sleep disturbances and a reduction in social, sporting, professional or school activities.

In all cases, treatment combining preventive and curative measures must be instituted.

Prevention

As always in allergology, reducing the contact with the allergens is the first measure to be applied. Washing the nose of the sensitised subject will make it possible to significantly reduce the quantity of allergens in contact with the nasal mucosa and the concentration of local inflammatory mediators.

Other hygiene measures will make it possible to eliminate or reduce the contact with the allergen in question: by using anti-acarid slip covers, by getting rid of pets, by airing living areas and by limiting cofactors that promote the allergy (passive smoking, solvents and other irritants).

Curative treatment

In order to reduce the allergy and its local consequences, one must resort to various combinations of a systemic treatment (essentially antihistamines, or indeed immunotherapy and corticosteroid treatment) and local treatments aimed above all at washing and decongesting the nasal mucosa, while reducing inflammatory phenomena.

WASHING THE NOSES OF SENSITISED SUBJECTS

During episodes of allergy, washing the nose with STÉRIMAR® MANGANESE as first-line treatment appears entirely appropriate, regardless of the origin and severity of the rhinitis. Washing the nose will reduce the local concentration of allergens and inflammatory mediators. Use of STÉRIMAR® will allow, by means of its gentle microdiffusion, mechanical decongestion of the nasal mucosa and the manganese cation will contribute its own well-known action of defence against allergens.

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For both patients and professionals, the choice of STÉRIMAR® as prevention and STÉRIMAR® MANGANESE during allergic episodes comprises many advantages. Seawater contains many elements (gold, copper, silver and of course manganese) the health advantages of which are well-known. Its administration via the nasal route makes it possible to take maximum advantage of its properties, with the microdiffusion system of STÉRIMAR® MANGANESE providing the immediate comfort of a decongestant action.

Furthermore, STÉRIMAR® products contribute towards restoring the ciliary functions of the nasal mucosa. STÉRIMAR® MANGANESE therefore also improves nasal clearance, which allows better elimination of allergens and pollutants.

Furthermore, its anatomical nozzle allows completely safe use for the entire family.

with the advice of Dr. Ph. Contencin, ENT
Results from two studies among Maltese Nurses in Malta & Gozo

Maltese Hospitals’ Nurses’ Study

Abstract

This study looked at the impact of burnout on the psycho-social and spiritual variables of Maltese nurses. Participants (N = 241), who work in three different hospitals in Malta, were assessed on burnout levels and related variables. Nurses completed the Maslach Burnout Inventory-Human Services (Maslach, Jackson, &Leiter, 1996), the Satisfaction With Life Scale (Diener, Emmons, Larsen, & Griffin, 1985), the Faith Maturity Scale (Benson, Donahue, and Erickson, 1993), the Positive and Negative Affect Scale (Watson, Clark and Tellegen, 1988), the Big Five Personality Inventory (Donahue and Kentle, 1991) and demographic variables. Results from this cross-sectional correlational study indicated that: a) professional nurses in Malta suffer from high levels of burnout, particularly from high exhaustion and depersonalization and low professional accomplishment; b) as expected, burnout negatively correlated with subjective well-being; and c) a path analysis indicated the progressive impact of burnout, first on one’s personality and affective mood, and eventually on one’s wellbeing and spirituality. The implications and recommendations from these results were discussed.

Descriptive Statistics:

a) Participants: Maltese professional nurses from 3 hospitals (64% Female):
   a. Mater Dei Hospital (MDH), (4 units: A&E, Cardiac & Crises, Gynae, FW1)
   b. Rehab Hospital KarenGrech (RHKG) (3 departments);
   c. Mt Carmel Hospital (MCH) (5 units: Secure unit; Mixed Ad; MW1, FW1, YPU)

b) Respondents: 88% nurses, 12% nursing (& deputy) officers

  c) Response Rates: 87%, 69%, 70% for MDH, RHKG, & MCH respectively; Total Average Response Rate of 75%.

  d) Employed for: 52% worked for <10 yrs
     22% worked for 11 – 20 yrs
     26% worked for 21 + yrs

  e) Data collected: 1st trimester of 2013.

  f) Measures: Burnout, Personality, Wellbeing, Spirituality, Positive & Negative Affect, Demographics

Key Results

a) No significant differences of burnout levels were found among these 3 different hospitals;

b) Maltese nurses are prone to high levels of burnout (see Table A)

c) Limitations:
   a. This study is correlational in nature. No inferences of causality can be made
   b. Study’s reliance upon self-reported & recalled data may have introduced error

d) Strengths:
   a. Study’s inclusion of Burnout is a strength, especially as it is a novel aspect in research done locally, despite the extensive focus it receives elsewhere.
   b. Study’s multidimensional focus (bundling together measures of personality & psycho-social & spiritual wellbeing) is noteworthy.

