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

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

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

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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.

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Media image matters

Unfortunately we live in a society, and most nurses would agree on this statement, that the media's treatment of nursing and midwifery falls short of a fair and accurate portrayal of our profession. Actually in some media products, nurses tend to be no more than submissive helpers of the physicians, known as the 'handmaiden', who do everything that matters. Traditionally, media stereotypes depicted nurses as angelic, relatively low-skilled, and highly deferential to physicians. There are also famous fictional TV series including Hollywood stuff, which depict female nurses as 'naughty nurses' or nursing as a job for 'less able females'. This is totally wrong. It can actually influence our young people if they aspire to join our Nursing programmes at the Faculty of Health Sciences. The general public does not base its viewpoints on careful observations and positive sentiments; they mindlessly follow the 'celeb culture' and rely on stereotypes. The public only become interested when it affects them personally and then they make their own minds up. And there is another problem, people nowadays seem less respectful or tolerant and show scant regard for authoritative figures, let alone nurses and midwives.

Unfortunately undervaluation of nursing by the media and the general public leads to a lack of power in our profession. Media stereotypes undermine nursing. The problem is that Nurses and Midwives in general, do not have the mindset or the backbone to deal with this. Actually the powerlessness that nurses and

midwives feel may lead to abuse and poor standards of care across the board. In order to reinforce a positive image of nursing as a career, nurse educators themselves should alter negative stereotypes about the profession.

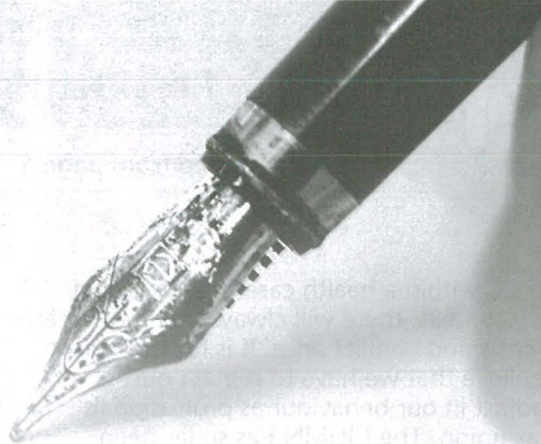
Media projection of nursing is not entirely to blame. We do need to educate ourselves and others to improve on self imagery and give support for our professional integrity as a whole.

We should by now be changing this stereotyping and project our profession in our own right. We also need to be wary of any tendency to be nostalgic for some 'golden age' when nurses were angelic, patients were uncomplicated and the health service had ample resources. There was no such age.

To make matters worse, this nursing image business makes it worse when nursing itself still has challenges such as short-staffing of our wards and clinics, unattractive working conditions, and in my opinion inadequate pays as per our skills and responsibility of the work. When nurses are understaffed, they are burned out or underpaid; they just leave the bedside and look for another profession.

Improving how people see our profession, eliminating media stereotyping and addressing our challenges are important factors that we as nurses and midwives must constantly work on for the betterment of our future. Crucially, we need to make nursing a more rewarding and meaningful career option for the brightest and the best of our young people.

President's message



Dear Colleagues,

Our summer season so far has been very challenging. During the past few weeks your union was at the forefront representing each one of you at different levels. Being the President of a union could be considered as a privilege, but it is a responsibility too. However, I can say that such a responsibility can be shouldered to with the dedicated and hardworking council members, group committee members and active members. Through the invaluable input of each one of us and that include each individual member of the MUMN; we will endeavour to maintain the momentum reached so far.

During the last few weeks, the MUMN council and group committee members met with several stakeholders to discuss key issues – and this included meeting members at their respective workplace. I can say that the new council took up the reins of office as each profession represented by the MUMN has their unique pitfalls and challenges. But, there are also tremendous opportunities for each profession, and if we keep on working together we can positively meet these challenges. During the past weeks, we kept informing you of what we as the union representing you, were doing by meeting you at your workplace or by updating you via regular emails and through social media. This brings me to nudge you to follow the MUMN's contribution towards various facets of ongoing industrial relationship issues. Your union works incessantly to keep you at the cutting edge of what is happening. We are using different platforms to reach you quicker with efficient service. We are dedicated and proactively work to understand you better, to reach you more and to strengthen ourselves in a professional manner. I thus invite you to keep regular contact with us via the group committees, emails and other means of communication.

As the warm summer months draw to a close, the MUMN's Council, group committee members and office administrators are busy preparing for a very active autumn. Exciting challenges are coming up! Our schedule is already jam-packed with events, sectoral agreement meetings and industrial relations meetings to support our members coming from different professions. Although we are facing a number of challenges ahead, the council is very optimistic about the professions represented by the MUMN. Clearly, quality patient care and our professions are both under fire. But together,

we know we are able to advocate for both. That is why your union is on the forefront – we want to build on what we have learned during our work together during the past years. As the President of the MUMN, I stand with you. Your union is ready to face these challenges with you and to be your advocate for wages, benefits, working conditions and a quality work environment. We already know that we are a stronger, more effective union when we work together, and doing so can only result in more successes – at the bargaining table, at the policy decision-makers' level and with the public/media. Being the union representing you, we are now building on growing our group committees – professionals representing you from the same workplace – who know the realities of the front lines and the impact of workloads and working conditions, both on themselves and on patient care. Remember, we are working together for better patient care and amelioration of our working conditions. Over the past months we have continued to invest in our group committees to ensure we provide the experience our members are looking for. In each respective hospital, and in each respective profession within the MUMN, members now have a group committee, who works thoroughly and diligently for the best interest of the members they represent. Each Group committee is an investment in our future. On a positive note, I am happy to inform you that in July the MUMN gained the sole recognition of social workers working within the public service. Also, special thanks go to the physiotherapists' group committee who are effectively and efficiently working to enhance the physiotherapists' inclusion within the MUMN structure.

While I was preparing for this issue's address, I reflected on the situation of the local health care system and I came to the realities of the present. 'Supporting Health Care Professionals, Promoting each Profession and Serving the Public Interest' – and I said to myself that this should be this issue's address tagline. This is what we need to stay intensely focused on. However, sadly enough this is not always the reality each one of us perceives as a health care professional. One would ponder how this could happen, after all the efforts from each individual professional. Admittedly, lest unjustifiably say that as long as we remain humans, sporadically and in times of crunch and

• continued on page 6

President's message

• continued from page 5

within a health care organisational context, there will always be times when crisis and conflict arise. It is for this reason I believe that we have to remain obsessively steadfast in our behaviour as professionals and as union. The MUMN has so far been instrumental in upholding the highest degree of its members' interest. I believe that we are extremely well-positioned and entrenched with strong values. What matters though is that we all use the qualities imparted by our professional training and standards to actively and consciously provide effective and efficient health care, while at the same time ensure governance. However, at times due to organisational pitfalls, we might find ourselves in difficulty to attain these professional qualities. We must not be led to believe that we are in any way immune to such a crisis. The MUMN have a vital role to play. We cannot work in isolation, and I wish that under my tenure ship the MUMN will be involved in active collaborative work with other professional organisations and patient or service user groups. My aim has always been – and will always be – to develop patient-centred care, while at the same time ensure a rewarding and meaningful work

for members of the MUMN. I am determined that through a collaborative effort the MUMN can achieve this for our members and to make a difference. The brand of the MUMN should remain squarely based on the highest ethical behaviour and proficiency behind all information and assistance that we provide for stakeholders to take decisions on. This is what matters. This is 'ensuring professionals' wellbeing and serving the public interest'.

Before I conclude I would like to take the opportunity to congratulate all the students coming from different health care professions who successfully finished their studies. On another positive note the MUMN would like to thank all stakeholders involved in the recruitment of the newly graduate nurses and midwives. Last but not least special thanks goes to all employees who in some way or another worked and made sure that the migration from Boffa hospital to SAMOC will be a SUCCESS!

I look forward enthusiastically to keep working with all of you.

Maria Cutajar
MUMN President



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Kelmtejn mis-Segretarju Ġenerali

Wasalna għall-ħarġa oħra tal-Musbieh. Iz-żmien itir qiegħed. Kemm kemm temmen li diġà għaddew disa' xhur mis-sena u f'tit taż-żmien ieħor nerġgħu nibdew naħsbu għall-Milied. Ir-raġuni ewlenija li ma tarax iż-żmien għaddej hija li jkollok il-ġurnata mimlija b'affarijiet x'tagħmel u trid dejjem tara kif ser tlaħhaq biex tlesti dak kollu li jkun ipplanat. Il-ħajja tagħna fil-Union hekk hi. Nixtieq li l-ġurnata fiha aktar siegħat biex jirnexxieli nlaħhaq nagħmel dak kollu mitlub minni però r-realtà sfortunatament hija ħaġa oħra.

Fil-mument qegħdin involuti f'diskussjonijiet li jinvolvu tlett ftehim settorali – ECG Technicians, Social Workers li huma impjegati mal-FMS u s-Social Workers li huma impjegati mas-Servizz Pubbliku. Qed jiġi ffinalizzat ukoll id-dokument tal-ftehim settorali li jirrigwarda n-Nurses u l-Midwives sabiex fi żmien qarib jibdew ukoll in-negozjati fuqu. B'hekk l-MUMN tkun għaddeja b'negozjati fuq erba' ftehim settorali f'isem il-membri tagħha. Nawguraw li fi żmien qasir jingħaqdu magħna wkoll sħabna l-Physiotherapisti.

Kultant nisimgħu xi union li tippronunzja ruħha dwar l-investment privat. Min jgħid ħaġa u min oħra. S'issa hadd għadu ma jaf il-fatti eżatti għax il-proċess finanzjarju għadu għaddej. L-MUMN ukoll tkellmet fuq dan l-investment fejn serrhet ras il-membri li s-sitwazzjoni dwar il-kundizzjonijiet tax-xogħol u proviżjonijiet oħra jridu jitjiebu minn dawk li għandna llum. Mhux biss il-pazjent irid imur aħjar imma anki l-impjegati membri tal-MUMN. Tlabna wkoll biex il-Gvern f'dan il-proċess ikun intermedjarju u t-talba tagħna ġiet milqugħa. Dan għalina huwa pass importanti ħafna għall-membri però f'tit unions apprezzawh. Tista' sserrah moħħok li fil-mument li l-MUMN tara li inti ser tmur minn taht, tkun l-ewwel Union li tiddikjara tilwima industrijali mal-Gvern u tagħti direttiva biex hadd ma jiċċaqtaq minn postu. Mhux l-istil

tal-MUMN però, li toqgħod tparla issa għall-gallarija imbagħad meta naslu għall-fatti proprja ninħbew. L-MUMN qegħda f'dan il-mument tiġbor l-informazzjoni, tanalizza u tikkonsulta mal-membri tagħha. Fil-mument li tara li l-membri ser imorru hażin, ikun il-waqt li tagħmel gwerra u dak kollu li jkun jinħtieġ. Nifhem li d-dewmien joħloq anzjetà żejda u dan ma jagħmel l-ebda ġid kemm għall-membri involuti kif ukoll għall-pazjenti.

