IL-MUSBIEH

MALTA NURSING AND MIDWIFERY JOURNAL

Malta Union of Midwives and Nurses

No.69 - Diċembru 2015

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contents

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Ħarġa nru. 69

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Pubblikat: Malta Union of Midwives and Nurses

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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.

Ċirkulazzjoni: 3400 kopja.

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

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

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

Il-Musbieħ jiġi ppubblikat 4 darbiet f'sena.

Ritratt tal-faċċata: Uffiċċju President ta' Malta

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

Editorial

Unsocial hours payments?

It is high time that Nurses and Midwives in Malta start negotiating with the authorities with regards the issue of unsocial hours payments as additions to the basic pay. These apply for staff that works standard hours, within the normal working week. For example in some countries, unsocial hours payments are worked out using basic salary and if Nurses are working on Saturdays from midnight to midnight and if they are working on any week day after 8 p.m. and before 6 a.m., they are remunerated even up to 'Time plus 50% or 44%'.

Weekends were invented to refresh oneself by making contacts with friends and family and to make time to revive the inner being. One must be paid more if the time is used as any other day. These unsocial hours need to be compensated as they may damage one's health or a family life. Nurses do not live to work, they work to live. Nurses and midwives often have health problems associated with working unsocial, and often long, hours, which warrants additional pay as compensation. Faithful nursing staff that strive to care for their patients deserve better.

Unsocial hours payment is also an initiative for young people to join the Nursing workforce in our public hospitals, therefore increasing considerably the Nursing compliment. Healthcare providers and their families suffer due to inadequate staffing numbers and many are looking for different employment already. Such a measure will ensure that most of us will think otherwise.

Unsocial hours must also be clearly defined under Public Service Commission regulations and must respect Work Life Balance policies. One augurs that such a matter is taken seriously by all concerned for the benefit of the Nursing and Midwifery profession.

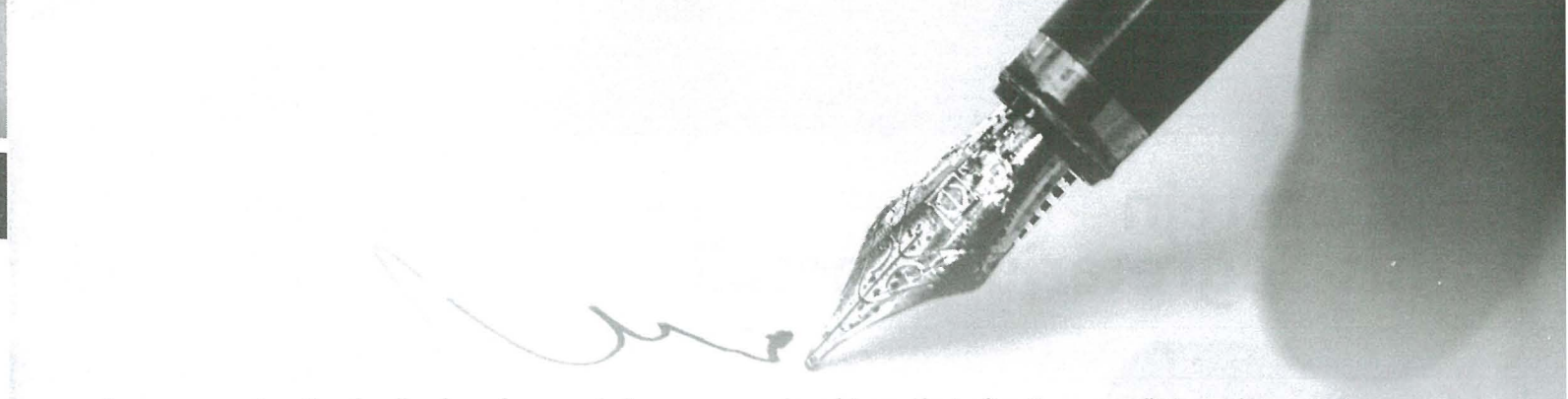
President's message

Dear colleagues,

As I sit down to write this edition's note, I realize that another year is almost over, with many of us including myself preparing for the Christmas season. I don't know about the rest of you, but during this time of the year, I tend to get caught up in all the hustle and bustle of Christmas, becoming stressed out as I try to "get ready" for the Christmas season. With Christmas just around the corner, it is easy to get so busy with the cooking, decorating and shopping that occasionally we may forget why we're doing all this in the first place. Sometimes, the very people we love get lost in the busy days of packed schedules, holiday parties, and Christmas musicals.

Yet again, despite being in the Christmas season, union matters still keep popping up and we keep full speed ahead with the work of a dynamic union. As we approach year-end, it is both useful and appropriate to review the accomplishments of the MUMN in 2015. While reflecting on the past months' work, I reckon that as a union the MUMN had accomplishments, projects in progress and work still needing attention. To me, one of the items I am most pleased with is the increase in the MUMN membership – and the council is welcoming it with open arms. It would seem the time being devoted to individual follow-up with members, holding meetings with members at ward or hospital level, the 'Il-Musbieh' coming to our members quarterly, the use of emails as an informative and consultative process and the increased use of social media have had some impact. These forms of communication together have provided a mechanism to give the members current, important information regarding both their union and their individual practice parameters. With hindsight, the work and the realisation of the MUMN achievements, represents our commitment to enhance the professions the MUMN represent. Yet again, as a union we're committed that the projects or issues needing attention will be worked upon.

In my last President's note, I wrote that work was progressing well to find avenues where we as a union have a consultative process with our members. As I look back at the past quarter, I am quite proud and pleased at what has been accomplished by our union. This presidency is not a one man/woman show nor is working within one's castle amenable to growth and productivity. The past few months have been quite hectic for the MUMN. It is my goal and that of the council to be transparent and our decision to take a consultative approach with our members was a very efficient one. Through this process, as a union we continued to be grounded firmly in our commitment to be there for our members. Taking this decision and use a consultative approach, has brought you as members more on board and has made our decisions more members focused - much thanks to all of you,



for your constructive feedback and support. As a union we are working to enhance the social media role within the union. The use of online tools has given the union, the opportunity to obtain more in-depth information from our members. One of the goals for the use of information technology to keep in touch with our members via different means is not only to inform our members about recent achievements and forthcoming events but also to stimulate healthy discussions on issues pertinent to future developments of the professions we represent. All around this effort seems to be a win-win for all. Your union is looking for constructive feedback to continue working in the best interest of the members, so let us hear from you.

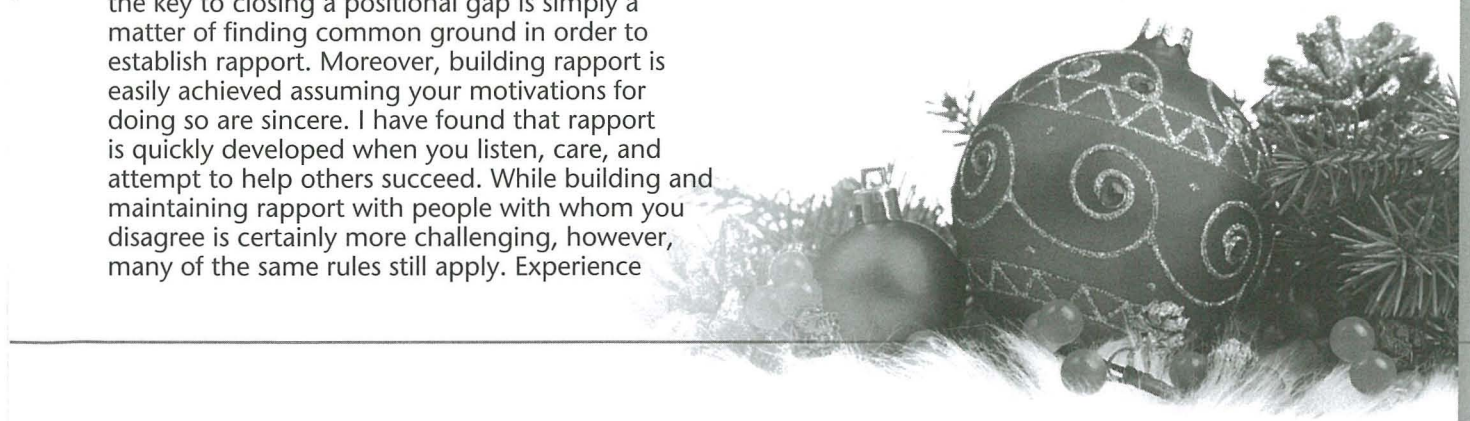
On another note, it can be noted that this is a very exciting time for the health care in Malta. With changes in health care and healthcare initiatives, the need to educate more nurses and other health care professionals to meet the demands for healthcare services has never been greater. Such changes bring with it other opportunities and challenges. Nonetheless the MUMN is well-positioned to face these opportunities and challenges with our outstanding commitment. During the past months, as a union we held various meetings with the management of various health care entities – further information on what was achieved will be found in the General Secretary address. During these meetings, there were serious issues to discuss and unusually for a potentially disparate group, in most cases harmonious consensus was reached on a number of key matters. I'm not saying that both parties reached a consensus in a blink of the eye. Have you ever been leading a meeting or in situation where you wanted to get to a certain point but others wanted to get to another? Everyone has been there. It is natural to want to surround yourself with like-minded people so this does not happen. It may be comforting, it might even seem like a good idea, but it's not great leadership. What I like to refer as "positional gaps" are best closed by listening to all sides, finding common ground, and then letting the principle of doing the right thing guide the process. During the years, I learned that regardless of a person's original intent, opinion, or position, the key to closing a positional gap is simply a matter of finding common ground in order to establish rapport. Moreover, building rapport is easily achieved assuming your motivations for doing so are sincere. I have found that rapport is quickly developed when you listen, care, and attempt to help others succeed. While building and maintaining rapport with people with whom you disagree is certainly more challenging, however, many of the same rules still apply. Experience taught me that oftentimes conflict resolution just requires more intense focus on understanding the needs, wants, and desires of the other party. If opposing views are worth the time and energy to debate, then they are worth a legitimate effort to gain alignment on perspective and resolution on position. However, this will rarely happen if lines of communication do not remain open. Over the years, I have watched many great leaders and have observed some key actions that each display. These actions are consistent with what we hear and learn about in leadership classes. Putting these actions into practice may seem difficult, but often it is not. During the years, trade unionism experience taught me that it is important to pick your battles and avoid conflict for the sake of conflict. However, if the issue is important enough to create a conflict, then it is surely important enough to resolve it. If the issue, circumstance, or situation is important enough, and there is enough at stake, people will do what is necessary to open lines of communication and close positional gaps. By actually seeking out areas of potential conflict and proactively intervening in a well-reasoned and decisive fashion, you will likely prevent certain conflicts from ever arising. If a conflict does flair up, you will likely minimize its severity by dealing with it quickly. This is how your union is working, and continuously striving to support and look after the interests of all professions it represent.