  e) Burnout among Maltese nurses is a worrying reality that requires immediate attention. Reaching one’s breaking point through job-related issues is definitely a serious component that requires attending to. Considering that such a reality has a direct bearing on patients’ holistic wellbeing, it is clearly important to attend to it.
Results from two studies among Maltese Nurses in Malta & Gozo

Table A - Burnout levels:

<table>
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<tr>
<th>Category</th>
<th>% High</th>
<th>% Moderate</th>
<th>% Low</th>
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<tr>
<td>a)</td>
<td>42%</td>
<td>34%</td>
<td>24%</td>
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<td>b)</td>
<td>59%</td>
<td>32%</td>
<td>9%</td>
</tr>
<tr>
<td>c)</td>
<td>90%</td>
<td>9%</td>
<td>1%</td>
</tr>
</tbody>
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b) Burnout negatively correlated with wellbeing
c) Spirituality indicated as a resource to buffer burnout.
d) Nurses who score high on spirituality, feel more professionally efficient, and are less likely to be exhausted and feel depersonalized towards other staff and patients at work.
e) Nurses are encouraged by ongoing formation. However, they seek remedial measures in 2 key areas: physical and moral environment of GGH (see Table B).

f) Limitations:
   a) Correlational nature
   b) Some variables left out
g) Strengths:
   a) Population study on a reality never studied before as such locally,
   b) Good response rate

Concluding remark:
Happier and healthier nursing leads to a happier & healthier health system!

Table B: Qualitative Section Results:
Two open-ended questions focused on present strengths & future recommendations. Results:

a) Potential Strengths: 85% agreed with such ongoing formation programs as helpful;

b) Recommendations: grouped into two classes, and relate to the amelioration of:

1. Physical environment. Nurses suggested:
   i. Better management of nurse-patient ratios (86%),
   ii. Refurbishment required in certain areas (79%),
   iii. Wise management of crowded wards (68%),

2. Moral environment. Nurses recommended:
   i. Enhanced communication between staff and management (73%),
   ii. More consultation on decisions affecting staff (74%),
   iii. Positive reinforcement (of staff) for greater motivation (64%),
   iv. Less bureaucracy (60%), and
   v. Less undue interferences by third parties on staff (43%).
   vi. Local health system perceived to be more consultant-focused than patient-focused.

Concluding Results

Considering the three scales that make up the Maslach Burnout Inventory, nurses in both studies scored extremely high on the Depersonalization scale. In other words, Maltese nurses highlighted a very high sense of unfeeling and impersonal response towards patients, care treatment, and/or instructions from their respective superiors.

Nurses in Malta scored more emotionally exhausted than their counterparts in Gozo, with 59% scoring highly exhausted in the Malta study vis-à-vis 30% in the Gozo study. Half of Gozo’s participants scored moderately exhausted.

A different scenario resulted on scores of the Personal Accomplishment scale. In the Malta study, the bulk of scores varied between moderate to high, thus suggesting that nurses working on the mainland feel more satisfied at work. On the other hand, 94% of Gozo participants scored in the low range.

It is interesting to seek the reason/s for such a disparity with reference to Personal Accomplishment scores (one’s satisfaction with employment). One possible reason may be the average age and period of employment of nurses, in both studies. The majority of nurses in Gozo have been working for over 21 years, with half of respondents being 47 years old or older. The opposite is true with the Malta study. Younger nurses may have more updated formation possibilities, than those who have been working for a longer time as nurses. Although experience brings with it skills, it may also require ongoing formation programs. In fact, this may resonate well with the qualitative result from the Gozo study, in which they highly favored more programs of formation, as the annual one presently taking place. Another reason may yet be the mobility possibility and flexibility of nurses in Malta, which is obviously different from that in Gozo.

Overall Suggestions:

a) Maslach and Leiter (1997) 6-step method to counter nurses’ burnout. These are: workload (good nurse-patient ratios), perception of self-control at work, job-related reward/s, social support at work (by administration and colleagues), fairness of/at work, and values.

b) Fearon and Nicol (2011) suggested a combination of both positive emotion-focused and problem-focused strategies, which may offer protection against the development of burnout. Nursing managers should explore ways of reducing job stress and also techniques for building social support networks at the hospital. Three reasons for this: 1) to protect nurses against stress; 2) to protect and ascertain better service to patients, and 3) to lessen the concerns and worries of patients’ relatives.

Fearne’s pledge to tackle nurses’ stress level

The government is committed to driving down stress levels for nurses as well as increasing their job satisfaction, according to Parliamentary Secretary for Health Chris Fearne.

In his reaction to a study which found that nurses are suffering from burnout and are treating patients in an impersonal way as a result, Dr Fearne said: “The Health department intends to continue working together with all stakeholders, including the Faculty of Health Sciences, the nursing union and the management at both public and private hospitals to ensure that this job satisfaction is attainable and to find ways to decrease stress levels to a minimum.”
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from our diary...