Nixtieq niringrazzja lil dawk kollha li attendew għall-BBQ li kienet l-attività ewlenija tas-Sajf. F'dsatax-il sena qatt ma kien hemm attendenza daqs din id-darba. Prosit lil Alex Lautier u lil Giselle Curmi li jieħdu tant paċenzja jorganizzaw dawn l-attivitajiet. Diġà qed jaħsbu għall-attività tal-Milied. Inħegġeġ aktar membri sabiex jattendu l-attivitajiet tal-Union tagħhom.

Is-sena d-dieħla l-MUMN tagħlaq 20 sena mit-twaqqif tagħha, preċiżament fid-19 ta' Settembru. Il-Kunsill ser jappunta kumitat apposta għal dan il-ghan sabiex jiehu hsieb jorganizza attivitajiet varji għal dan l-avveniment. Inti ukoll tista' tagħti daqqa t'id. Żgur li l-għajnuna tiegħek tiġi apprezzata. Tajjeb li ngħidlek li f'dawn iċ-ċelebrazzjonijiet ser ikun hemm sorpriza sabiha li kulhadd żgur ser japprezza però.....

Fil-15 ta' Ottubru li ġej ser tiġi organizzata protesta fit-toroq tal-Isptar Mater Dei dwar is-sitwazzjoni prekarja tal-parkeġġ. Ma jistax jiġi ttollerat li l-Gvern għandu soluzzjoni u minħabba kwistjonijiet burokratiċi, ix-xogħol fuq il-parkeġġ il-ġdid għadu ma nbediex. Jekk sa din id-data x-xogħol ikun għadu ma nbediex l-MUMN ser torganizza protesta fil-hinijiet ta' filgħodu biex nagħtu sinjal ċar lill-Gvern li s-sitwazzjoni preżenti hija inaċċettabli.

Punt pożittiv huwa l-ammont ta' attivitajiet edukattivi li qed jorganizza l-Kumitat Edukattiv fl-uffiċċju stess tal-Union fil-Mosta. Minn issa sal-aħħar tas-sena, il-ġranet kollha huma mimlija b'xi kors jew ieħor. Il-membri huma dejjem herqana biex jitgħallmu aktar. Barra minn hekk huwa ppjanat li fil-5 ta' Novembru tiġi organizzata konferenza b'tema differenti mis-soltu però aktar dettalji jiġu mogħtija fil-ġimgħat li ġejjen.

Naħseb li għal din il-ħarġa aħjar nieqfu hawn għaliex l-ispazju huwa limitat. Ftakar li l-MUMN huwa int. Huwa importanti għalina li nkunu nafu int x'tixtieq li l-Union tiegħek tagħmel jew li ma tagħmilx u fejn inti tixtieq tikkontribwixxi. Toqgħodx lura u kkuntatjana.

Colin Galea
Segretarju Ġenerali



Colophony allergy

PART 1

Colophony or Rosin, is a sticky amber substance found in the sap of pine and spruce trees. Due to its tackifying properties, it is used in many products. On distillation, colophony oleoresin residue consists of 90% resin acids and 10% neutral matter. The primary component of colophony is abietic or sylvic acid and air oxidation results in the formation of potent contact allergenic compounds. Currently, colophony represents the 4th most frequent allergen in Germany and the 3rd highest cause of occupational asthma. It is also a cause of allergic contact dermatitis.

Development of colophony sensitivity mainly depends on the length of exposure, the concentration of the allergen, the site of exposure, skin integrity, and the specific chemical constituents of the colophony involved. Dermatitis tends to occur within 1-3 days after contact, although reactions can appear within 24 hours or even after a week following exposure. Dermatitis tends to be confined to the site of contact. Typical symptoms of colophony allergy are skin redness, swelling, itching and fluid-filled blisters. However, continued exposure may result in dermatitis becoming chronic with thickened, lichenified skin.

Colophony exposure in the medical setting is very common, since it may be found in a variety of products including adhesive tapes, dental devices, wart treatment gels⁴, ostomy appliances, wound dressings, skin 'butterfly' sutures, diapers, sanitary pads and surgical clothing (gowns and drapes).

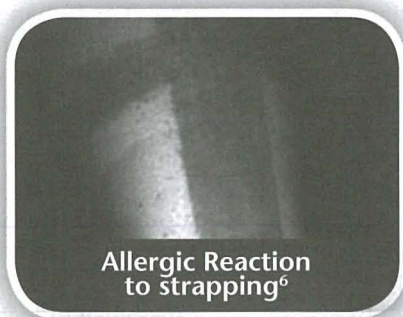
Colophony in Wound Dressings: Several studies have reported allergic contact dermatitis to chemicals found in the adhesive or the dressings themselves. Allergic contact dermatitis from the presence of a colophony derivative in a tape skin closure had already been reported in 1984. A study of 155 patients showed that 70.6% of skin injuries whilst using dressings, were due to contact dermatitis. Such allergenic chemical components often involve modified derivatives of colophony. Whilst a study revealed that some patients reacted only to abietylic alcohol, others showed allergic reactions to methylabietate, used as plasticiser

in adhesive "hypoallergic" plasters. Contact dermatitis was observed to occur more frequently when the tapes or bandages were left on the skin for longer. Three case studies showed that patients had a massive eczematous reaction, 1 also with lesions, to 3 types of hydrocolloid dressings. The hydrocolloid dressings contained pentaerythritol ester of hydrogenated rosin as the tackifying agent. Another study showed that repetitive treatment with hydrocolloid dressings induced major functional alterations of the stratum corneum, whilst polyurethane and soft silicone

adhesive dressings did not. Patients with chronic wounds often have a tendency for contact sensitivity, and a study of venous leg ulcer patients in Germany showed 13.9% prevalence of colophony sensitivity. Hence, the inclusion of highly potent allergens, such as colophony, should be strictly avoided in the material composition of wound dressings.

Colophony in Surgical clothing: Reports of allergy due to colophony in paper-based surgical clothing had already been published in 1994 by Bergh, Menné and Karlberg. Contact dermatitis from clothing is quite common and is usually located in body areas in contact with the garment. Textile fibers mostly induce irritant dermatitis, often due to the presence of textile resins which are used to enhance the touch and quality of clothing.

Colophony in Incontinence devices: Allergy to sanitary pads was clearly shown in a case study of a teenage girl who recurrently presented with vulval dermatitis starting several days after using a sanitary pad. The rash subsided, but recurred on subsequent use of the pad. Colophony was present in all diapers tested, in a study conducted on disposable diapers available on the Swedish market. A higher concentration of colophony was found in the top layer, which is in close contact with the skin. The risk of triggering dermatitis in sensitive individuals to colophony in diapers is quite high when considering that penetration into the skin is enhanced by occlusion and irritation. Long-fibred



Allergic Reaction to strapping⁶



Contact dermatitis to adhesive plaster⁶

chemical pulps (kraft or sulfite) have traditionally been used for the absorbent medium in diapers and pads. However recently, less-expensive mechanical grades of pulp have taken a significant share of the market. Whereas, the major part of the colophony content in chemical pulp, is separated and removed; the colophony components in mechanical pulp remain incorporated in the pulp, resulting in a higher concentration of colophony in the cellulose obtained. The increase in popularity of mechanical pulps for production of cheaper fluff for less expensive diapers thus increases the risk of allergic contact dermatitis. The adhesive used in some diapers may also be a source of rosin allergens and should be exchanged for a colophony-free alternative.

The best way to minimise risks of colophony contact allergy is to avoid using products containing colophony. Hence, it is very important for one to be aware of the chemical content of medical

devices in use. This can be done by consulting the product label, material safety data sheets or contacting the manufacturer.

A significant rise in prevalence of colophony sensitivity was revealed in 2 studies involving patch testing in the Netherlands and Greece. The increase in popularity of mechanical pulp manufactured cheaper paper products tends to promote an increase in prevalence for the future. This evidence supports the reasoning that in the long term, cheap alternatives might turn out to be the most expensive.

"Despite the demand of low priced dressing materials, which, it must be said, are rarely dependable or of high quality, I refuse to abandon my principle of delivering the best there is to offer, time after time."
Paul Hartmann, 1885

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

Defence Against Trauma

Women's use of defence mechanisms following childbirth related trauma

Abstract

Objective: To explore and identify women's use of defence mechanisms in the aftermath of a traumatic birth.

Background: Following childbirth related trauma women adopt a range of unconsciously mediated functional and dysfunctional responses in their attempts to 'cope' with their complex emotions.

Methods: A secondary analysis was undertaken on existing qualitative research (n=13) that considered women's psychosocial responses following a traumatic birth, using Freudian defence mechanisms as a conceptual lens. Analysis involved repeated readings of defence mechanisms literature together with the findings in the selected studies. A framework of defence mechanisms was developed and extracted findings were mapped against these headings until saturation and consensual validation occurred.

Results: Ten defence mechanisms were identified to resonate with women's trauma related responses. Women tried to 'repress' and 'supress' their memories of childbirth and used 'avoidance' to protect themselves from reminders. 'Sublimation' and 'undoing' were adopted in attempts to convert their negative emotions into more constructive responses and to present themselves as good mothers. However, the pervasive impact of a traumatic birth was evident

through 'displacement', 'somatization', 'reaction formation', 'turning against the self' and 'regression' with women expressing anger and hostility towards themselves, their infants, partners and others.

Conclusion: Training and context-related screening processes to identify defence related responses are needed. Raising awareness of defence mechanisms could provide reassurance of the 'normality' of women's psychological responses in the short-term. Recognition of how long-term adoption is indicative of undesirable and unhealthy behaviours may also promote and encourage access to suitable psychological support.

Keywords: childbirth; trauma; PTSD; mother's; qualitative methods, defence mechanisms.