To close up this edition's note, I would like to extend a heartfelt thank you to all council members and the office administrators who are always enthused and dedicated to pushing the values of the MUMN. I also thank all of our tireless group committee members who give so generously of their time.

During the Festive season more than ever, my thoughts turn gratefully to those who have made our progress possible. And in this spirit I say, simply but sincerely - thank you and best wishes. May this Christmas be bright and cheerful. May the New Year be blessed with peace, love and joy. Sending my heartfelt season wishes to all of you and your families.

Until next time.

Maria Cutajar, MUMN President



Kelmtejn mis-Segretarju Ġenerali

Is-sena d-dieħla l-MUMN tiċċelebra l-20 sena anniversarju mit-twaqqif tagħha, preċiżament fid-19 ta' Settembru 2016. Il-Group Committee responsabbli mill-attivitajiet qed iħejji programm apposta sabiex kollha flimkien niċċelebraw kif jixraq dan l-avveniment. Tajjeb li ninfurmakom però li f'din il-ġurnata partikolari ser ikun hemm sorspriża eċċezzjonali...

Is-sena d-dieħla l-Kunsill tal-MUMN ser iressaq ukoll il-proposti lill-Gvern biex jiġi milħuq Ftehim Settorali ġdid għan-*nurses* u l-*midwives*. Il-Kunsill ġabar ma' tiegħu dawk il-proposti li ressaqtu intom sabiex dan il-Ftehim ikun jirrifletti t-talbiet u x-xewqat tagħkom. Fil-preżent għaddejjin ukoll bid-diskussjonijiet sabiex jintlaħqu żewġ Ftehim Settorali oħra għas-*social workers* u l-*ecg technicians*. Konvinti li s-sena d-dieħla nżidu wkoll dak tal-*physiotherapists*.

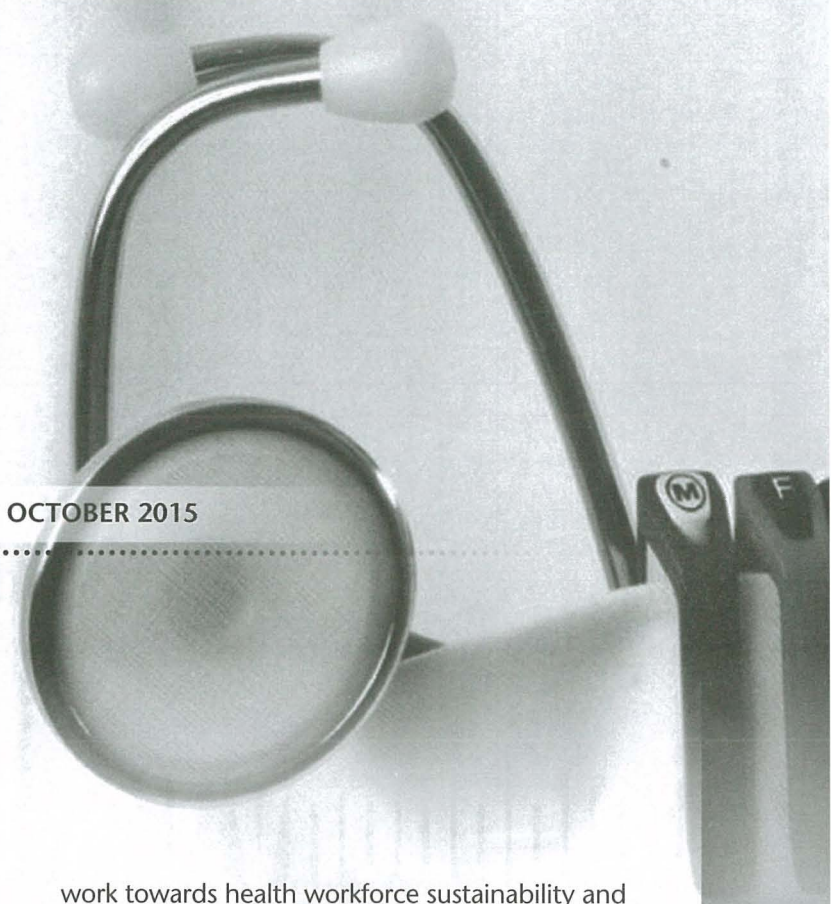
Ftit tal-ġimgħat ilu bagħtna wkoll l-informazzjoni dwar il-konferenza tal-Commonwealth li ser issir f'Londra fit-12 u t-13 ta' Marzu 2016 u tagħrif ieħor dwar is-sussidju ta' l-MUMN għall-membri tagħha. Din il-konferenza, fost affarjiet oħra, isservi ta' *platform* għal dawk li jkunu ser jippreżentaw *paper* għall-ewwel darba. Hija konferenza sabiħa u fl-istess ħin interessanti għax niltaqgħu ma' numru sostanzjali ta' *nurses* u *midwives* ġejjin mit-52 pajjiż tal-Commonwealth.

Għal dawk li jħarsu 'l quddiem biex jattendu xi konferenza interessanti nixtieq ninfurmakom li f'Mejju tas-sena 2017 ser tiġi organizzata l-konferenza tal-International Council of Nurses ġewwa Barċellona. L-aħħar konferenza tal-ICN saret fil-Korea u kien hemm preżenti 'l fuq minn 5 t'elef *nurse* minn madwar id-dinja. Is-sensazzjoni li tħoss ma tistax tispjegaha. Barra minn hekk matul il-konferenza ser ikun hemm ukoll l-elezzjoni tal-*Board Members* tal-ICN fejn ġie deċiż li Paul Pace ser jerġa' jikkontesta f'isem l-MUMN għal 4 snin oħra. Dawk kollha li jippjanaw kif ser iqassmu l-fondi tas-CPD, ħudu nota fuq din il-konferenza.

Bħal ma kulħadd jaf qegħdin isiru bosta laqgħat mal-*management* tal-isptarijiet kollha u postijiet oħra tax-xogħol dwar il-problemi li qed isibu l-membri waqt il-qadi ta' dmirijietom. Il-Kunsill tal-Union qed isib għajnuna tremenda mill-*Group Committees* kollha sabiex l-MUMN tkun viċin il-membri tagħha. F'dawn il-laqgħat qed jinstabu s-soluzzjonijiet u fejn le l-MUMN qed tirrikorri għad-Direttivi Industrijali.

Nixtieq nagħlaq dawn iż-żewġ kelmtejn billi f'isem il-Kunsill tal-MUMN nawgura lilek u l-familja tiegħek Milied Hieni u Sena Ġdida Mimlija Saħħa, Risq u Barka.

Colin Galea, Segretarju Ġenerali



International Council of Nurses' Workforce Forum 2015 calls for safe staffing levels and a better future for patients and nurses

GENEVA, SWITZERLAND; HELSINKI, FINLAND; 7 OCTOBER 2015

The International Council of Nurses' (ICN) 21st International Workforce Forum 2015 was held in Helsinki, 28-30 September 2015 to discuss the situation of human resources and working conditions in the nursing profession. A Communiqué was released following the meeting which called on all governments to recognise the imperative for nurses to be involved in healthcare decision making and reaffirm the value of nursing in the delivery of quality healthcare.

Hosted by the Finnish Nurses Association, the International Workforce Forum (IWFF) brought together nursing experts from Canada, Denmark, Finland, Ireland, Japan, New Zealand, Sweden and the United States of America. Topics of discussion included: bullying, safe staffing, retention of nurses, lobbying strategies and skills, and a training session on negotiating agreements. Two priority areas for ICN, Universal Health Coverage and the WHO Global Strategy for Human Resource for Health 2030, were also on the agenda.

The Forum was led by Lesley Bell, ICN Nurse Consultant, who commented, "The participants spoke passionately about the role of nurses in providing people-centered primary care, recognising that there is no healthcare without a workforce and no workforce without adequate nurses and midwives working to their full scope in positive practice environments."

Christiane Wiskow, a Specialist in the Health Services Sector of the International Labour Organization (ILO), discussed the ILO Nursing Personnel Convention which recognises the vital role of nursing personnel and sets minimum labour standards specifically designed to highlight the special conditions in which nursing is delivered.

"The competition for qualified health workers will grow in the next decades both inside the countries and globally. Poor working conditions, low pay and limited career opportunities are significant factors contributing to increasing healthcare workers' migration and also to the early exit of nurses from the healthcare sector," Wiskow said.