During a conference organised by the International Council of Nurses a specific meeting was held for the countries pertaining to the region where MUMN is allocated. The countries present were Cyprus, Palestine, Israel, Egypt, UAE, Turkey, Iran and Malta.

The President and the General Secretary met the Police Commissioner to discuss certain issues pertaining to our professions.

MUMN together with the Health Ministry organised a historic press conference to launch the annual Nurses’ Recruitment Campaign.

During a ceremony organised by ICN, MUMN Officials met with H.E. Princess Muna of Jordan and Dr. John Paul Grech Ambassador and Permanent Representative of Malta to the United Nations.

MUMN organised a meeting for the Student Nurses pertaining to the Diploma Group who will be graduating this year.

Last March a group of about 50 nurses and midwives attended a conference in London organised by the Commonwealth Federation of Nurses and Midwives.

Once again the Florence Nightingale MUMN Benevolent Fund Group Committee organised a special ceremony to thank and express its appreciation to all those nurses and midwives who retired from work last year.

The Pensioners’ Group Committee organised once again a day outing for their members.
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When the captives are set free

Every five days when I am on duty, precisely during my first day of my Mater Dei Hospital shift, starting early at 7.30 am to finish on 7.30 pm in the evening, except of course on Saturday when I end my shift an hour early not as a matter of privilege of course but to spend it on the altar celebrating Sunday Mass for the staff, patients and their relatives, my pager goes off. Normally it rings at the same time. 9.30 am. And the number that comes up on the screen is the usual one 6079 or 6080. It is the Renal Unit number.

The first that I ask to the ward’s secretary when I take up the receiver and call at the Unit is simply this: “How many people are going to receive Holy Communion?” The answer ranges from 8 and usually it goes up even to 20. Every now and then the ward’s secretary tells me: “And Father please there are two patients who want to confess”. As I get the message I make sure to have enough hosts for the patients as well as for a number of staff members who might want to receive the Eucharist.

When I arrive at the Renal Unit I am immediately greeted by a gentle clerk. “I come to accompany you Father”. And he goes before me asking every patient with that singular smile characteristic of him: “Do you want to receive the Holy Communion?” This typical tour around the patients is so significant to me. Because I am an avid learner by nature I take the opportunity to observe what is going on at ward. Let me now take the opportunity to wholeheartedly thank and congratulate the staff for working in such a sensitive unit. How challenging it must be to assist people that, due to their fragile health condition, now you see them now you don’t! Renal problems can indeed be catastrophic and fatal! The sheer fact that a person is attached to a machine for at least five hours three times a week already says much of their poor health condition.

In this simple reflection I want to limit myself on some of the findings I made as I researched on the subject. To begin with kidney failure may badly result in failure on the brain and nervous system. In fact when kidneys do not fulfill their task anymore the brain and nervous system are negatively affected. In her article entitled “The effect of kidney failure on the brain and nervous system”, Dr Kathleen Coetzee writes that “When urea is removed from the blood too quickly during dialysis, a net movement of fluid into the brain seems to occur. This is quite rare and causes headache, double vision, nausea and vomiting. Tremors and seizures may follow. Dialysis dementia is a progressive disease found in some patients on long-term haemodialysis. The cause of this disease is still controversial, but thought to be due to the deposition of aluminum in the brains of those patients”.

Furthermore it has now been established that longstanding kidney failure (chronic renal failure) is identified by anaemia. Patients with anaemia suffer from insufficient red blood cells. These blood cells carry oxygen to a person’s body and vital organs such as the heart and brain. Although anaemia in renal failure is caused by multiple factors it is mainly triggered off by the decreased production of an important hormone called erythropoietin (EPO). This hormone empowers the bone marrow to produce more red blood cells. The kidneys make a 90% of a person’s erythropoietin, hence a loss of functional kidney cells will lead to anaemia. If the healthy physical state of the hemodialysis (HD) patients gets complicated how much more the psychological-spiritual domain deteriorates because of HD condition. In a joint article by Liang-Jen Wang and Chih-Ken Chen entitled “The Psychological impact of Hemodialysis on patients with chronic renal failure”, it was found that “depression is one of the most common psychological problems among HD patients”. This article goes on by saying that even if there is lack of reliable data concerning the direct comparison between the prevalence of depression between HD patients and the general population, “extant investigations generally agree that the rate of depression is high among HD patients”. Another negative impact of HD is anxiety. Liang-Jen Wang and Chih-Ken Chen quote in their article a 16-month follow-up study which revealed that “9% of patients had both anxiety and depression at baseline; the incidence of both conditions rose to 13% by the end of the study. At the end of the study, two-thirds of individuals with comorbid depression and anxiety at baseline had both diagnoses (Cukor et al., 2008b)”. Fatigue severely impairs the psychological well-being of a person who is undergoing hemodialysis. In fact authors Liang-Jen Wang and Chih-Ken Chen quote in their article different sources which substantiate the claim that fatigue in hemodialysis is caused by tiredness, weakness together with lack of energy. “Fatigue is also one of the most debilitating symptoms reported by HD patients, and roughly 60% to 97% of patients on HD experience some degree of it (Jhamb et al., 2008). People with chronic renal disease, regardless of whether they are predialysis or receiving either HD or PD, are reported having high levels of fatigue and are often unable to engage in normal daily activities (Bonner et al., 2010). In addition, fatigue is positively correlated with depression.
It is obvious that lack of energy, weakness and tiredness necessarily bring about on the patient as well as his close relatives, a decreased quality of life. Liang-Jen Wang and Chih-Ken Chen comment that “health-related QoL is an important measure of how a disease affects the lives of patients. The QoL domains include physical, psychological, and social functioning and general satisfaction with life (Tsay & Healstead, 2002). Once patients with ESRD (end-stage renal disease) start to receive HD, they must face the chronic stress related to restrictions on their time, the economical and vocational costs related to treatment, functional limitations, dietary constraints, and possible adverse effects of medications (Son et al., 2009)".