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A comparative study of the social work department and the Community Outreach Team in a Psychiatric setting

D. Farrugia, Dr. S. Buttigieg (2009)

Abstract

Background: Management is continually searching for that synergy that will increase performance in the organisation. Many argue that teams provide this synergy and are crucial for an organisation's success. However, calling a group of people "a team" does not automatically make it a team, since "a team" can be differentiated from "a group" on a number of points, mainly: goals, roles, priorities, leadership and dynamics. Research shows that a problem that health care systems are facing is, that it is becoming even more difficult to provide health care that meets the needs of patients within tight budget constraints. It is suggested that a way to address this serious and real problem is to channel the energies of people more constructively to work as teams. Literature also shows that a team working approach can help to manage resources, improve task performance, learning and communication. Since their inception, the management of the said psychiatric hospital refers to the Community Outreach Team as a "team", while the social workers are referred to as the "Social Work Department".

Methods: The study attempts to analyze the difference, if any between the Social Work Department and the Community Outreach Team, which will be referred to as a work-group and a team respectively, on the basis of how they have been labelled at this hospital since their inception. The study also attempted to find out any differences in group dynamics between the Social Work Department and the Community Outreach Team. Qualitative interviews were carried out with 3 persons from management, and the members of the Community Outreach Team (10) and all the members of the Social Work Department (10). Moreover, a focus group was held with both work-settings.

Results: Management at the psychiatric hospital seems to have the perception that the Community Outreach Team is more of a "team" and although, the Social Work Department has characteristics of a team, there are some factors which make it resemble more a "group", due mainly to the fact that social workers function both within the uni-disciplinary Social Work Department, as well as within multi-disciplinary teams. Management is also greatly aware of what the barriers to the implementation of successful teams are. Management also seems to support teams, through

various initiatives such as their personal intervention with different settings, support for employee training and the yearly Team of the Year Award. What seems to be lacking is the proper selection of employees, that is, excluding those who show that they are not able to work in a team, as well as the reward of appropriate behaviours. The members of the Community Outreach Team seem to have positive relationships between themselves. They trust each other and find time to joke amongst themselves. When there is conflict, this is addressed in a constructive manner. On the other hand, although the members of the Social Work Department feel that they are on good terms with each other, most of them do not trust each other. Moreover, humour is hardly used and half of the members of the Social Work Department feel that at present conflict exists. All the members in both settings feel that their work-settings were very effective in the work that they provide, that is, all the members of both work-setting feel that the work they do, produces results. However, it would be beneficial if data which can be identified as effectiveness indicator, such as re-admissions and quality of life, were appropriately captured and analysed.

Conclusion: A number of recommendations were outlined which would be beneficial for both settings:

1. The Social Work Department should be given the opportunity to participate in team building activities. For example, more meetings should be organised, and more time should be dedicated to build good intra-departmental relationships.
2. Both work-settings should have better access to resources, such as: computers and journals.
3. There must be more direct input from management when it comes to rewarding good team behaviours.
4. Both settings must have access to information on both tasks and performance.

Future research should replicate the study once the above recommendations are implemented, in order to determine whether these recommendations did in fact show an improvement in teamwork, and upon the effectiveness of both work-settings. This study is the first report of its kind, which provided management of the psychiatric hospital with an in-depth perspective into the group processes of both work-settings.

For more information you can contact Ms. Daniela Farrugia Social Worker on daniela.farrugia@gov.mt

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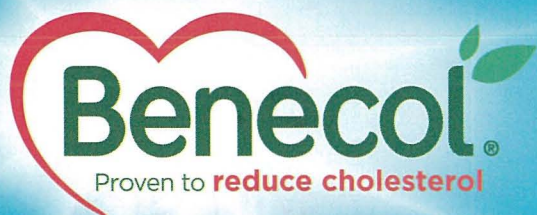
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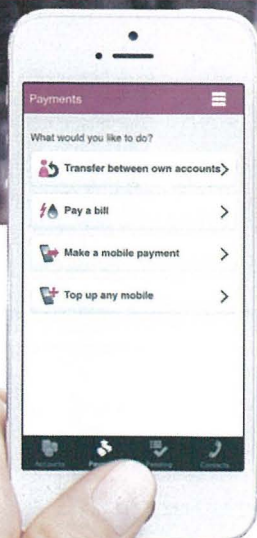
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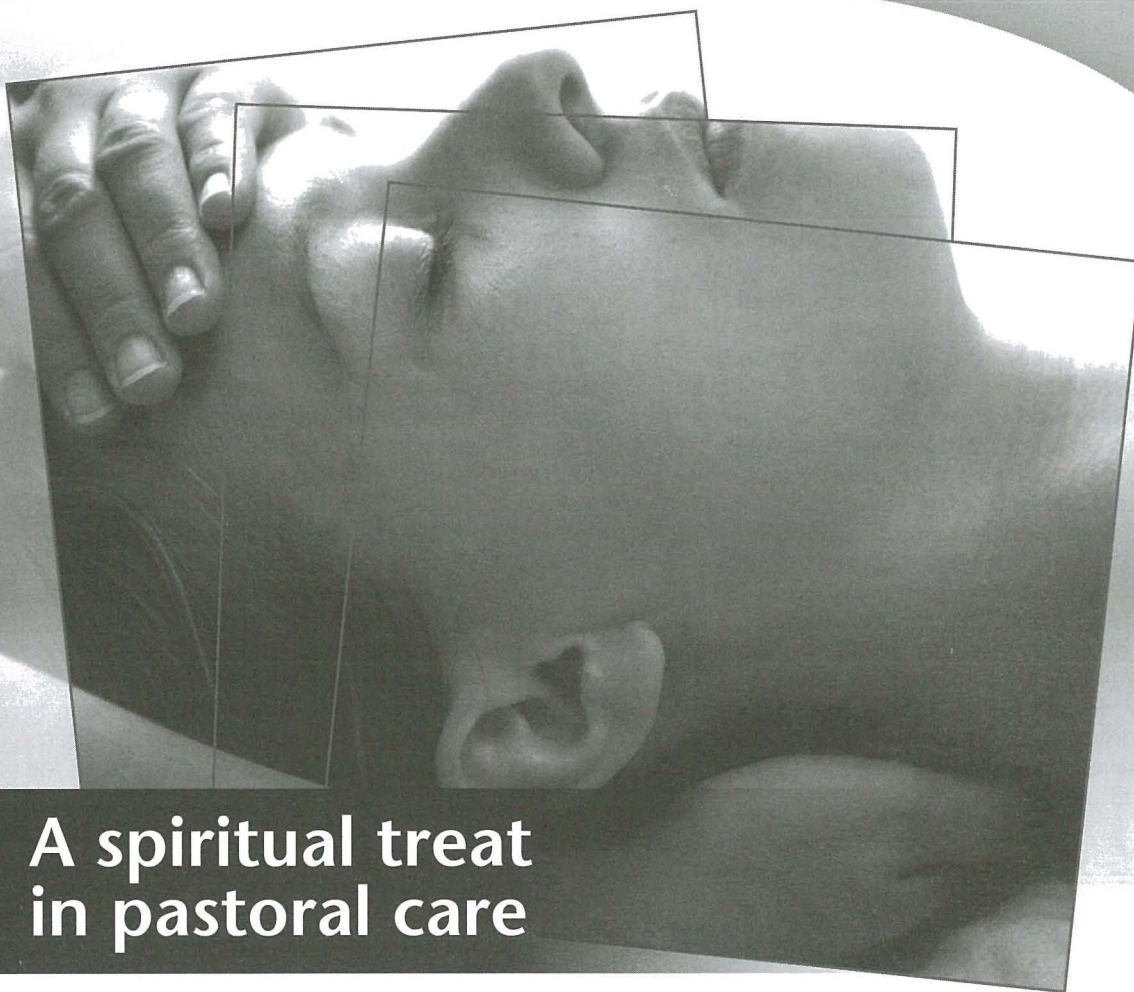


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A spiritual treat in pastoral care

How come that a chaplain carries with him what he has aptly termed as "spiritual treats?" Do patients really need a treat? And is this treat simply addressed to patients alone?

To begin with, let me ask the simplest and most obvious of questions, what is a treat? As a verb it means behaving towards or dealing with in a certain way. Or regarding something as being of a specified nature with implication for one's actions concerning it. Moreover, the word treat also has a curative connotation. It means giving medical care or attention to. Or, try to heal or cure. The latter meaning is surely of great significance to pastoral care. If spiritual care is not meant to heal then what is its purpose? Evidently there are various kinds of healing. Certainly pastoral experience has taught me that helping one to find his/her meaning in the situation s/he is living in is undoubtedly a huge step towards figuring a meaning. It can be said that a treat constitutes the healing one needs in dealing with the issues that greatly challenge his/her personal security at the moment.

Before sharing with you the treat God shows me to offer gratuitously to our patients, families and staff at Mater Dei Hospital, I would like to cite two citations which greatly motivate me in giving this particular treat to all those I come across in my pastoral ministry.

The first one is taken from one of the most beloved authors of all time, Og Mandino. Among

his famous books he wrote the bestselling book *The Great Salesman in the World*. Og writes:

"Live this day as if it will be your last.

Remember that you will only find 'tomorrow' on the calendars of fools. Forget yesterday's defeats and ignore the problems of tomorrow. This is it. Doomsday. All you have. Make it the best day of your year. The saddest words you can ever utter are, 'If I had my life to live over again.' Take the baton, now. Run with it! This is your day! Beginning today, treat everyone you meet, friend or foe, loved one or stranger, as if they were going to be dead at midnight. Extend to each person, no matter how trivial the contact, all the care and kindness and understanding and love that you can muster, and do it with no thought of any reward. Your life will never be the same again."

Another citation which invigorates me as a chaplain to hand on with care these "special treats" is the one that comes from the mouth of Lao-Tzu, the great philosopher and poet who founded philosophical Taoism in ancient China. This great thinker said: "Treat those who are good with goodness, and also treat those who are not good with goodness. Thus goodness is attained. Be honest to those who are honest, and be also honest to those who are not honest. Thus honesty is attained ..."

• continued on page 16

A spiritual treat in pastoral care

• continued from page 15

Now comes the bride! The treat you have been expecting so far to know about is none other than a simple little parchment which is closed by a small cute ribbon. In each and every parchment I deliver to others there is a written citation that it directly taken from the Bible. As you might know this sacred text holds some awesome human and spiritual insights that not only caress but actually keeps the person to move on despite life's harshness.