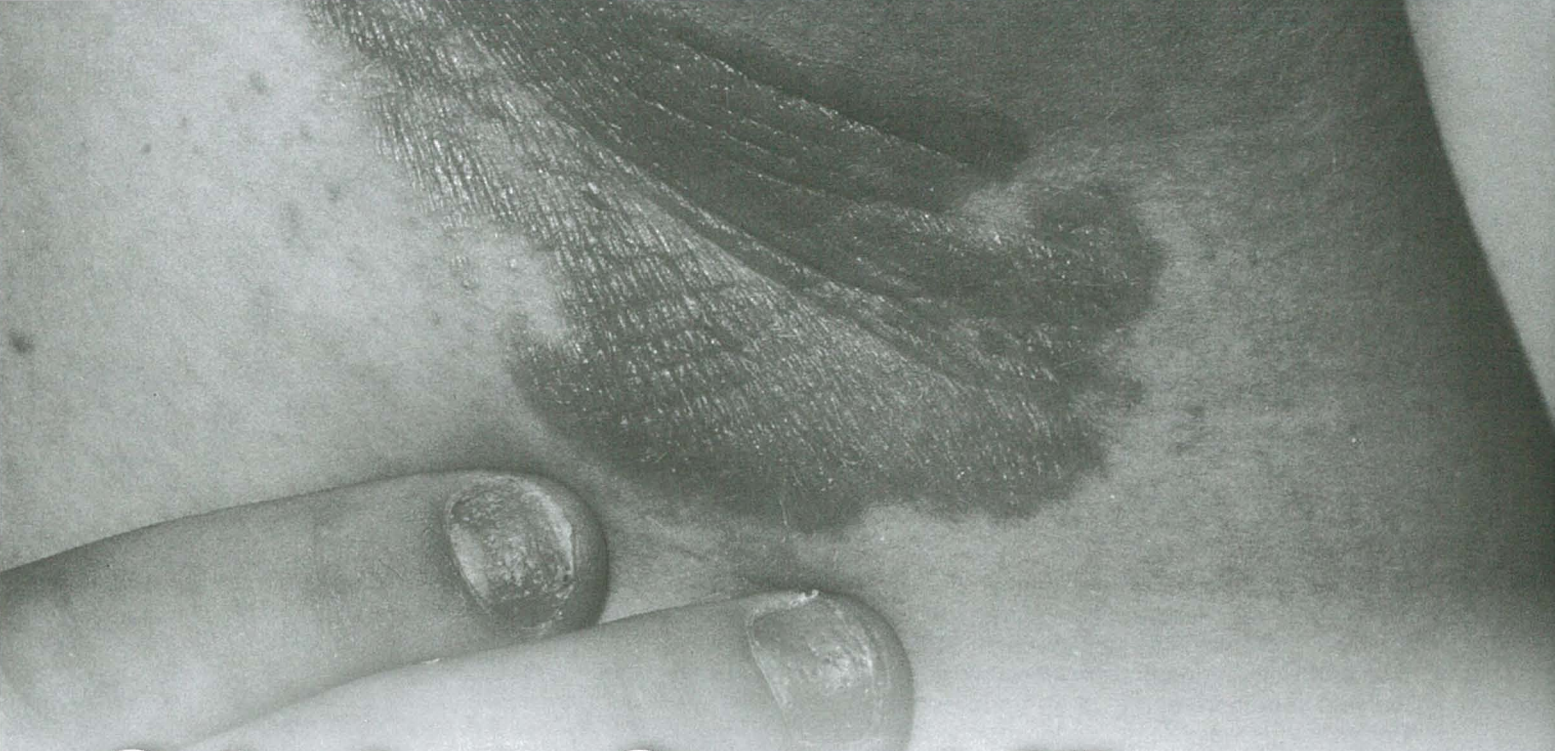
The unequal distribution of health workers is problematic both at global level and within countries between rural and urban areas because it implies inequities in access to health care, Wiskow pointed out. It is important that countries work towards health workforce sustainability and invest sufficiently in health personnel.

"This does not only mean that we invest in educating more health workers," Wiskow added. "We also need employment opportunities, good working conditions and wages that can provide for their living."

"The effects of the deteriorating economy are already evident globally in the reduction of eligibility criteria for nurses, wage cuts and bargaining with the quality of care and patient safety," said Merja Merasto, the President of the Finnish Nurses Association. She added that the situation is worrying from the perspective of nurses as well as patients. Cuts will not improve the effectiveness of health care or the appeal of the sector. On the contrary, it is now that new methods should be tried out, such as new forms of work distribution, expanded job descriptions for nurses and solutions to ease the combining of working and family life.

The government of Finland is currently trying to restrict the rights of registered nurses to free collective bargaining. The nursing leaders in attendance declared their solidarity with the Finnish Nurses Association and Tehy, the Union of Health and Social Care Professionals in Finland,and called on the Finnish government to protect and enhance the rights of nurses.

The ICN's International Workforce Forum is an annual gathering that probes and debates nursing workforce issues and working conditions. ICN also holds regional Workforce Forums which stimulate thinking, enhance learning and ultimately to develop proactive strategies. The Forums also assist to maintain the relevance of ICN programmes and support international work. More on ICN's Workforce Forums, including country report and database summaries can be found here: www.icn.ch/what-we-do/icn-workforce-forums/



Colophony Contact Allergy

PART 2

The previous article mainly dealt with the clinical issues of colophony contact allergies. The aim of this article is to explain in more detail about possible, un-intended causes of exposure. Due to its various properties, colophony is used in a range of different products, and exposure to it, or its derivatives, is very common.

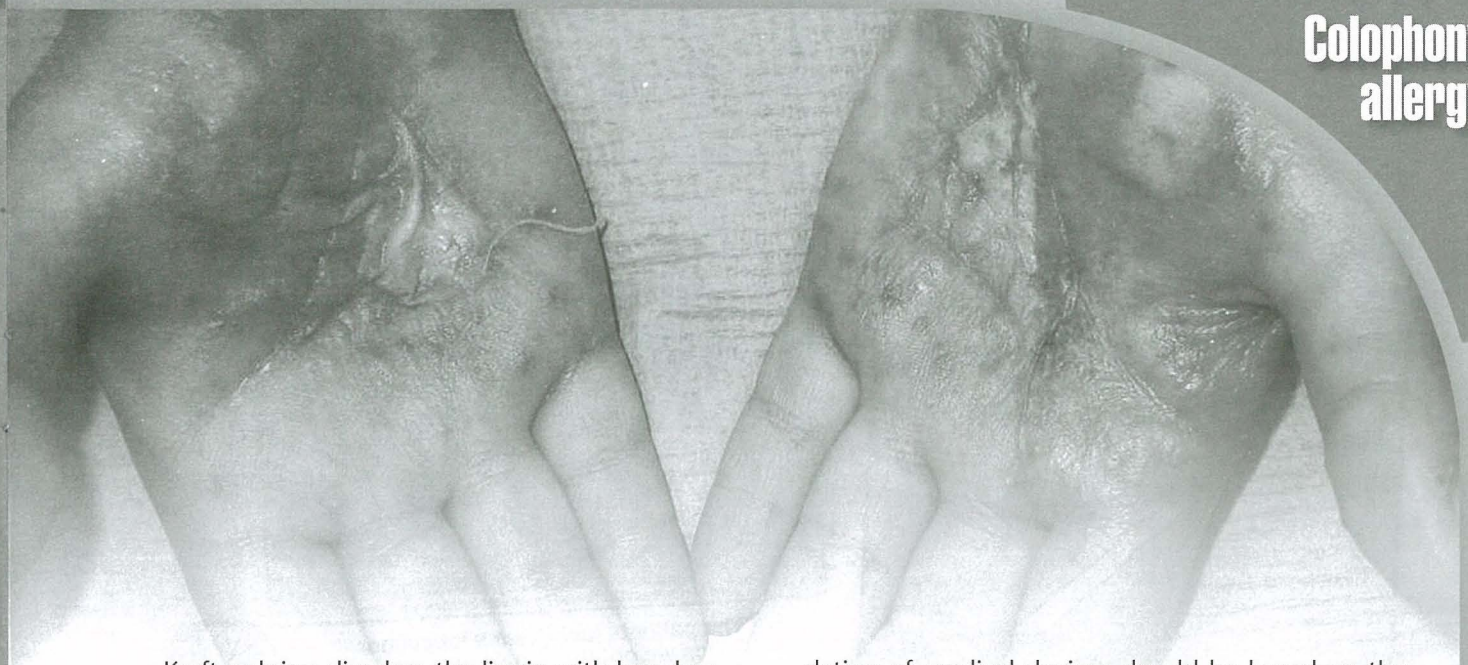
Colophony is often used in cleansing agents for leather and clothes, disinfectants and insecticides, fireworks, newspaper, paints, epoxy resin and violin bow rosin. However, it can also be found in chewing gum, cosmetics such as eye-shadow, mascara, rouge, soaps, sunscreens, dental floss, and also in tacky preparations to prevent slipping, in athletic grips and sports handles (golf, tennis). The main allergens in colophony are its oxidation products and the resin acids formed during modification. Colophony can either be an additive in the manufacture of medical devices or else it could be a naturally occurring substance in the components of a device.

Colophony as additive: As seen in the previous article, colophony can be used as a plasticiser in adhesive plasters, as the tackifying agent in certain hydro-active wound dressings, in surgical drape adhesives and other medical devices. It is also used to enhance the touch and quality of clothing in disposable surgical wear. Since, the best way to minimise risks of colophony contact allergy is to avoid using products containing it or its derivatives, one has to check the chemical content of medical devices being used. This can be done by consulting the product label, material safety data sheets or contacting the manufacturer.