The last psychological effect which impacts negatively on HD patients is suicide. In their article Liang-Jen Wang and Chih-Ken Chen show that suicide can be the most dangerous consequence caused by mental illness among HD patients. "Kurella et al. (2005) reported the death rate from suicide was 0.24% per 1000 dialysis patients years at risk. Patients with ESRD had a significantly higher rate of suicide compared with the general population in the United States".

The physical and psychological disorders which HD patients have to face due to their health condition principally caused psychosomatic hazards like anaemia, malfunctioning of the brain and nervous system, depression, anxiety, fatigue, decreased quality of life and the will to attempt suicide clearly inform me that these HD patients are indeed captives of their own illness. Like Jesus Christ in his Church whom I personally and corporately have the greatest honour to represent as a chaplain in Mater Dei Hospital, I feel it my mission “to preach good news to the poor. He [God] has sent me to proclaim release to the captives and recovering of sight to the blind, to set at liberty those who are oppressed, to proclaim the acceptable year of the Lord” (Luke 4:18-19).

I bring God’s salvation to HD patients by listening to their fears; administering to them the Sacrament of Penance and Reconciliation; anointing them with the oil of physical, mental and spiritual healing; feeding them with the bread and blood of eternal life, the Eucharist; and for the with God’s reassuring blessing. To top it all, I let the Lord instill in them his enduring hope by the comforting and saving recitation of the Divine Mercy Chaplet.

My pastoral experience with the HD patients have relentlessly taught me that irrespective of the severity of their illness prayer is powerful enough to break them free internally. It gives them an eternal hope to live and suffer for. That is why in this I happily subscribe to what Saint Ephrem of Syria says: “Virtues are formed by prayer. Prayer preserves temperance. Prayer suppresses anger. Prayer prevents emotions of pride and envy. Prayer draws into the soul the Holy Spirit, and raises man to Heaven”.

By prayer HD patients are transformed from slaves into conquerors over their health condition. They now have a reason to live and a reason to die for since their life has ceased to be shortened by space and time but is now amplified into the everlasting now of eternity. Amen!

Fr Mario Attard OFM Cap
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) 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.

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**In vitro studies show that a hydroxyapatite-like layer forms over exposed dentine and within the dentine tubules.**

Adapted from Earl et al., 2011 (A). In vitro cross-section SEM image of hydroxyapatite-like layer formed by supersaturated NovaMin® solution in artificial saliva after 5 days (no brushing).

Significant reduction in gingival bleeding index (GBI) over 6 weeks with a NovaMin® containing dentifrice.

Adapted from Toz et al., 2006. Randomised, double blind, controlled clinical study in 95 volunteers given NovaMin® containing dentifrice or placebo control (non-aqueous dentifrice containing no NovaMin®) for 6 weeks. All subjects received supra- and subginival prophylaxis and polishing and were instructed in brushing technique. GBI scale ranges from 0–3.

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Babies with colic are distressed, tend to draw their knees up, clench their fists, and just cry inconsolably no matter what. This is very distressing for parents, who just cannot console their baby in any way.

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Case Management is becoming an established tool to integrate services around the needs of individuals with long term conditions. It is a targeted, community-based, proactive approach to care that involves case finding, assessment, care planning and care coordination. Where it has been implemented effectively, it has improved the experiences of users and carers, resulting in better care outcomes, reducing the utilisation of hospital based services and enabling a more cost effective approach to care. (Ross et al 2011)

In Care and Case Management the focus on the individual, enables an identified key manager and user, to work together to discover the required available resources, and develop and establish a workable care network. Case Management can be defined by responsibility and support for care, which aims to achieve the user's wellness through advocacy, communication, education and facilitation. It ends when all the supports have been set up and the user can move on to become either a self manager or where an informal carer can take over, where and when, this is possible if still required.