I would like to share with you three of the most powerful treats that served as great hope stimulators to distressed people I regularly encounter at Mater Dei Hospital. Two of them are taken from the Old Testament and the other one is a direct quote from Jesus as found in the New Testament. "Fear not, for I am with you, be not dismayed, for I am your God; I will strengthen you, I will help you, I will uphold you with my victorious right hand" (Isa 41: 10). "I have loved you with an everlasting love; therefore I have continued my faithfulness to you" (Jer 31:3). "Come to me, all who labor and

are heavy laden, and I will give you rest. Take my yoke upon you, and learn from me; for I am gentle and lowly in heart, and you will find rest for your souls. For my yoke is easy, and my burden is light." (Matt 11:28-30).

The comforting reactions of those who received these parchments assured me, first and foremost, that God's Word is, in fact, truth in itself. Psalm 119 line 105 says that God's Word sheds the light of truth in a world hugely dominated by darkness. "Thy word is a lamp to my feet and a light to my path". Because the Word of God is the truth, as God, its divine speaker, is Truth in Himself, the Letter to the Hebrews says: "For the word of God is living and active, sharper than any two-edged sword, piercing to the division of soul and spirit, of joints and marrow, and discerning the thoughts and intentions of the heart" (Heb 4: 12).

Besides the intellectual aspect the Word of God also targets the emotional world of the human person. Psalm 119 says it so clearly when the psalmist proclaims God's comforting truth for him/her when presented with his/her challenging life situations. "Remember thy word to thy servant, in which thou hast made me hope. This is my comfort in my affliction that thy promise gives me life" (Psalm 119: 49-50).

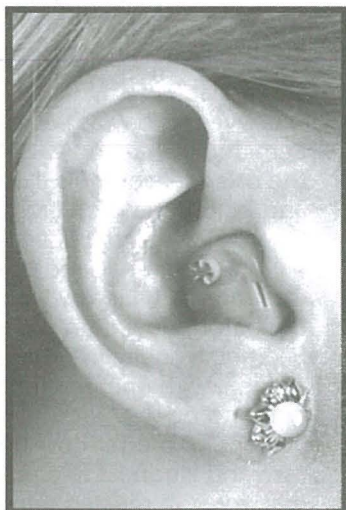
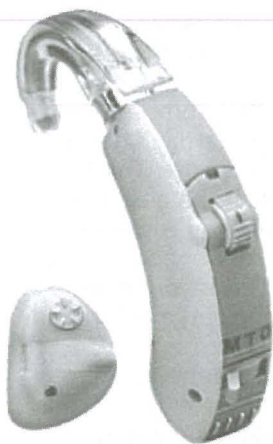
Because God's Word is food and drink for the human person in his and her entire existence Mother Church wisely suggests that each Christian undertakes a biblical approach to everyday life. Such an approach is vital if Christians are to be "the salt of the earth" (Matt 4:13) and "the light of the world" (Matt 5:14). In this perspective Pope Benedict XVI's post-synodal apostolic exhortation, *Verbum Domini*, smartly recommends "a greater 'biblical apostolate', not alongside other forms of pastoral work, but as a means of letting the Bible inspire all pastoral work" (§ 73). If hospital ministry is not inspired by the Bible then what other kind of apostolate would? Are not patients, relatives and staff in dire need of a divine word that comforts them and gives them that assuring hope to hold on to?

As a chaplain and a priest I am duty-bound, by my divine and ecclesial calling, to aid other people nurture a personal encounter with Christ.

The latter gives himself to us through his life-giving Word. Sharing with others God's Word in a parchment attached with a ribbon is more than a simple treat. It is forming others intellectually and spiritually in Jesus Christ. The form of how this is brought about is not that important. But if it helps them to deepen their relationship with Christ then let me keep sharing God's Word by means of his cute spiritual treats!

Fr Mario Attard OFM Cap

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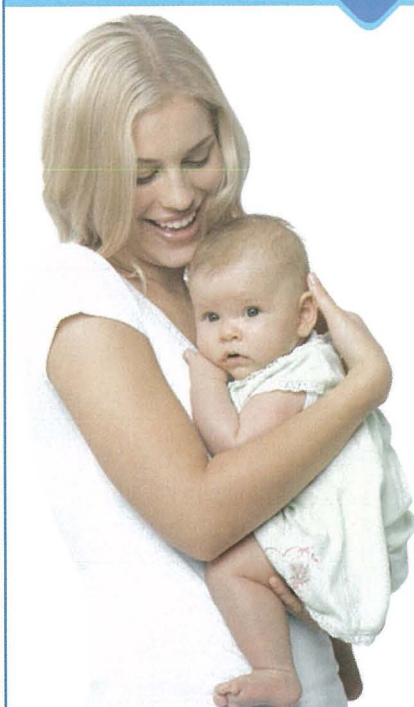
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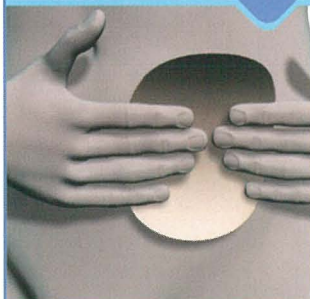
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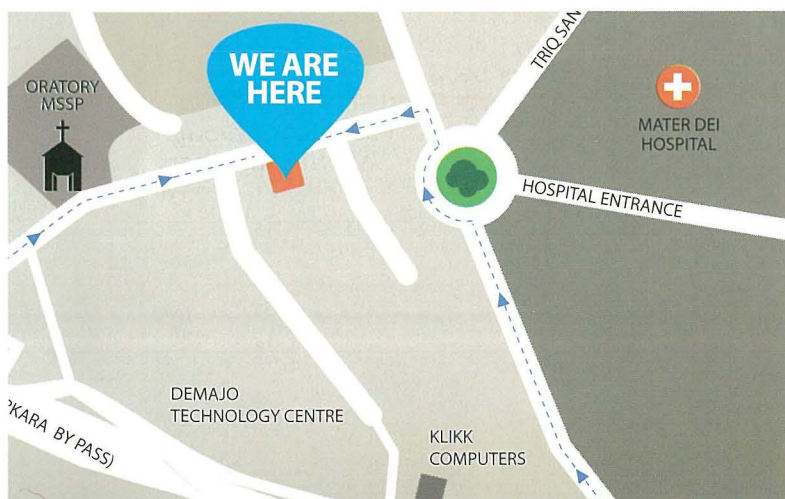
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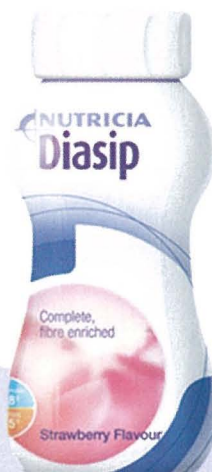
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References: 1. A Ceriello, M Lansink et al. 2009; 2. Mann JI et al 2004; 3. American Diabetes Association. Diabetes Care. 2008; 4. IDF. Guideline for management of postmeal glucose 2007; 5. Taste Study. Data on file 2008.

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MUMN organised its Annual Activists Seminar.



H.E. President of Malta met MUMN Council on Nurses' Day & Midwives' Day.



Hon. Chris Fearne addressed MUMN Council on the occasion of Nurses' Day and Midwives' Day.



Hon. Claudette Buttigieg Pace attended MUMN Office.



An important meeting was organised for the Physiotherapists MUMN Members.



MUMN's Entertainment Group Committee organised its annual summer activity. It was really great.



The Nursing and Midwifery Council met at MUMN Office for the first time - it was a historic day.

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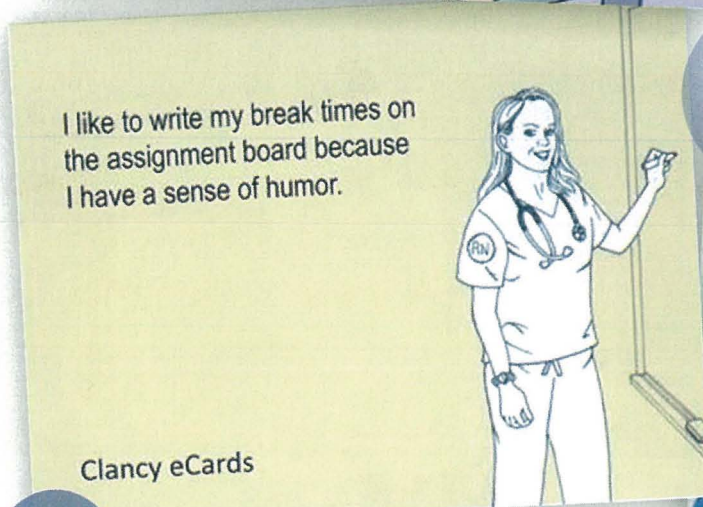
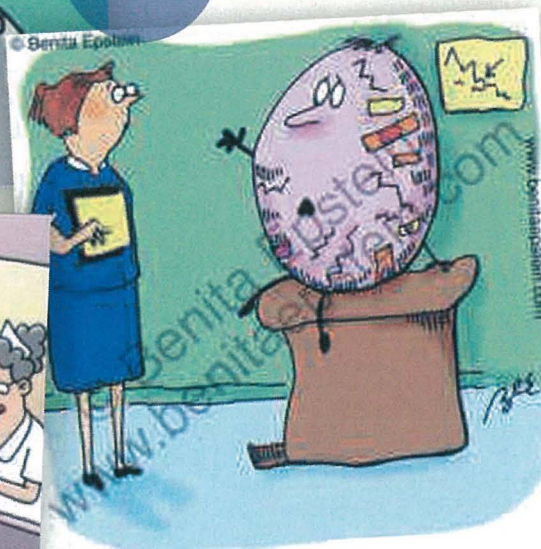
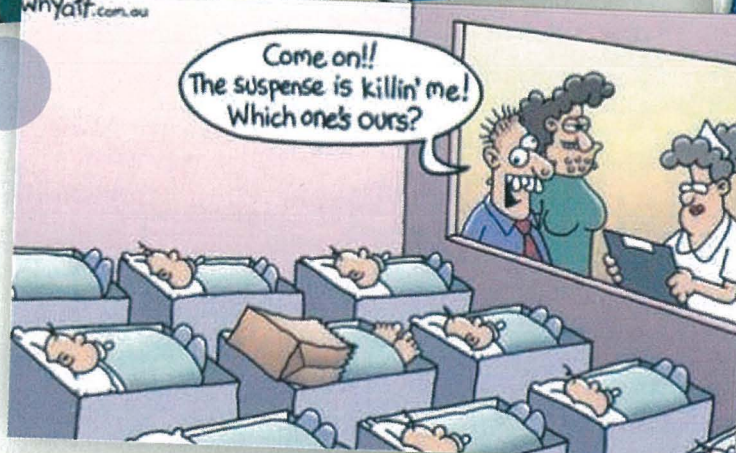
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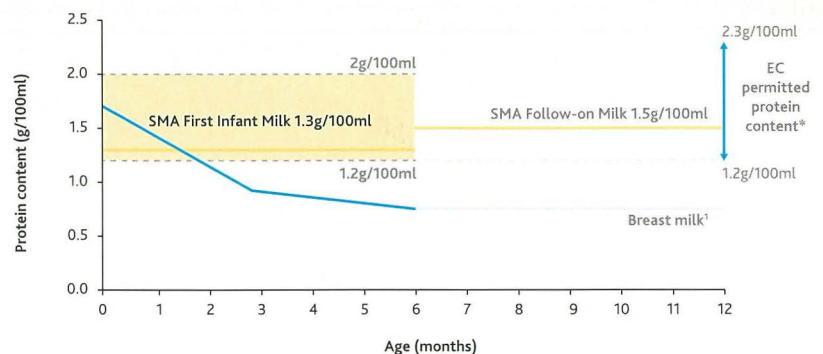