However, since colophony and its derivatives have many synonyms, it is very important to be aware of such names by which it may be identified. The following is a list of the most common synonyms: Rosin, Abietic acid, Abietic alcohol, Abietyl alcohol, Abitol, Methyl abietate alcohol, Dercolyte ZS, Dermatol 18, Dertophene 18, Foral 105, Granolite SG, Staybelite 10, Gum rosin, Resina terebinthinate, Tall oil, W-W wood rosin, Hercolyn D.

Colophony as a naturally occurring substance: is found in paper products, such as diapers, incontinence pads and feminine hygiene products, where the main component is cellulose. A study conducted in Sweden clearly showed that cheap quality continence care products can be the source of exposure to colophony resulting in incontinence associated contact dermatitis. The author discussed that the method of extraction of cellulose fluff from wood, greatly influences the colophony content in the fluff being used for the absorbent layer in such continence devices. In this manner, it directly influences the allergenic potential of such devices. Whereas chemical pulp had traditionally been used for the fluff, less expensive mechanical pulp is recently being used for cheaper continence products. Wood pulp is prepared by either chemically or mechanically separating cellulose fibres from wood. Mechanical pulping involves grinding of wood, resulting in physically tearing the cellulose fibres one from another with most of the lignin remaining adhered to the fibres[12]. The hydrophobic nature of lignin may also interfere with the absorption capacity of mechanical pulp when compared to that of Kraft pulp. Kraft or Chemical pulping degrades hemicellulose and lignin, which glues the fibres to each other in wood, into small water-soluble molecules, which are then washed away from the cellulose fibres.

Colophony allergy



Kraft pulping dissolves the lignin with less damage to the cellulose, thus resulting in longer more flexible and more porous cellulose fibers when compared to mechanical pulp. During this chemical process, rosin soap rises to the surface, and is skimmed off. Kraft pulp, hence, consists of almost pure cellulose fibres with most of the colophony content removed. This is a very important factor, since development of colophony sensitivity mainly depends on the length of exposure, the concentration of the allergen, the site of exposure and skin integrity. Concentration of colophony in continence devices should be kept at a minimum, because these devices are in constant contact with the skin for long periods of time and skin integrity in such individuals is compromised due to occlusion and irritation, and hence risks of allergies are greater.

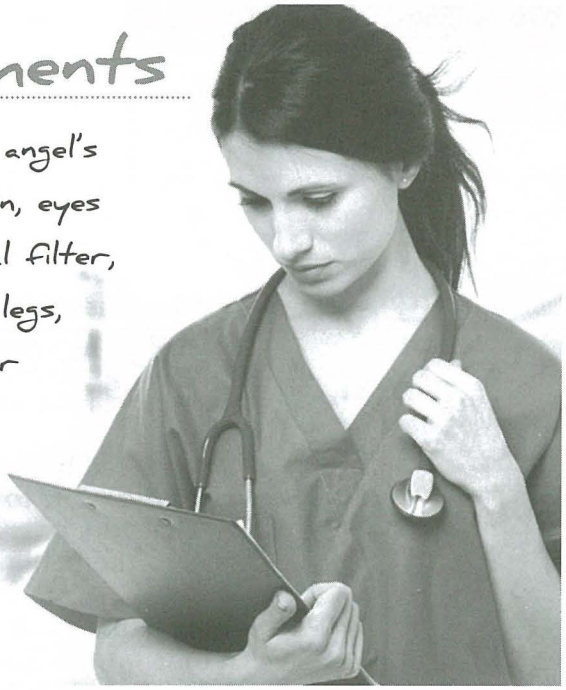
In patient centered care, where recommendation of medical devices should be based on the best possible outcome expected, it is very important for Healthcare professionals to be well informed about the different devices available on the market. They should be aware of both physical and chemical properties of medical device components and their possible colophony content, since these may greatly influence the out-come of their clinical interventions.

"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)

Nursing Requirements

(to have) the memory of an elephant, an angel's patience, a heart the size of the sun, eyes on the back of your head, a nasal filter, 8 arms like an octopus, resistant legs, a back strong enough to hold and transfer full grown adults, a 5-liter bladder and an impenetrable immune system. Even so, they say this is an easy profession. Share this to your wall if you are proud to be a NURSE.

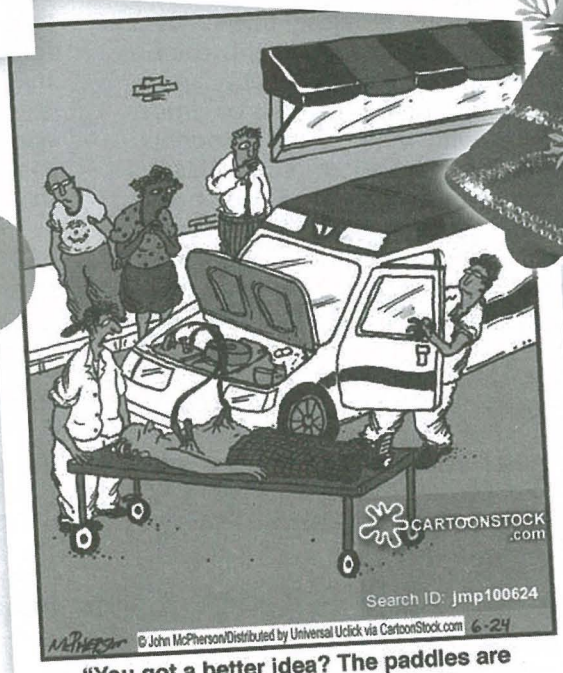


Humour Page

"Kevin! Put this clean underwear on before you get to the hospital!"

"The patients just seem a lot calmer since we got these new IV bags."

Obsessive Compressive Disorder: The irresistible urge to burst bubble wrap



"You got a better idea? The paddles are BROKEN. Just turn the key."

Happy Nurses Week

Jingle Bells *(nurses style)*

Dash-ing through the ward
No help on the way
In ste-rile fields we go
Char-ting all the day

Pa-tients call bells ring
Makes me want to cry
Oh what fun, pass-ing out
Meds to them all night

Jin-gle bells, pa-tient smells
Ad-mits on the way
Oh what fun it is to work
E-very hol-i-day

About a Nursing Student

"Thanks to nursing school, I didn't have to buy a costume to make me look like I've been dead for years."

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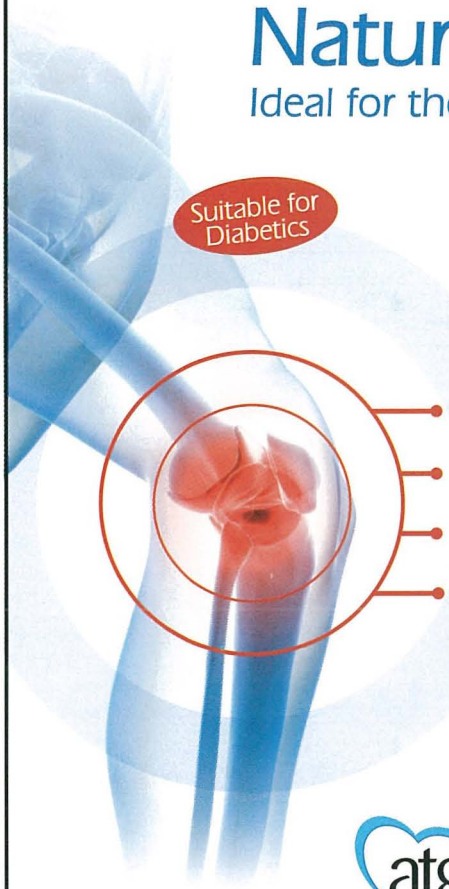

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Anne-Marie Conway

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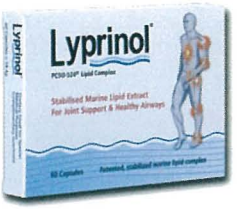

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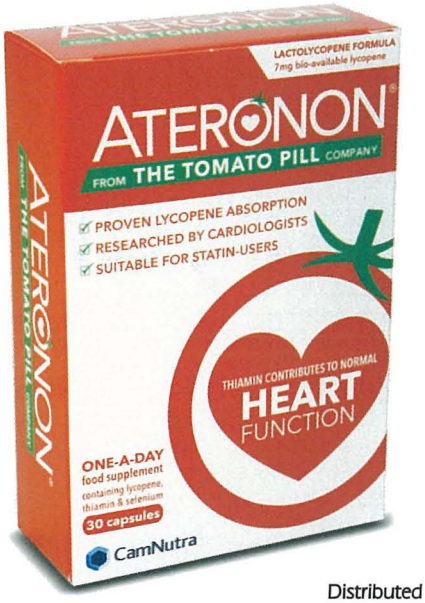