The Malta Memorial District Nursing Association otherwise known as the MMDNA, had identified an urgent need to boost opportunities for inter-agency collaboration. This was the starting point leading to a couple of workshops about Care and Case Management which were held in April 2013. The Programme was led by Prof. Dr. Ingrid Kollak PhD and Stefan Schmidt M.Sc, who both came from the Alice Salomon University of Applied Sciences in Berlin (ASH). Dr. Ingrid was the first Professor and Head of Nursing at ASH where BSc and MSC programmes of Health and Nursing Care were set up. For the past seven years, she has focussed on the education of case managers. The Continuing Education Programmes, which are followed by nurses and social workers have been Certified by the German Society of Care and Case Management. MMDNA organized this learning experience for 33 participants including some of its own staff members, as well as other health care professionals, who worked in the community care centres, primary, secondary and tertiary health care settings. The participants found the workshops to be inspiring, dynamic and interactive. They focused on a subject which was very much related to their own work and experience in a creative way.

Dr. Kollak together with a working group are currently working on the preparation of a forthcoming hand book, ‘Just in Case — Care and Case Management’, depicting examples of Case Management in the Maltese environment. Consultation meetings with nursing leaders from the Faculty of Health Sciences, University of Malta, Mater Dei, Comm Care, MMDNA and Community Services were also held in November 2013. MMDNA would like to thank everyone who gave such an enthusiastic contribution to this project in progress. It is anticipated that this venture will soon be an inspiration to improve and integrate the care currently being provided both from the hospitals and into the community. The book is expected to be available later this year.

Reference

Grace A. Jaccarini
Chairperson MMDNA
Almost half the number of women giving birth experience urinary incontinence during pregnancy and/or postpartum. Urinary incontinence was reported by 31% of women with a first-time pregnancy, who were continent before pregnancy. The incontinence observed during this period tends to regress in 60 to 80% of the cases. However, this might be the result of a light pelvic alteration which could cumulate at each delivery. Prevention and treatment of incontinence normally involves recommendation of pelvic floor muscle training during pregnancy and after birth. However, it is also important that such persons use good quality continence devices which are adequate for urinary incontinence as well as for absorption of blood, to help improve their quality of life during this period.

Urinary incontinence is the loss of bladder control. Symptoms can range from mild leaking to uncontrollable wetting. Most bladder control problems happen when muscles are too weak or too active. Stress incontinence may happen if the muscles, that keep the bladder closed, are weak. Hence, there may be accidents when one sneezes, laughs or lifts heavy objects. On the other scenario, urge incontinence or overactive bladder, takes place when bladder muscles become too active. One may feel a strong urge to go to the bathroom when she has little urine in the bladder.

Pads and Pull-up pants are the main products used for bladder incontinence. Levels of incontinence in different persons may vary in range, from light to medium to heavy. The absorption capacity of product chosen should be based according to patient needs. The more absorbent the product, the less it is discreet. Hence, persons who have light incontinence do not need to use highly absorbent products, which are possibly less discreet and more expensive.

Users' perceptions and desirable features of incontinence products mainly concern security and reliability, odour control, absorption capacity, leakage protection, skin friendliness, wearing comfort, ease in handling, discretion and a good quality/price ratio.

Good quality continence devices are able to provide:

- A Perfect fit since they are anatomically shaped to fit closely and safely to the body. Friction from clothes or continence devices is one of causes of groin rash.
Choosing the right continence device to address a person’s needs will lead to the achievement of cost-effectiveness through better use of the products’ potentials, thus avoiding excessive consumption and waste. Not all continence devices are indicated for absorption of blood as well as for urinary incontinence. However, these are available on the market, and although not being the cheapest, such devices are not necessarily the most expensive. A summary of the advantages to be achieved when using such good quality products would be: better comfort, substantial savings in laundry costs, less skin problems and a better value for money. The Nurses’/Midwives’ input, in recommending the right continence device to their patients, is of utmost importance, since they are able to understand the necessary features, built into such products, in order to lower health associated risks.

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Workplace Role - A Literature Review

Drucker (1994) had, as far back, highlighted the needs that the social transformation would herald on society at large, providing particular focus on responsibilities to be placed on the workplace. The assertion that it will be knowledge that will carry the economic order and not labour, raw material or capital in itself, brought the stark reality to the fore. This foresight pictured the future employee as one who will need to have a diverse mindset, with a different approach to work; one that requires a habit of continuous learning (Drucker 1994). Where it not close to the reality the practice setting I come from, the latter would have been regarded as anachronistic.