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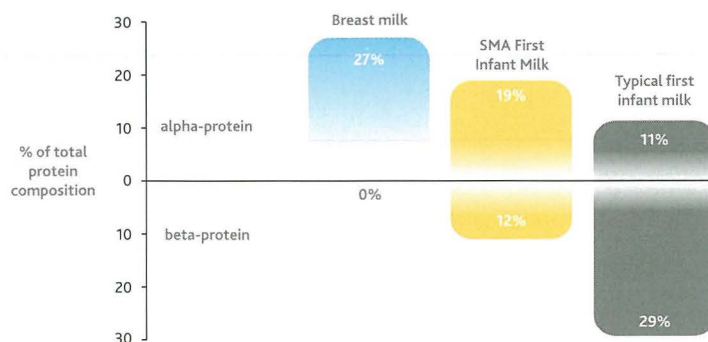
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EC (European Commission) (2006). Directive 2006/141/EC on infant formulae and follow-on formulae and amending Directive 1999/21/EC. European Commission.³

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References:

1. United Nations System 2006. Standing Committee on Nutrition. Third World Urban Forum, Vancouver;
2. Koletzko B, et al. Am J Clin Nutr 2011;94(suppl):2036S-43S;
3. EC (European Commission) (2006). Directive 2006/141/EC on infant formulae and follow-on formulae and amending Directive 1999/21/EC. European Commission.
4. Lien EL, et al. JPGN 2004;38:170-176

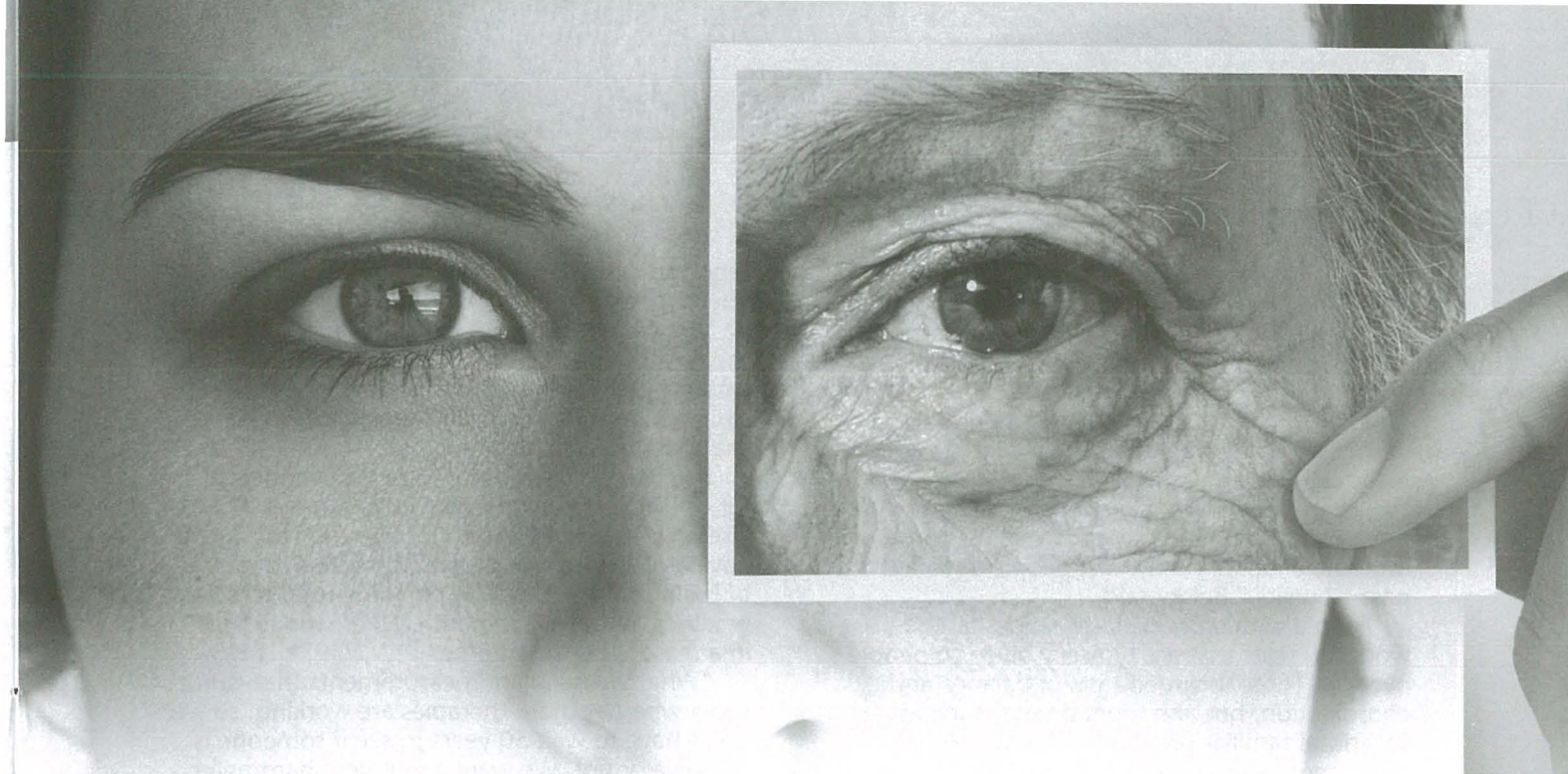
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Old before your time?

People age at wildly different rates, study confirms

If the school reunion was not proof enough, scientists have confirmed that people grow old at radically different rates, with some ageing much faster than their fresh-faced former classmates.

A study of nearly one thousand 38-year-olds found that while most had biological ages close to the number of birthdays they had notched up, others were far younger or older.

Researchers used 18 physiological markers, including blood pressure, organ function, and metabolism, to assess the biological age of each of the participants. For some, the past dozen years had taken no obvious toll on their body's biology.

But others were not so fortunate. A good many participants had biological ages in the 50s, while one, described by scientists as an "extreme case", had a biological age of 61 years old. That meant that for every birthday over the past dozen years, their body had aged three years.

"The overwhelming majority are biologically in their mid-40s or younger, but there are a handful of cases who are in pretty bad shape. In the future, we'll come to learn about the different lives that fast and slow ageing people have lived," said Daniel Belsky at Duke University in North Carolina.

The researchers drew on data gathered on 871 people enrolled in the Dunedin study,

a major investigation that has tracked the health and broader lives of around 1000 New Zealanders born in 1972 or 1973 in the town of Dunedin, New Zealand. Of the original group, 30 had died by the age of 38 due to serious diseases such as cancer, or by accidents, suicides and drug overdoses.

"Our goal was to see if we can measure ageing in young people," said Belsky. "It's becoming increasingly clear that ageing is really the cause of much of the disease and disability burden we face, but our existing science is based on ageing in older people who already have a lot of age-related diseases."

According to Belsky, studying ageing in younger people gives researchers the best chance of teasing apart

the biological changes that drive ageing from those that underpin specific diseases.

The scientists drew up a list of 18 biological markers that together reflect a person's biological age. They included measures of kidney and liver function, cholesterol levels, cardiovascular fitness and the lengths of telomeres, which are protective caps that sit on the ends of chromosomes.

The set of markers were measured when the volunteers were aged 26, then 32, and finally at the age of 38. The researchers then looked to see how much the markers changed over time, to

Tests on physiological markers in nearly 1,000 38-year-olds found that some had biological ages many years older than their birthdates would suggest
Ian Sample, science editor

• continued on page 26

Old before your time?

• continued from page 25

produce a "pace of ageing" figure. Across the group, the biological ages of the 38-year-olds varied from 28 to 61. If a 38-year-old had a biological age of 40, it implied a "pace of ageing" of 1.2 years per year over the 12 year study period. Details of the study are published in Proceedings of the National Academy of Sciences.

"Even before they develop age-related diseases, their physiology shows signs, and there is great variation in how fast people aged in the past 12 years," Belsky said.

People with older biological ages fared worse on tests that are typically given to people over 60. These included tests of balance and coordination, but also mental tasks, such as solving unfamiliar problems. The biologically older people also reported more difficulties with activities like walking up the stairs.

The scientists went on to see whether volunteers' biological ages matched how they old they looked. They invited students to view photos of the study participants and guess their ages. The biologically older people were consistently rated as looking older than their 38 years.

"Already, before midlife, individuals who were ageing more rapidly were less physically able, showed cognitive decline and brain ageing, self-

reported worse health, and looked older," the scientists write.

The next step in the research is to sift through the lives of the Dunedin participants to see how factors such as lifestyle, medical history, family circumstances, and stressful events might affect the speed at which people age.

Belsky called the study a "proof of concept" for using biological markers to measure the ageing process in people who are too young to have age-related diseases. An objective measure of biological age, he said, could be used to assess whether new anti-ageing therapies work or not in a reasonable time frame.

"What we need are measurements that can show whether these therapies are working, so we don't have to wait 50 years to see if someone is still alive or not. We want a real-time barometer of how a person is doing, and whether the therapy is really changing their rate of ageing," he said.