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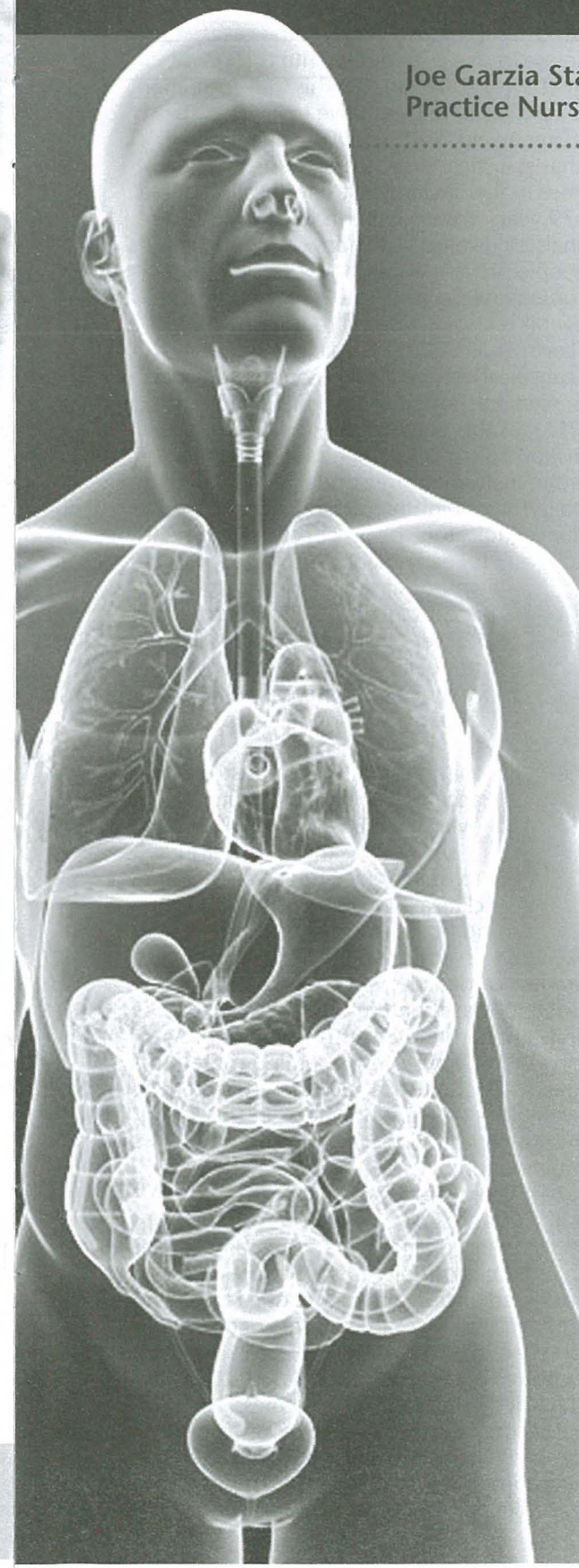
Colorectal Cancer
Screening, a life saving opportunity



Joe Garzia Stafrace BSc (Hons) Health Science, RN, CGN
Practice Nurse Gastroenterology

The US Office of Disease Prevention and Health Promotion (2010), in its' Healthy People 2020 national agenda, recommended that access to comprehensive and quality health care services are important elements necessary for the achievement of health equity and for increasing the quality of a healthy life for everyone. This fundamental approach embraces access to preventive services and awareness programmes that aim to prevent diseases through early detection of pathology before such pathology presents itself (Champion and Rawl, 2005). Cancer screening is a strategy that aims to detect cancer early when it is potentially most treatable in asymptomatic individuals (Mahon, 2000, p. 19). This yields significant decreases in cancer morbidity and mortality (Hiatt and Rimer, 1999). Cancer of the large bowel is a pathology that can manifest itself at a very late stage of the disease and individual symptoms may be poor predictors (NICE, 2005). Therefore creating conditions in which individuals and communities have control over their lives, such as pre-empting the disease through screening, prevents unnecessary interventions and late complications (Marmot, 2010).

This reasoning is valued more when one is presented with late-stage disease cases that could have easily been prevented if information, health education and screening practices were available indiscriminately to everybody and at the opportune time. Emmons et al. (2008, cited in Oliver et al. 2012, p. 94), in their study on 692 unscreened participants, concluded that when apprehension and awareness on the importance of screening is delayed beyond the age of 50, there will probably be a delay in screening uptake which may ultimately result in increased incidence in CRC morbidity and mortality. Health practitioners know that lives can be saved, and advanced pathologies and serious medical conditions can be avoided if individuals are made aware of screening facilities. Colon cancer is easily controllable if detected at an early stage, and screening practitioners face these situations during their practice. Their prime role is to educate individuals against turning their backs to this potential life threatening disease and to come forward to screening. They demonstrate the benefits of early findings, such as growths or polyps against late stage diagnosis of tumours. They explain how minimally invasive procedures can detect possible findings and how these same interventions can help to remove such problems at the stage where the growth would not have progressed to proliferation.

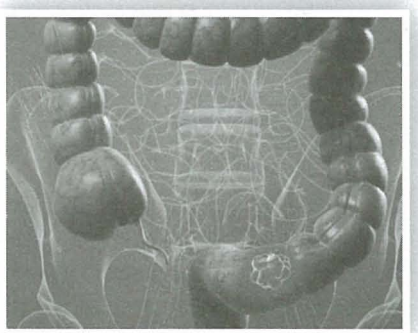
CRC screening is a valuable tool that also supports the healthcare system in general. The endoscopic approach to CRC control contributes

• continued on page 16

• continued from page 15

in managing the negative impacts of this disease by reducing the need for advanced surgical interventions, hospitalisations, case managements, costs, and infections risks. Endoscopic therapeutic innovations enable direct intraluminal interventions that previously required open surgical approaches, with all its relative implications. However, the most important positive impact is that which concerns the patients; physically, socially and economically. Day surgical interventions, such as colonoscopies, enable individuals to continue with their routine life with minimal disruptions; physical harm is negligible and healthcare costs are kept low when compared to major interventions and lengthy hospitalisation. All this contributes to the significance of screening and the impact from screening practitioners. SSPs strive to achieve these goals and their clinical attributes lead to further development of the health belief model.

Preventive health behaviour is a concept based on the individual's understanding of the need to undergo investigations as a preventative measure in the best interest of their health (Cutilli 2010 cited in Tucker and Tucker 2012). CRC Screening promotes an effective way of preventing, controlling and treating colorectal cancer (Bean, 2005, p. 1). There is evidence (Kronborg et al. 2004; Scholefield et al. 2002; Mandel et al. 1999; Kewenter et al. 1994) which suggests that using annual or biennial screening with periodic follow up check-ups, reduces CRC mortality by 16% [OR 0.84; CI 0.78-0.89] in the screened trials. Evidence regarding the efficacy of a test is not the only factor influencing screening behaviour, but it is nevertheless inextricably linked to prevalence in use (Meissner, 2004, p. 1108). Jemal et al. (2009) argue that this significant statistical data encourages healthcare professionals to establish clinical pathways that target early detection and easy accessibility through formative assessments and minimally invasive interventions.



Colorectal Cancer Screening Considerations

Colorectal cancer (CRC) accounts for 9.7% of the total global cancer cases, with around 1.4 million new cases yearly. It is the third most common cancer in men and second in females, with a worldwide mortality rate of 694,000 deaths annually (Globocan, 2012). In the United States it is the nation's second leading cause of cancer mortality. According to the Australian National Health and Medical Research Council (NHMRC, 1999), 1 in 20 individuals will develop CRC at some stage in their life. In the United Kingdom, 41,500 new bowel cancer cases, i.e.13% of all cancer cases, are reported every year with a mortality figure of approximately 16,150 (Cancer Research UK, 2011). In Malta, incidence from CRC has doubled in the last 10 years; 2003 M 87, F 66; 2012 M 113, F 112 (Malta National Cancer Registry, 2012).

CRC starts as a small non-malignant adenomatous polyp. However, in some cases, these increase in size and mutate into malignant pathology (Lowe, 2004, p. 23). This transformation may take a period of between five to 15 years to develop (Greenwald, 2005, p. 90). Together with the fact that statistical evidence demonstrates there is a 50 times higher incidence it develops in people aged 60-79 years, these elements give healthcare professionals an invaluable window of opportunity to help people prevent and monitor this cancer (Centre for Disease Control, 2003).

However it is also one of the most preventable cancers (Levin et al. 2002). Unlike some other forms of cancer, there are clear recommendations for CRC screening (American Cancer Society {ACS}, 2011), as this demonstrate the appropriate characteristics. These recommendations include that the screening instrument must not cause morbidity and mortality; have high predictable prevalence and incidence indicators; be an effective treatment for early diagnostic value; present appropriate accessibility and acceptance; and finally that it is delivered to an asymptomatic population in a cost-effective manner (Champion and Rawl, 2005). The World Health Organisation also emphasises that these must demonstrate acceptable levels of accuracy (Meissner, 2004, p. 1109).

As early as the 70s, measures to train nurse endoscopists and clinical nurse specialists were undertaken in the US (Rosevelt and Frankl, 1984) in anticipation of the impact CRC awareness campaigns would generate. The British Society of Gastroenterology (BSG, 1994) was a significant contributor to this evolution. As practitioners were themselves becoming more knowledgeable and statistical evidence collected was demonstrating the devastating effects of this killing disease, health organisations and instituted bodies were combining forces to better understand how to monitor and control the colon cancer problem (Gipsh et al. 2004, p. 263). Awareness campaigns, dedicated screening practitioners and health models were seen as an opportunity to start addressing this issue, through education and prevention strategies (Ueland et al., 2006). Primary and secondary prevention strategies were contemplated, initially aimed at controlling the incidence (Price, 2003). The need for dedicated healthcare professionals to lead these common elements towards further levels was becoming more evident. Advanced nurse professionals would take dedicated screening practitioner roles to compliment this challenge.