The fact that knowledge is not necessarily individualised, (Cullen et al 2002; Barnett 2001), brings to the fore the organisational collective potential, and its subsequent instrumentality towards innovation and profitability. This assertion turns into a caution, when one is warned that if one does not contextualise workplace learning in this way, one will simply prepare people with the skills and competencies for today, but not for tomorrow (Cullen et al., 2002). This would run counter to much of the point of workplace learning as something more than simple training with a narrow focus on surface-level skills (Mathews, 1999; Winch & Ingram, 2002). For this reason, looking at work from the simple perspective of competencies needed in order to perform the job well, will fundamentally differ from looking at work from the perspective of its learning potential (Cullen et al., 2002).

A study, involving a cross sectional survey, focussing on nurses’ use of learning organisation principles (Jeong et al 2006) held within South Korea, which attracted a 95.5% response rate, found a strong correlation between these notions and organisational effectiveness. While team learning was the most important predictor for job satisfaction, shared vision was for organisational commitment. This dual characteristic seems to enhance the implicit belief of a need for overt organisational commitment if one is to expect the participation of the nurse in continuing learning.

When referring to the above title, Argyis (1999) draws on various notions of organisational traits. This continuum includes a range of characteristics ranging from adaptability, flexibility, to realisation of human potential for learning in the service of organisational purposes, and creation of organisational settings as contexts for human development, two fundamental ‘humanistic’ perspectives hallmarks of any Practice Development initiative.

With the latter assertion and confirming Senge’s vision, a learning organisation is visualised as a group of people, who are continually enhancing their capabilities to ‘create what they create’ (1994). Pedler (1991) had viewed this phenomenon of the learning organisation as that of visioning the possible. It is further stated that it is not brought about by simply training individuals; it can only happen as result of learning at the whole organisational level. This disseminated learning will in turn facilitate the learning of all its members, whilst facilitating its continuous transformation. This transformation, through a dissemination of learning, is achieved through the ‘on the floor’ building capacity (Griscti and Jacono 2006pp. 450). Hence, although the evident potential of classroom learning is recognised, it is the enhancement of nurses within the clinical area which will eventually be the key component in the dissemination of clinical learning across the organisation (Twentyman et al, 2006 in Henderson et al 2008).

Whilst Argyis (2001) claims that the view of this practice oriented, prescriptive literature, focussing on the broad concepts of the ‘learning organisation’, is extensively shared amongst experts on the subject, needless to say different authors express the subject matter in diverse ways. The point of convergence with what is stated above, will be the opportunities for learning that the work place tends to offer and the role ward managers have in creating contexts within which all this will become possible.

In a clear confirmation of the diversity in approach to the subject of workplace learning, Eraut (2004) presents one’s own perspective about this approach and describes it as an ‘ill defined concept’, but which tends to provide ‘useful ideal types’, possibly fomenting unrealistic expectations on naîve learners in the process. This assertion, albeit sounding suspicious, may provide an idea of the extent of the distance between the two poles, that of theory and practice.

It is further stated that, there has been an ever growing recognition by both managers and policy makers, for the need of continuous change (Eraut 2004). This evolvement, rather than being perceived as a learning process, is often seen as an administrative process involving decision making (Eraut 2004). This so called ‘political’ tinge to the process of learning is very often attributed to the individual manager resolute in leaving one’s own distinctive imprint (Eraut 2004).

Within all this prescriptive literature, Eraut (2006) had, but highlighted particular influences which may impinge on the quality improvement, an organisational focus of the desired learning. Workload, culture and physical environment are believed as being the main culprits, acting as a barrier to this learning. This, through the encouragement of coping behaviour and the placing of a great value on priority setting, hence depriving one of the opportunity for timely discussion or reflection with colleagues. Moss and Garside (2001) tend to reflect this state of affairs when referring to the maintenance of status quo, through performance monitoring, audit and error reporting. This type of approach to leadership, though perceived as appropriate in particular situations, does have its doubters, namely in dynamic circumstances of significance, where a transformational approach may possibly be more appropriate. This transformational view as an inherent characteristic of managers in health care management was also projected as a need in a study by Johnson (2005). In the latter study, the findings of a self rating assessment tool, demonstrated a low disposition to risk taking; an incomprehensible trait for an organisation continuously seeking to renew itself.

Senge (1993) puts all further into perspective where
the learning organisation is termed as a space were people continually expand their capacity to create the results they truly desire and nurturing of new and expansive way of thinking, takes place. A more explicit drive towards individual learning will be hard to get by. To the former assertion, the author adds the freeing of collective aspiration and the continuous search for people to incessantly keep learning how to learn together. The space, termed by McPherson et al (2009) where one may learn about each other, from each other and together. Particular to healthcare scenario, the impetus provided by Pollard’s study (2008), is brought to light where the necessity of inter professional collaboration, (a possible organisational imperative), is highlighted. The synergy between and within the various professions providing care in the particular clinical environment, is given its due credit. This for all the learning to take place, hence, maximising learning situations. This inter-professional affinity within a collaborative, working experience seems pay dividends through positive clinical outcomes.