The ultimate goal is to target ageing instead of the multiple separate diseases that people are increasingly likely to develop as they age. "As we get older, our risk grows for all kinds of different diseases. To prevent multiple diseases simultaneously, ageing itself has to be the target," Belsky said.

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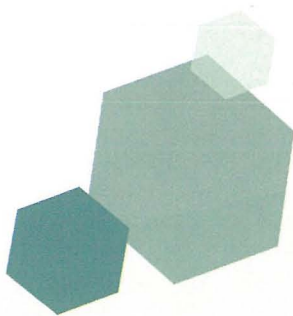
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OptiFibre® helps maintain normal bowel functions in patients suffering from constipation, diarrhoea and irritable bowel syndrome.

Besides a regulatory effect on gastrointestinal function, Optifibre® has shown positive effects on lipid metabolism and mineral absorption. The main clinical benefits of 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.

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, OptiFibre® mixes easily into hot and cold meals and beverages without impacting texture or flavour, thus assuring maximum acceptance by patients. Consequently, 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. 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.

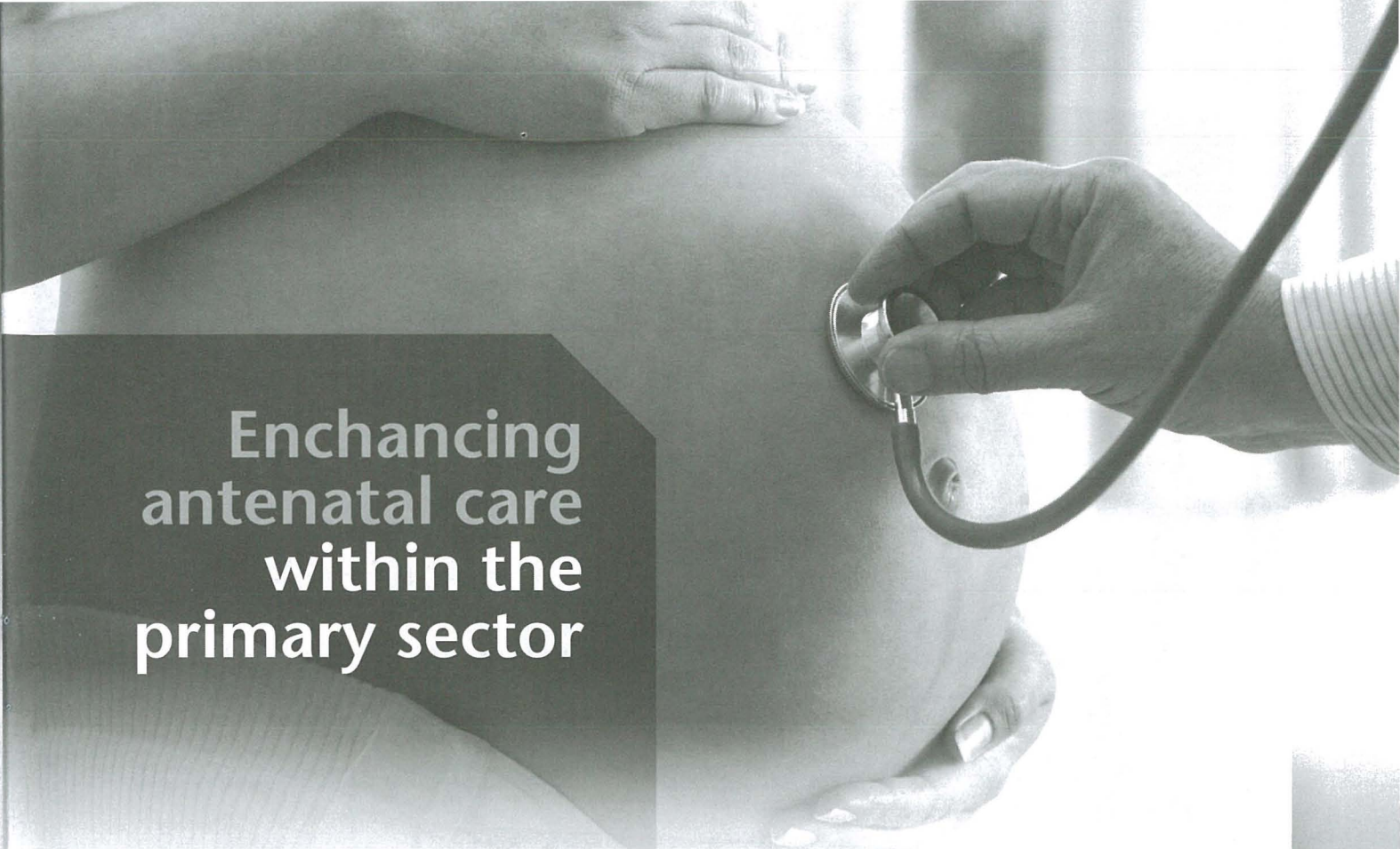
Optifibre® should be introduced gradually by simply adding 1 scoop (equivalent to 1 sachet) to foods or liquids for the first 3 days. This dose may be gradually increased by adding another scoop every 3 day interval until the desired effect is achieved. The maximum amount administered should not exceed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

Formerly known as Resource® OptiFibre®

Reference:

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





Enchancing antenatal care within the primary sector

Pregnancy in itself is not an illness but a healthy process for reproduction. It is a time of changing physiologically and a period of great anticipation. If uncomplicated, without any other illness or condition, a pregnancy is assessed as low-risk pregnancy. This means that there are no active complications and that there are no maternal or fetal factors that place the pregnancy at increased risk for complications.¹ Midwives are the experts in the provision of antenatal care for low-risk women. The midwife is a person who works in partnership with women to give the necessary support, care and advice during pregnancy. This care includes preventative measures, the detection of complications in mother and child, the accessing of medical care or other appropriate assistance and the carrying out of emergency measures. The midwife has an important task in health counselling and education. This work should involve antenatal education and preparation for parenthood².

Locally we are missing the service of a midwife who can give the antenatal care at primary levels as there is no midwives for such service in the primary health care sector. If a midwife will be in charge of the well-woman clinic, it will be beneficial for various reasons:

- The work load at the Obstetric and Gynaecological Clinic in Mater Dei will be reduced.

- Women and their partners will have less

waiting time when they go for a visit.

- Service will be more within reach for the mothers as it will be in their local areas.

- The obstetrician will have more time to concentrate on high-risk cases.

- Midwifery-based antenatal care is less costly.

The recommended service to be offered in the our local health centres could be:

- While an obstetric BST/HST is today running the well-woman clinic, a midwife will provide antenatal check-ups to low risk mothers. This service is recommended because if a midwife will need to refer or consult with a doctor, the option for instant referral will be readily available.

This recommended service could be easily offered as in most health centres there is already a space available as there are two adjacent rooms already allocated for the well-woman clinic.

1 University of California. (2013). *Maternal-Fetal Medicine* Retrieved online on 31/05/2015 from <http://obgyn.medschool.ucsf.edu/mfm/lowriskpregnancies.aspx>

2 Baston. H. & Hall. J. (2009). *Midwifery Essentials: Antenatal (Volume 2)* London: Churchill Livingstone Elsevier





My first Nursing Experience

1970

From left to right Louis Abdilla, Angelo Sammut, George Abela and me, Carmel Saliba. Photo taken in 1972.

On the 11th December 1970, the Chief Government Medical Officer notified that a competitive examination for admission to the Training Schools for Enrolled Nurses was to be held in February. The examination was sponsored by the Department of Health.

The examination - through which 25 female students and 5 male students were to be admitted into the school. Candidates were required to be aged between 17 and 25 years by the closing date of the application, be of good character and be certified medically fit to the satisfaction of the Chief Government Medical Officer.

The requirements of application were:

- *Be in possession of a certificate, to be certified, in each case, by the Director of Education, showing that they have at least completed such studies as are equivalent to those of Form 3 of the Government Secondary School;*

- *Citizens of Malta (Besides their birth certificate, candidates are to produce certificates of birth of their parents and paternal grandfather, showing their place of birth).*

- *Candidates who hold the General Certificate of Education at Ordinary Level, or a Malta Matriculation Certificate in English Language and Mathematics were exempted from such written test, but had to attend for an interview.*

The vacancies for this course were allocated to the successful candidates according to the order of merit obtained. Preference was, however, be given to those candidates who were exempted from the written examination on the strength of their General Certificate of Education, and who

pass the interview. If the number of candidates didn't reached the needed number a competitive entrance examination which consisted of a written test in English (two papers) and in Arithmetic (Maths); was followed and those successful were submitted to an interview.

Successful candidates accepted for training had to undergo the following studies:-

- *An introductory course which lasted a period of four weeks, during which basic instruction were imparted before the entry to the wards; and*

- *A final course which consisted for a period of 23 months, during which pupils had to complete their clinical experience in the field hereunder, evidence of which must be shown on the form of application:-*

1. *General Medical Nursing of Men and Women;*
2. *General Surgical Nursing of Men and Women;*
3. *Nursing of children, or where this was not practicable, an adequate period in the out-patients Department of a Children's Unit with attendance at paediatric clinics.*
4. *Geriatric or long-stay chronic and/or Psychiatric Nursing.*

The successful candidates admitted to the training school were known as 'pupil nurses' and were under the direction of a Sister Tutor or an experienced sister interested in teaching.

The course consisted of a written test at the end of the introductory course, a written mid-course test on completion of nine months training, and an assessment test at the end of the final course.

The assessment test consisted of a written part in which the pupil nurses were required to give

written answers to two questions and a practical test. If a pupil nurse failed the introductory test or the mid-course test he/she was allowed to sit for a supplementary test. If the student failed the supplementary test, he/she had to repeat the course or training – as the case may be.

No pupil nurse was allowed to enter to the assessment test unless he/she shall have passed the test at the end of the introductory course and the mid-course test referred to at above; and unless he/she had completed the required clinical experience.

During the final course, pupil nurses also had to perform night duties at regular intervals.

The application form for the entry to such test had to be accompanied by the prescribed fee of 10 shillings equivalent to 20 cents.

A pupil nurse wasn't deemed to have passed any of the tests unless he/she had obtained at least 50% of the marks awarded at any such tests and of parts thereof,

The Assessment Test of the pupil nurses for admission to the Roll of Nurses had to be held at the end of the Final Course and at least two months' notice of the relative date had to be given.