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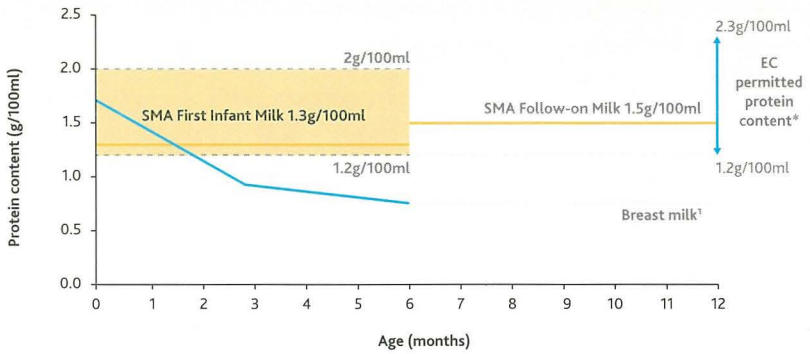

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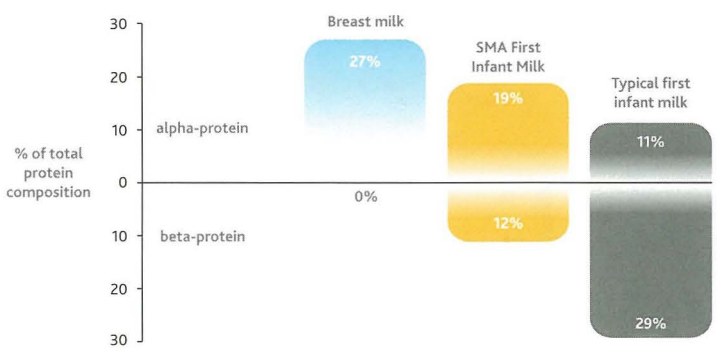

References:
1. United Nations System 2006. Standing Committee on Nutrition. Third World Urban Forum, Vancouver;
2. Koletzko B, et al. Am J Clin Nutr 2011;94(suppl):2036S–43S;
3. EC (European Commission) (2006). Directive 2006/141/EC on infant formulae and follow-on formulae and amending Directive 1999/21/EC. European Commission.
4. Lien EL, et al. JPGN 204;38:170–176

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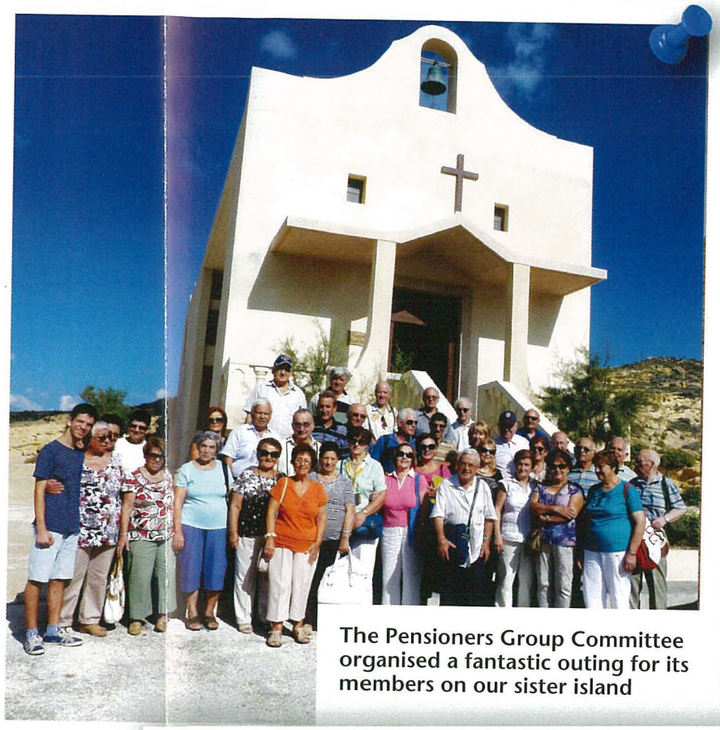
Date of print: 1-6-2015
MF#IRG26P030

from our diary...

MUMN 1996
Malta Union of Midwives and Nurses

MUMN participated at an honourable ceremony organised by H. E. President of Malta to launch a €1 campaign for all employees in aid for the Community Chest Fund

MUMN President & General Secretary during a meeting with Hon. Parliamentary Secretary regarding the Nurses' & Midwives' Specialist Framework. Chief Nursing & Midwifery Officer also present at the meeting



The Pensioners Group Committee organised a fantastic outing for its members on our sister island

MUMN is proud that H. E. President of Malta together with MUMN President planted a tree in appreciation for the duties that Health Care Professionals perform towards the patients, mothers and babies. Mr. Paul Bezzina who is the most senior member at MUMN used his skills and participated in this ceremony.

MUMN President together with our Physiotherapists Group Committee Members

MUMN President donated a painting featuring Our Lady breastfeeding Baby Jesus to H. E. President of Malta during the opening ceremony of a Breast Feeding Facilities at San Anton Palace

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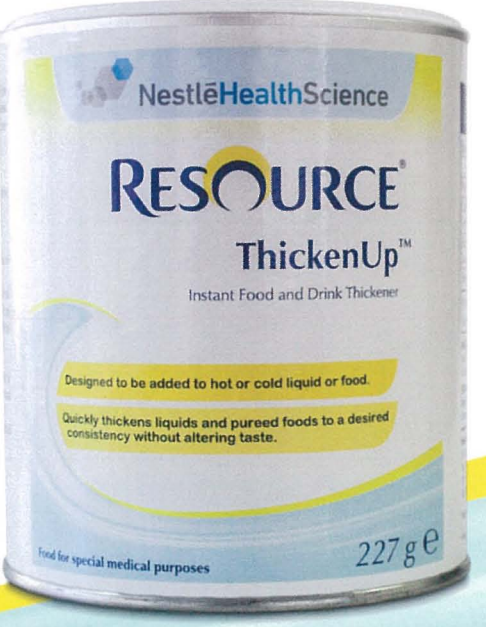

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OptiFibre® is a soluble dietary fibre that helps maintain normal bowel function. The difference between insoluble and soluble fibre is that insoluble fibre is completely insoluble in water and minimally fermented in the colon, thus serving primarily as bulking agents; in contrast, soluble fibre dissolves in water and may be fermented by intestinal microflora. Additional beneficial effects of fibre are associated with their fermentability. Partially hydrolysed guar gum (PHGG), the active component of OptiFibre® is fermented by colonic bacteria liberating short chain fatty acids (SCFA's) which accelerate colonic absorption of salt and water. SCFA's are used as an energy source by the intestinal mucosa and are absorbed through the colonic wall, where they are metabolized to produce energy or transported into the general circulation. SCFA's also promote a healthy gut environment by stimulating the growth of beneficial bacteria such as bifidobacteria and lactobacilli, and inhibit the growth of harmful bacterial strains. Beneficial bacteria promote intestinal health by stimulating a positive immune response and out-competing the growth of harmful bacteria.

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.

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

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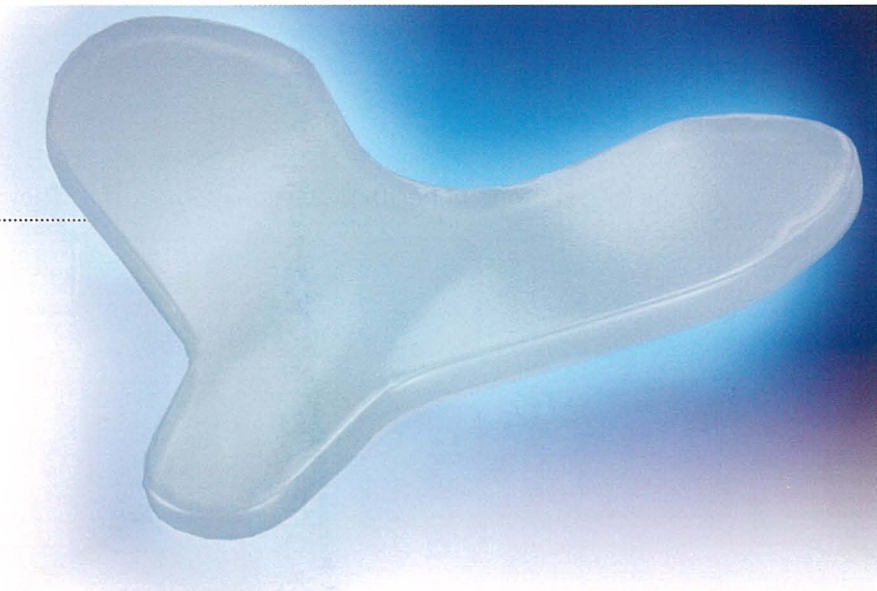

KerraPro Pressure Reducing Pads help protect the skin in at-risk patients as part of a pressure ulcer prevention programme.