This assertion is further amplified by Eraut (2004) when consideration is advised on the practices across teams, groups, departments or even whole organisations, a claimed to be much neglected dimension of practice. Professional practices, it is stated, are, very often, dependent on those of other people. Consequently one would not be able to practice competently unless others were also practising likewise. This brings to light interactions between individual team members, but which (interaction) cannot be judged in isolation from each other. This realisation strongly supports the interpretation presented by Lave et al (1991) where the exchange between practitioners within the same and also across the various units, is claimed to offer significant learning opportunities. This path, possibly utopian and yet trifle idealistic for some, may provide the realistic conceptual pathway towards a win-win situation, between the organisational objectives and the individual’s learning aspirations.

Supporting the workplace potential as a learning focus, the view of the effective transferability of formal learning is dealt a blow by Renkema (2006) who tends to stifle its significance by claiming that formal arrangements for training and development amongst employees tend to have a rather low return on investment. What is further claimed is that ‘this’ training often lacks transferability. This, while the lack is attributed to changing work place demands, implicitly asserting that traditional training models may provide the realistic conceptual pathway for all levels of the workforce to be accountable as needed at all levels; and values and beliefs which should be widely shared and disseminated and encouraged in an open blame – free culture. With these shared notions in mind, if everyone is a learner, then – potentially, at least – one can continue learning from each other all the time (Barnett 2001).

The move towards a knowledgeable society has brought fresh demands on organisations. The main component of these entities, the human one, is being acknowledged as having to carry an appreciable chunk of this responsibility. The simultaneous restructuring of both managerial and work structures, including practices is an imperative need towards a rewarding facilitation within a learning environment.

Acknowledgements
Caricature reproduced with the kind permission of Mr Antonio Caricature. References can be obtained from the author himself at the below email address.
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After a series of meetings with the Health Division, MUMN registered an agreement on certain longstanding disputes both in Gozo General Hospital, Mater Dei Hospital and Boffa Hospital.

Such an agreement paved the way that as from today, Wednesday 16 April, a number of directives are being removed from such hospitals.

What is important to register is that issues are now open to discussions and not being presented as finalized before any discussions have taken place.

It was also agreed that the issue on the autonomy of Boffa Hospital is now to be discussed including the matter of utilising Boffa Hospital as a pilot project for Mater Dei Hospital.

There are still pending issues, such as the non-existent parking at the new oncology hospital at Mater Dei Hospital, the constant watches not being provided and other issues related to lack of nursing compliment. It was also agreed that these issues are going to be discussed in the coming weeks.

MUMN is looking forward so that this momentum will continue in the interest of everyone concerned so that the hardships and pressures which nurses and midwives are facing by working against all odds will give a decent service to our patients.

It is clear that the lack of policies and strategy to manage Mater Dei Hospital and other hospitals cannot be allowed to continue.

The Health Ministry has already started taking on proposals made by the Nurses Union in a bid to ease industrial action, Parliamentary Secretary Chris Fearne said earlier today.

In the first official meeting between the newly appointed parliamentary secretary and the Malta Union of Nurses and Midwives, Dr Fearne said the government had implemented a number of proposals put forward by the union. These included changes to the Mater Dei Hospital emergency department.

The latest order issued by the union came on the back of a decision to halt dermatology outpatient services on Sundays.

Dr Fearne said the Health Ministry wanted to work closely with unions to find an amicable solution to any disputes.

"We feel that the union’s views are those of the health care professionals so we want to work together for the good of the whole health care profession,” he said.

MUNM President Paul Pace said he was excited by the prospect of finding a solution to the health care industry’s problems. The union will be presenting a report on its proposed way forward in the coming weeks.

“This is about what led to the directives. The last straw was when (Former Health Minister) Godfrey Farrugia went behind our backs to make changes. We can’t have situations like that,” he said.

Ivan Martin

The MUMN has urged nurses to ignore a case of cyber bullying.

In a statement this morning, it said it had been informed that a patient was using a social network to bully nurses working in a particular unit at Mater Dei Hospital.

"While nurses go out of their way to see to the needs of their patients, offensive remarks are being expressed on a particular social network, ridiculing such a noble profession in an attempt to lower the dignity of the nurses concerned," the union said.