Pupil Nurses who failed in such test could sit for a supplementary test after an interval of six months. Those who passed the Assessment Test were eligible for the admission to the Roll of Nurses and thus were eligible for the appointment when vacancies in the grade occur.

Female Enrolled Nurses were required to resign their appointment on marriage.

During the course of training pupil nurses were provided with free meals, free uniforms, as well as free medical attention and treatment in hospital during the periods of sick leave. Male pupil nurses received the following cash allowance for the purchase of books and for personal expenses:

First year of the Course –£160.

Second year of the course – £205.

With effect from 1st April, 1970, female pupil nurses were paid 95% of the above rates, this percentage was increased by a further 5% on the 1st April of the following year when the parity with the male rates was reached. This means that the parity payment in Malta began on 1st April 1971 after it began decreasing slowly by 5% each year.

Applications for the nomination were to be received by the Chief Government Medical Officer at No 15, Merchants Street, Valletta by noon of Saturday, 26th December, 1970, and had to be accompanied by the official certificates of birth, Police Certificate of Conduct, a certificate of education signed by a competent authority and a fee of 10 shillings.

The application forms were obtained from the



From left to right. Angelo Sammut, Carmel Saliba, Louis Abdilla, George Abela and Carmel Micallef at Upper Barrakka Valletta Re-union 2015.

CGMO at 15 Merchants Street Valletta and from the Office of the Commissioner for Gozo as from Monday, 14 the December, 1970.

It is interesting to note that:

- It is to be noted that as from 1970 attention to the teaching of Geriatric and psychiatric care was already being implemented in Malta.

- The Maltese currency was the same as the British.

- The course for State Enrolled Nurse Course in Malta was the same as that in England.

- As from 1969 pupil nurses had a booklet containing the different placements and procedures implemented in different hospitals assigned by each pupil nurse. This had to be filled by the head of the unit or the hospital.

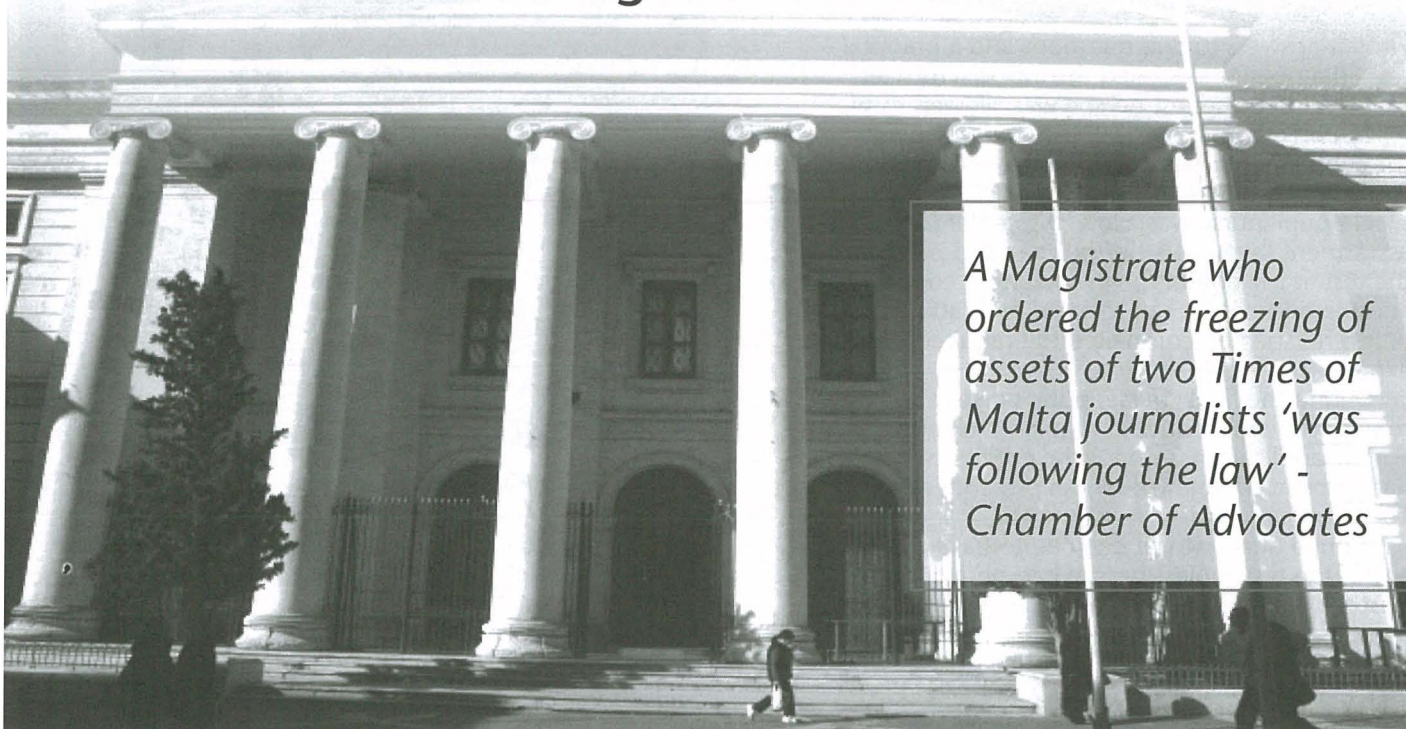
- Our first tutors were Mr. Cordina, Mr. Vancelle and Miss Sloan. Then Miss Muscat was included as a tutor to help as the number of groups of pupil nurses was increasing.

- The number of candidates admitted for a course was mostly female. When male candidates were included the number of male candidates was always five only.

Today this is part of the nursing history in Malta and Gozo. I admit that male pupil nurses had a little increase in cash allowance at that time during the course, but the hardest situation was when I, as a male gender, was being told that the call for admission is for female candidates only. For our class, Group 7, we needed only five male pupil nurses. Ten were successful in the admission examination. Five of us were included within Group 7 and the other five had to wait till were included in Group 9. Group 8 was also for female candidates only.

Carmel Saliba SN, P.G. Dip Ger.

Advocates defend magistrate in Times of Malta garnishee order



A Magistrate who ordered the freezing of assets of two Times of Malta journalists 'was following the law' - Chamber of Advocates

Staff Reporter - Malta Independent, 21st July 2015

The Chamber of Advocates issued a statement in defence of the magistrate who last week accepted an asset freeze on two Times of Malta journalists after the newspaper failed to pay damages it owed.

The garnishee order was issued against head of news Ariadne Massa and editor-in-chief Steve Mallia, on request of former nurses' union boss Paul Pace.

The Sunday Times of Malta carried an editorial expressing its disapproval at the judgments of the Court of Magistrates and the Court of Appeal, saying it was surprised that the magistrate who signed the executive warrant was the same magistrate who had decided the case.

Four MUMN officials were damages by an appeals court in a libel suit against The Times. Two officials subsequently instituted proceedings against the Attorney General before the Constitutional Court contesting the appeals judgement, while two other officials who were not party to the constitutional case, demanded payment of the sum awarded to them with a garnishee order.

"The editorial incorrectly implies that the magistrate, who happened to be the duty magistrate when the warrant was filed, should have, or could have done otherwise. There are very specific circumstances at law that would allow a judge or magistrate refuse to sign a demand for the issue of an executive warrant and the existence of a constitutional case, even

had he been privy to its existence, is not one of them," the Chamber said.

"The editor should have been advised that the magistrate would have acted against the law had he not signed the application for the garnishee order. The claim of the Head of News and the Editor-in-Chief of the Times of Malta that payment of an amount declared due by the Court of Appeal is not payable pending the outcome of the constitutional case, citing as justification a decision in another case that judgments should not be executed pending constitutional proceedings, is at best doubtful and is certainly not established case-law."

The Chamber said that treating the matter as a "vindictive act on us (journalists)" betrayed "a degree of paranoia and a misplaced belief that journalists are entitled to preferential treatment and should be held above the law".

"The Chamber, believes in the importance both of the role of a free press in a democracy and a free and independent judiciary as one of the pillars of the rule of law – but it must voice its concern when in the name of the freedom of the press a newspaper attempts to influence public opinion in supporting it to avoid payment of its dues.

"This is not healthy in a democracy, and the thinly-veiled insinuations against the Magistrate concerned, verge on an abuse of the power that the paper enjoys and unfairly undermines public confidence in the judiciary."



Libel proceedings against The Times were never about the money – MUMN

Malta Independent, Wednesday, 22 July 2015,

Libel proceedings instituted against The Times were never about the money but about the right which the MUMN officials had to defend their good name and repute, a right which has been vindicated not only once but twice by our courts, which judgments, it would seem, The Times is too haughty to accept, the union said in a statement this morning.

MUMN issued the statement in support of and solidarity with its president Maria Cutajar, general secretary Colin Galea and financial secretary George Saliba, together with its honorary president Paul Pace in view of the continued and unwarranted attacks being made on them by the Times of Malta.

These attacks, the union said, follow the issuance of a garnishee order with the authorization of the Court of Magistrates after a Times of Malta journalist and editor failed to pay their dues more than six months after a final judgement was delivered against them by the Court of Appeal.

In an e-article entitled 'Court freezes assets of Times of Malta journalists at request of Paul Pace, ex-MUMN president', as well as in the editorial of last Sunday's issue of The Sunday Times of Malta, the Times, apart from misinforming its readers as to the actual facts of the case, sought to vilify the four plaintiffs by portraying them as some money-hungry parasites who were unable to await the final outcome of the case prior to executing their request for payment, the union said.

Nothing could be further from the truth, it added. The MUMN officials could have sought the issuance of a garnishee order (albeit of a precautionary nature) against The Times editor and journalist in September, 2012, when the first judgement by the Court of Magistrates was delivered.

Not only did the MUMN officials refrain from doing so, but they exerted the utmost caution and only requested the issuance of an executive garnishee order six months after a final judgement had been delivered by the Court of Appeal and after a letter requesting payment went unheeded.

In its efforts to try and vilify the MUMN officials, The Times has only managed to vilify itself with the general public in view of the unprecedented arrogance manifested in its attacks on the MUMN officials and on the Courts themselves, the union said. The Times knows very well - or at least should know - that the filing of a constitutional case to which the MUMN officials are not even a party does not produce a stay in the execution of the court judgement, MUMN added.

The editorial of last Sunday's edition of The Sunday Times attempts to misrepresent the issuance of the garnishee order as a vindictive attack rather than for what it really is - that is, the legitimate recourse to judicial action by creditors against recalcitrant debtors, MUMN said.