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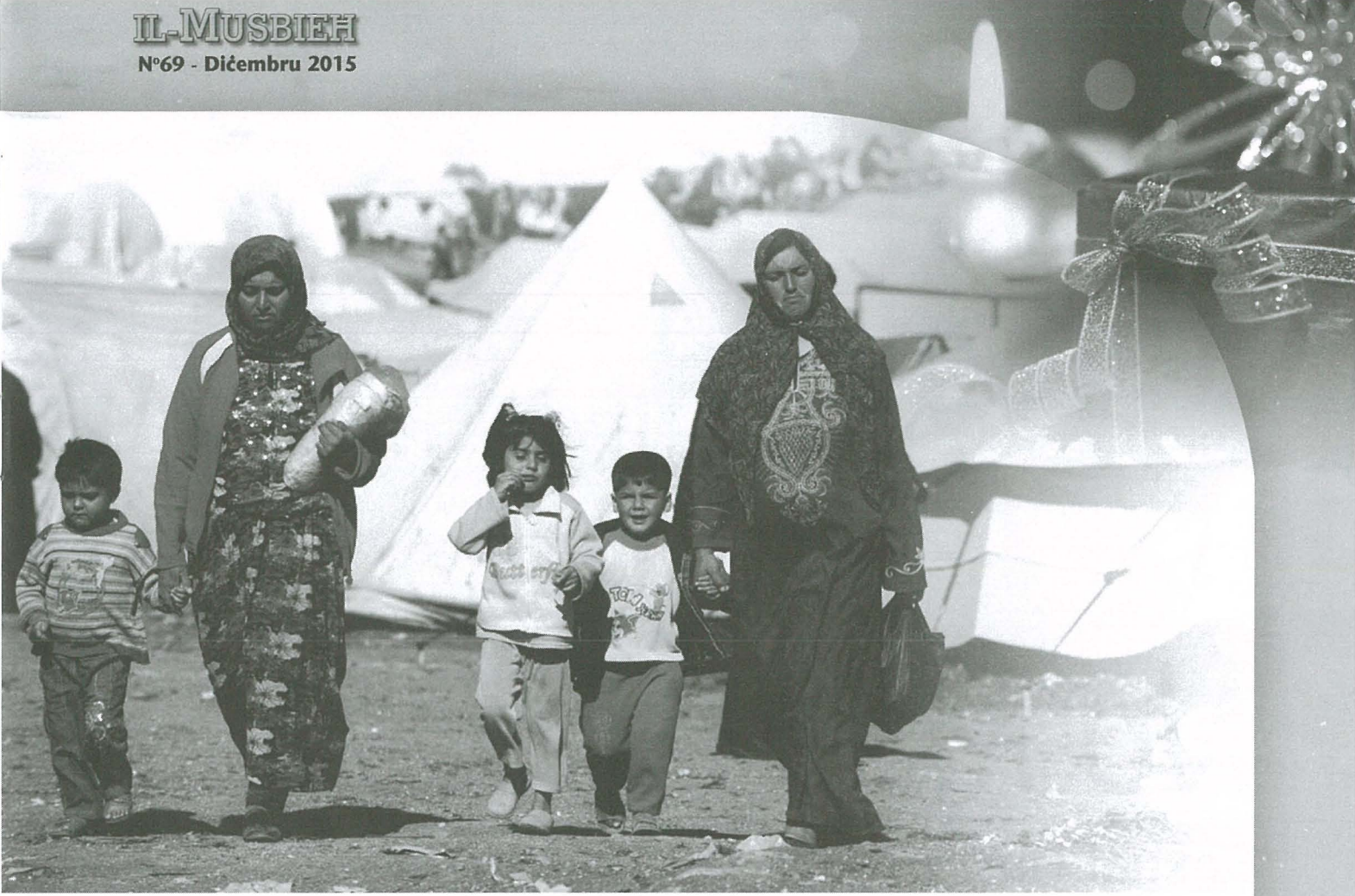
A common problem

A pressure ulcer can occur at the point where the skin is in constant contact with a surface (such as a patient's bed or chair), or with another part of the body (for example where the knees or ankles rest together). The high pressure that builds up can disrupt the flow of blood and oxygen, causing the skin to break down.

An easy & effective solution

KerraPro effectively redistributes this pressure, dissipating it over the pad to protect the skin from pressure ulcers.

KerraPro is available from leading pharmacies



"Nurses are key to healthcare for refugees and migrants" says International Council of Nurses

GENEVA, SWITZERLAND; 11 SEPTEMBER 2015

As the largest group of health professionals in the world, nurses are key to providing cost effective care during the refugee crisis in Europe. While politicians discuss ways to handle the crisis, nurses throughout Europe are at the forefront providing care for the sick and injured.

"The International Council of Nurses has tremendous respect for the work of nurses in this crisis, as in the many disasters and conflicts across the world," said Judith Shamian, ICN President. "We would like to thank them for their support and care for those who are suffering."

In the refugee camps in Europe, cramped living and poor facilities for hygiene can cause outbreaks of cholera, measles and scabies, Poor nutrition is adding to an increase in heart disease and diabetes. In addition, many refugees and migrants suffer injuries as they make their way to safety. The World Medical Association recently called for governments to ensure that migrants and refugees receive full access to healthcare, stating that "it was essential that the health care of migrants and refugees was not neglected in a bid to save money."

"Nurses provide cost effective healthcare, and open access to healthcare for all", said Pierre Théraulaz, ICN's Actiing Chief Executive Officer. "They are at the heart of the community and have a unique opportunity to put people at the centre of care, making services more effective, efficient and equitable." It is this presence of nurses at the forefront of healthcare providing a continuum of care that is a defining characteristic of nursing.

Earlier this year, Chris Maher, manager of WHO's emergency support team for the Syria crisis, said, "Governments dealing with the fallout of the Syria crisis are under incredible strain to address the health needs of their own people in addition to those of Syrian refugees. There is drastic need for increased funding, particularly for the health sector to ensure the continued provision of health services and to build and strengthen national systems so that they are able to cope with the increased burden."

Nurses can make significant contributions to improving health systems' resilience. They have an important contribution to make in health services planning and decision-making, and in development of appropriate and effective health policy. They can and should contribute to public policy related to preparation of health workers, care delivery systems, health care financing, ethics in health care and determinants of health.

No Means No...

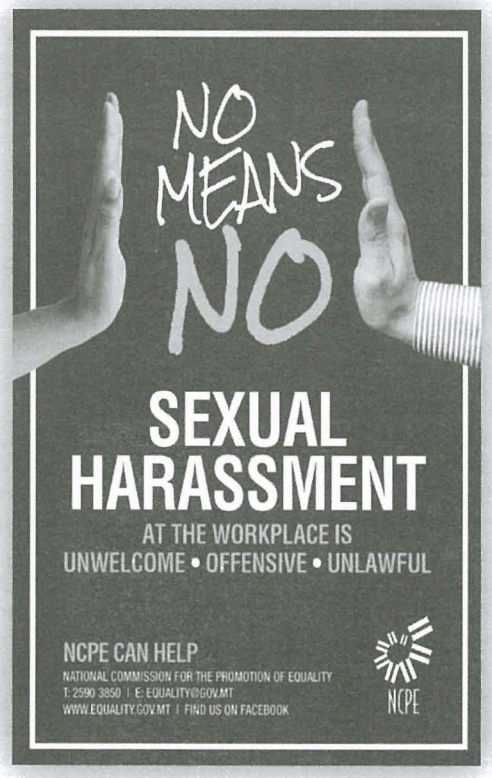
Sexual Harassment at the Workplace

Sexual harassment arises if the sexual conduct in question is unwelcome. Whether the behaviour is unwelcome is subjective and depends on the particular person against whom it is directed.

Different individuals will often perceive and react to behaviour in different ways. A person acting in a particular manner may think that their conduct is welcome and inoffensive, when in fact the person at the receiving end finds it distasteful or offensive.

It is irrelevant that the behaviour may not offend others or that it has been an accepted feature of the work environment in the past.

Sexual harassment does not have to be repeated or continuous to be against the law. One has the right to complain immediately after the occurrence of the first episode.



Sexual harassment may involve:

- Unwelcome physical contact such as touching, hugging or kissing;
- Staring or leering;
- Suggestive comments or jokes;
- Unwanted invitations to go out on dates or requests for sexual interaction;
- Intrusive questions about an employee's private life or body;
- Unnecessary familiarity;
- Insults or taunts based on your sex;
- Sexually explicit emails or SMS messages;
- Accessing sexually explicit internet sites;
- Sexually explicit pictures, screen savers or posters; and
- Behaviour which could be an offence under the criminal law, such as physical sexual assault, indecent exposure, and obscene or pornographic communications.

NCPE has published a poster (top) on sexual harassment at the workplace and is distributing it to various entities, schools and other public places. For a copy of this poster, contact NCPE.

If you are experiencing / know someone who is experiencing sexual harassment at the workplace, NCPE can help. Contact us on 2590 3850 or equality@gov.mt

ibqa' għix kif inti bħalissa

Il-kont il-ġdid ta' terminu fiss tal-BOV joffri soluzzjoni għall-ħarsien tal-kwalità tal-ġejjieni tiegħek. Bih tgawdi mill-eżenzjoni tat-taxxi fuq l-imgħax li tikseb minn dan il-kont. Għalhekk, hu x'inhu l-passatemp jew id-delizzju tiegħek, tkompli tgawdi l-ħajja kif qed tagħmel bħalissa anke meta tirtira.

Ibda faddal għall-futur tiegħek

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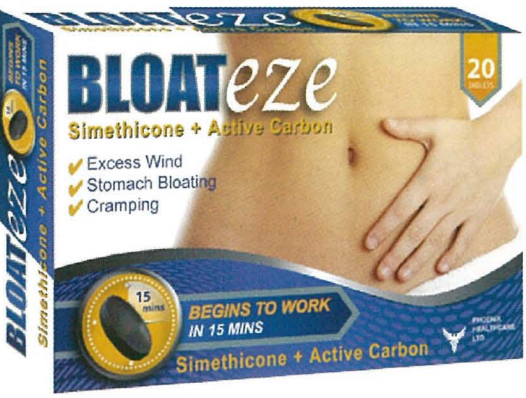

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With a baby it is really important to clean and disinfect your hands regularly. Dirty hands are an ideal way to transmit germs to your baby and the members of your family. To stop the transmission of germs, wash or disinfect your hands when you look after your baby (before and after feeding, changing, etc), but also before meals, after going to the toilets, in restaurant and public facilities.

2 - Keep floors and surfaces clean!