It condemned the incident and appealed to nurses to ignore such cowardice.
Jum in-nurse u Jum il-Midwife

Jum in-nurse u jum il-midwife Ta' kull sena ic-celebrat Xoghol sabieh u Alla jbierek Da'xoghol nobli u delikat Hemm is-sibha nurse, il-midwife Tiq tghadrek waqt il-krib, Titawwallek, tara x'ghandek, Tghinek terfa' das-salib. Min ser jghiini jien ninhasel? Min se jgbibi it-tabib? Trid tkun int in-nurse il-midwife Li tmur tghin dan il-haab. O xi hlew u x'gentilezza, Dawk l'idejn ta' dawn in-nies, Lil pazjent tbatja jtafu, Ma hemmx limitu, ma hemmx qies. Trid tkun veru vokazzjoni Biex dawn jahdumu mal-pazjent, Dejjem wicchom bi tbissima, Dawn jaghlmluh fetihan, kuntent.

Hemm is-sibha n-nurse, il-midwife Biex is-sabrek fid-dulur, Mieghek tibki, mieghek tifrah Zgur m'hawnx bhala tmur fejn tmur, Hekk tarhom ma l'omm qed twelled, Kolha hlewwa u tujbiha, Dawn jghidulha"kuragg isa, Daqt titwieled it-tarbijia." Sew in-nurse u sew il-midwife Ghal pazjent l'aqwa habib, Dan vangelu ikun kliemhom Jghid xi jghid l'aqwa tabib. Dawn in-nies tal-genn ta' veru. Min jaf kemm sigriet jghidulhom? Hemm fis-skiet u bl-akbar ghqal Ghand nies sew jirreferuhom. Kemm il-darba dawnha jkunu Ghal pazjent il-medjaturi, "Xejn ma ftim nitobhek ghidli, X'gew qaluli l-professuri."

Trid tkun int in-nurse, il-midwife Li turih li jimputak, Bit-taptipa hemm fuq spaltu, "Kuragg kul la tooghd oxjakk." Trid tkun int in-nurse, il-midwife, F'emergenza l'incident, Biex b'azzjoni sew u f'waqta, Din is-salva lil pazjent. Dan ix-xoghol hu job, karriera, Issa sajret professjoni, Ma Nghidx le t-tlieta tajba, Imma l'aqwa l-vokazzjoni. Jien qed nikteb dil-poezija Bhalu nurse u anke pazjent, Alla BISS irid ilhalas Dax-xoghol umli u stupend.

MaryRose Bugeja
Staff Nurse
International Council of Nurses holds meetings to highlight critical role of nurses in UHC and importance of effective regulation

19 May 2014, Geneva, Switzerland - A series of meetings held by the International Council of Nurses (ICN) in advance of the World Health Assembly highlighted the critical issue that the goal of Universal Health Coverage (UHC) cannot be achieved without a sufficient health workforce, adequately trained, appropriately remunerated and working under decent conditions.

Ninety-one representatives of ICN’s national nursing association (NNA) members met 14-15 May to discuss strengthening NNAs and policy influence as well as addressing key challenges of Universal Health Coverage (UHC). Dr. David Evans of the World Health Organization (WHO) described the goal of UHC, saying that “Universal Health Coverage must be available, of good quality and affordable.”

Xenia Scheil-Adlung of the International Labour Organization highlighted the key challenges to achieving UHC as the shortage of nurses and other health workers, along with low salaries and challenging working conditions. She concluded by saying, “UHC can only be achieved if funds are made available for a sufficient number of skilled health workers that is trained to be responsive, enjoys decent working conditions and is equally distributed across and within countries.”

Special guest Her Royal Highness Princess Muna al-Hussein of Jordan, an advocate of the provision of quality nursing services and the advancement of nursing service, practice and education, addressed the participants of the joint Triad meeting on 16-17 May, hosted by ICN, WHO and the International Confederation of Midwives (ICM).

“Universal health coverage cannot be achieved without a large, qualified workforce prepared to address the needs of the populations they serve,” said HRH Princess Muna. “As I have said many times in the past, we cannot attempt to strengthen health systems without addressing the health workforce crisis.”

The Triad meeting addressed issues critical to the provision of safe, quality nursing and midwifery care, the development of the nursing and midwifery professions and the effective regulation of these professions. The focus of this fifth Triad was strengthening the nursing and midwifery workforce to support universal health coverage as a means to achieve health goals. Key speakers included Akiko Maeda (The World Bank), Judith Shamian and David Benton (ICN); Ties Boerma and Mwansa Nkowane (WHO), and Frances Day-Stirk and Frances Ganges (ICM). A Communiqué released at the end of the meeting can be accessed here.

Also on 14-15 May, 41 participants from 23 countries attended the ICN’s Credentialing and Regulators Forum, co-hosted by ICM, to discuss key topics such as regulation, education, migration, UHC and advanced practice nursing.

Many nurses attending these meetings will also participate in the World Health Assembly (WHA), the supreme decision-making body of WHO. ICN encourages and supports nurses to attend the WHA as part of their country’s delegation, or as part of ICN’s delegation, in order to ensure that nurses, the largest health profession in the world, have a voice in high-level decision making and policy development.
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