NHS bosses paid by drug firms

Senior NHS staff are being paid thousands of pounds and taken on expensive trips by drug companies lobbying to get their products used by the health service, the Daily Telegraph can reveal.

Senior health staff who help decide which drugs are used by GPs and hospitals are being paid to work as consultants for pharmaceutical companies who want the National Health Service to "switch" to medicines they produce.

An undercover investigation has found that some NHS staff charge up to £15,000 to organise "advisory board" meetings for drugs companies.

- **UK medical professionals paid £40m last year by drug companies**

Many of the meetings take place in five-star hotels around the world, with some attendees telling this newspaper that they were taken to "flashy" restaurants and paid large sums while considering whether to "switch" drugs.

Health service staff who take part in "advisory boards" for pharmaceutical companies argue that their involvement helps them to make "best use" of NHS money by analysing drugs and providing expert advice.

However these disclosures will prompt concerns about a potential conflict of interest between NHS staff and drugs companies and raise questions about the impartiality of public sector staff who control budgets worth millions of pounds.

There are also concerns that, if drugs were being switched for financial, rather than medical reasons, it would not be in the best interests of patients.

NHS England and the Department of Health pledged to investigate the findings of The Daily Telegraph investigation. A spokesman for NHS England said: "These are extremely serious allegations so we have immediately directed NHS Protect to launch a full investigation of each and every case identified by this press report".

- **Coalition has put the NHS up for grabs**

A Department of Health spokesman said: "If these allegations are true, this is completely outrageous and amounts to an abuse of the trust that patients place in NHS staff. The NHS fraud protection body has launched an urgent investigation and we expect each Trust and Clinical Commissioning Group involved to launch a full inquiry."

The investigation identified two senior NHS managers who openly spoke about being paid

fees and accepting hospitality from pharmaceutical companies in exchange for sitting on the advisory boards. Undercover reporters posed as representatives of a pharmaceutical company selling an epilepsy drug and an adrenalin pen.

Omar Ali, the part-time formulary development pharmacist for the Surrey and Sussex NHS trust boasted that he had a "network" of more than 100 "payers" – NHS officials who sit on boards that decide which medicines are given to the public. The Trust said he had resigned.

He said each payer, involved with allocating budgets of up to £60million, would need to be paid £1,000 a day to attend an event in Dubai hosted by a drug firm. "I'm talking about the payers who will make a decision on which drug they have on the formulary," he said. He would charge £15,000 to organise the event, which he said would "give you a competitive edge".

- **Drug companies accused of blocking access to cheap drugs**

He suggested running a two-day meeting in Abu Dhabi or Dubai.

He added: "Each payer is also a customer... So whilst we're asking them for advice, we're also seeing if they might want to play ball."

Drugs are generally signed off by committees of which payers are members. Mr Ali said he could not "unilaterally" decide to switch to the firm's drugs, "especially as I'm working together with you on this".

Another NHS staff member, who was offering to organise a similar trip for representatives of a drug company, said that he and a colleague would charge £5,000 to arrange a two-day trip in Europe for NHS staff.

- **Doctors using NHS in 'abhorrent' way to push private practice**

Paul Jerram, the head of medicines management at the Isle of Wight Clinical Commissioning Group, revealed he had recently attended a meeting in Germany at which a company took 12 "payers" to "one of the top 10 hotels in the world". He claimed that each delegate was paid £500 a day to attend and all of those who were invited "switched" to the drug company's product after the trip. Several attendees separately admitted they attended, but denied they had changed medicines afterwards.

CCGs and hospital Trusts make decisions on which medicines should be used across the country – from GP surgeries to hospital wards.

The Isle of Wight CCG said it was launching an investigation, with which Mr Jerram told The Daily Telegraph he was "co-operating fully".

- **Pharmaceutical scandal: The NHS, the drug firms and the price racket**

"I believe that I have acted in the best interests

of the NHS seeking the most effective medicines for the benefit of patients and the wider NHS. In view of the investigation it would be inappropriate for me to comment further at this time," he said.

Michael Wilson, the chief executive of Surrey and Sussex NHS Healthcare Trust said that Mr Ali had "correctly declared his independent business with us", although, "we do not have knowledge of work that he undertakes in his own personal time".

Mr Ali said he had "never allowed my NHS work to be influenced by my other activities". His fees are "lower than most in the sector", he added.

Mr Ali said: "Since I had been told the client was based in India, holding the meeting in Dubai seemed geographically sensible." He said it was important for the NHS to engage with private companies to get the best treatment for patients.

Additional reporting by Melanie Hall

How the system works:

Clinical Commissioning Groups (CCGs)

- CCGs and Hospital Trusts make decisions on which medicines should be used across the country – from GP surgeries to hospital wards
- There are 209 CCGs operating in England, having replaced Primary Care Trusts in 2013, and they control 60 per cent of the NHS's annual budget - some £60billion
- The total NHS spend on medicines is around £7billion per year

How CCGs decide on drugs

1. They appoint committees to decide whether healthcare providers should switch from one drug to another – based on guidelines set by NICE, local budgets and their own experience
2. Their choices are supposed to be entirely independent of outside interests
3. In pharmaceutical circles, the health officials who take part in deciding what drugs are adopted are known as 'payers'

How it works in practice

- The 'payers' tell doctors which medicines are 'in', which are 'out', which should be introduced gradually, and which should be tailed off
- For pharmaceutical companies, finding a way to have their new drug at the top of a GP's list of preferred products can be crucial to their financial success
- The CCGs use special computer systems to give GPs prescription advice. Medicines are listed alphabetically - however decision-makers can use certain software, which allows them to promote their preferred products. Doctors may or may not accept CCG recommendations.

**By Claire Newell, Edward Malnick,
Lyndsey Telford, Luke Highton
and Syed Fayaz**

NHS England announces new plan to meet emergency care targets

GP services in hospitals, mobile treatment centres and mental health street triage among measures rolled out to try to meet A&E treatment targets

James Meikle

A drive to make more one-stop shops for urgent and emergency care will be announced on Friday as the NHS in England seeks to remedy its failure to meet its target for dealing with 95% of A&E patients within four hours last winter.

NHS England announced eight "vanguard" areas to transform services. Among the measures are the acceleration of the development of GP services in hospitals, mobile treatment centres using ambulance staff, and same-day crisis response teams including GPs and other acute home-visiting professionals. More mental health street triage services will also be rolled out, along with initiatives involving a broader role for community pharmacists.

The moves, designed to break down barriers between primary care and hospitals, are among £200m worth of experiments. The NHS hopes these will be as successful as the setting up of regional major trauma units three years ago, which are said to have brought about a 50% increase in the odds of survival for patients and saved hundreds of lives.

The new vanguards are in south Devon and Torbay, south Nottinghamshire, Cambridgeshire and Peterborough, north-east England, Leicestershire and Rutland, Solihull, west Midlands, the east London area covering Barking and Dagenham, Havering and Redbridge and west Yorkshire.

Keith Willett, NHS England director of acute care, said: "This proves a modern NHS needs a very different approach and shows, even in times of austerity, we can transform patient care. We cannot delay in now securing that same advantage for the thousands of other patients – such as those suffering a heart attack, stroke, or aneurysm, as well as helping critically-ill children.

"Equally important is that these networks support and improve all our local urgent and emergency care services, such as A&E departments, urgent care centres, GPs, NHS 111 and community, social care and ambulance services, so no one is working isolated from expert advice 24 hours a day. Our vanguard sites will spearhead these new ways of working together."

He added: "The solution does not lie in simply providing more and more money to emergency departments. It's clear that we need to deliver a step change in the way that health services in this country are used and delivered.

"All over the country there are pockets of best-practice models yielding enormous benefits; but to ensure our urgent care services are sustainable for the future every region must begin delivering faster, better and safer care."

Shift workers more likely to get cancer, scientists warn

ROSE TROUP BUCHANAN
TUESDAY 21 JULY 2015



Shift work is more likely to give you cancer, according to new research.

The study, published in *Current Biology*, claims that irregular sleeping patterns “unequivocally” led to breast cancer in mice.

Although scientists cautioned that the results needed further tests on human, they said women with a history of breast cancer should never work shifts.

The findings support previous research that has suggested health dangers linked to working irregular hours, such as shift workers or flight attendants.

Scientists have suggested that by disrupting the body’s internal clock – known as the circadian rhythm disturbance (CRD) – increases the chances of getting cancer.

However, researchers have been unable to find causal evidence to support their theory, with many suggesting the link may be because of factors such as social class, activity, or vitamin D levels.

The latest study, which used mice, circumvents some of the problems associated by examining humans for this theory and found that mice who had their body clock delayed by 12 hours every week for a year showed a “decrease in tumour suppression.”

The animals, who are prone to breast cancer, usually develop tumours after 50 weeks – but circadian disruption meant scientists found tumours eight weeks before that.

“This is the first study that unequivocally shows a link between chronic light-dark inversions and breast cancer development,” the report claims.

An additional finding was the mice under these pressurised situations put on more weight than mice in the control group.

Researcher Gijsbetus van der Horst, from the Erasmus University Medical Centre, in the Netherlands, said: “If you had a situation where a family is at risk for breast cancer, I would certainly advise those people not to work as a flight attendant or to do shift work”.

Trauma survival rates rise by 50 per cent, according to NHS England

CHARLIE COOPER
HEALTH CORRESPONDENT

The chances of surviving a major trauma injury have improved by 50 per cent in the past three years, the NHS in England has said.

New procedures which see seriously hurt patients taken swiftly to the nearest major hospital, rather than to smaller hospitals, even if closer, are thought to lie behind the improvement.

While it cannot be said for certain how many lives the new Regional Trauma Networks have saved, NHS England said that “hundreds” more patients had survived since they were introduced in 2012. Now the technique will be rolled out for cases of heart attack, stroke and aneurysm across 23 “urgent and emergency care networks” throughout England.

The health service has also seen early success with a pilot scheme in which ambulance call handlers are given two extra minutes to determine whether a vehicle should be sent out to people who are calling with serious but non-life threatening problems.

Tests of the system carried out in London and South-west England have led to a decrease in ambulances being dispatched unnecessarily, with no major safety issues, according to figures seen by Sky News.

Neil Le Chavelier, the director of operations for South Western Ambulance Service, said the extra two minutes gave call handlers time to assess if, for example, someone complaining of chest pains was having a heart attack or a suffering from a less serious condition. He added the system freed up ambulances for patients who most needed them.





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