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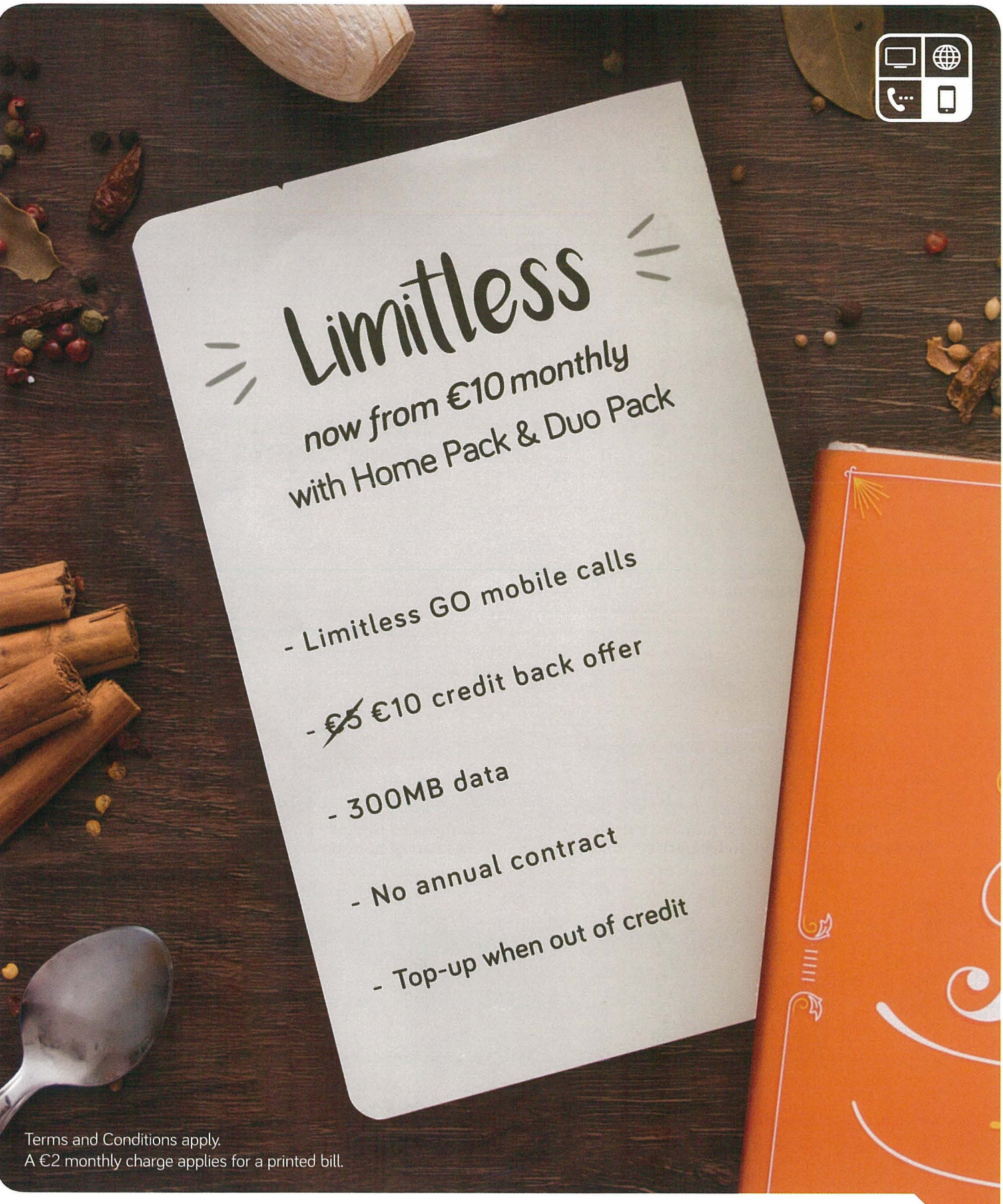

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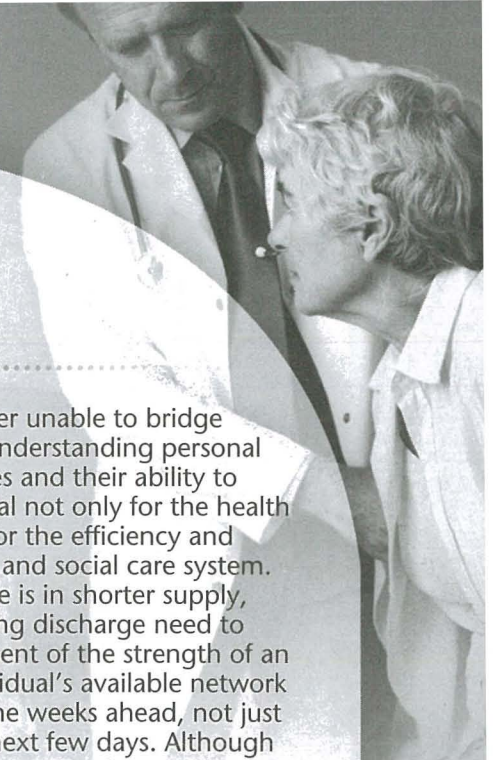


Better solutions needed to support older people leaving hospital care

DAVID McCULLOUGH

In last week's autumn statement, George Osborne announced that councils across Britain will be allowed to increase council tax by up to 2% to fund adult social care, as well as a top up of £1.5bn to the Better Care Fund. This funding for the struggling care sector is, of course, very welcome.

However, the obvious fact remains that vast numbers of older people with non-critical needs won't qualify for formal care but will still need support after a hospital stay. The situation we face is there simply isn't sufficient provision of care to go around when older people leave hospital.

Families have been asked by government to bridge the gap and often at discharge there is an expectation that family and friends will. However, while this can be exactly the kind of help vulnerable older people need, in modern-day Britain not everyone has this supportive circle to fall back on.

In the Royal Voluntary Service's Help Them Home report, and assisted by the King's Fund, we garnered insights on how families cope when an older relative goes into hospital and found that almost one in three don't have a strong family support network to fall back on. And even when they do, in many cases the real picture is disguised at the point of crisis where family rallies round the hospital bed before having to return to their own homes and work commitments.

Of course there are many families that can and do provide hospital care for their older relatives, but the number unable to bridge the gap is significant. Understanding personal circumstances of families and their ability to cope is, therefore, crucial not only for the health of individuals but also for the efficiency and outcomes of the health and social care system.

Now that formal care is in shorter supply, hospital teams overseeing discharge need to make a realistic assessment of the strength of an individual's available network for the weeks ahead, not just the next few days. Although most families felt staff had a good understanding of their relatives' personal circumstances at home, close to a third reported that staff hadn't talked to them directly about this or the impact on needs post-discharge.

Many older adults do not have a strong family network to fall back on after they are discharged from hospital

We believe that this assessment is pivotal in ensuring a good recovery and avoiding a rapid return to hospital. In the absence of a strong support network, we know that there's a clear opportunity for volunteers to provide the support that family or close friends would if they were able. And the value for the individual and the protection this can provide the NHS in terms of reducing the risk of future readmissions is highly significant.

As part of our ongoing Let's end going home alone campaign we're calling on communities, local authorities and NHS trusts to work in partnership to provide more volunteers in hospitals and support vulnerable older people in their homes following discharge from hospital.

It's time for more imaginative solutions.

Press Release

L-infermiera jsofru aggressjoni fl-Isptar Monte Carmeli

Fl- Isptar Monte Carmeli qed ikun hawn bosta ċirkostanzi fejn pazjenti qed jaggredixxu nfermiera kemm fiżikament kif ukoll verbalment. Dawn iċ-ċirkostanzi qed iseħħu b'medja ta' darba fix-xahar u xi drabi anki aktar frekwenti.

L-MUMN ma tistax tkompli tittollera li din is-sitwazzjoni tibqa' għaddejja. Mhix aċċettabbli li l-infermiera wara li jiġu għax-xogħol biex jagħtu s-servizz tant siewi tagħhom qed jiġu abbużati u aggrediti. Infermiera barra li xi drabi qegħdin isofru ħsara fiżika qegħdin isofru wkoll trawma psikoloġika. Din bosta drabi twassal biex l-infermiera konċernati qed ikollhom ifittxu għajnuna psikoloġika minħabba ħsara fuqhom infushom kif ukoll għal ħsara li qiegħda tiġi riflessa fil-ħajja privata u familjari tagħhom.

Fid-dawl ta' dan, l-MUMN qed tisħaq mal-*management* tal-istess sptar biex din is- sitwazzjoni tiġi rimedjata minnufih u l-infermiera jingħataw il-protezzjoni kollha meħtieġa, jkunu protetti u jkunu jistgħu jaħdmu f'ambjent sikur.

Dejjem tiegħek.

Noel Camilleri,
Viċi President MUMN

Facing christianly a dreadful enemy

Cancer! A catastrophic word which uncovers a hidden monster. That cruel robber of life's joys, dreams and hopes. Awful destroyer of families and relationships! In many respects cancer is in fact a dreadful enemy to be avoided and combated against at all cost!

What is cancer? According to the UK National Health Service (NHS)

website: "Cancer is a condition where cells in a specific part of the body grow and reproduce uncontrollably. The cancerous cells can invade and destroy surrounding healthy tissue, including organs."

Unfortunately cancer is a common condition. Among the many kinds of cancers that are detected one finds: anal cancer, bile duct cancer, bladder cancer, bone cancer, bowel cancer, brain tumour (high-grade), brain tumour (low-grade/ mixed), breast cancer (female), breast cancer (male), cervical cancer, eye cancer, gallbladder cancer, head and neck cancer, hodgkin's lymphoma, kaposi's sarcoma, kidney cancer, laryngeal cancer, leukaemia (acute), Leukaemia (chronic), liver cancer, lung cancer, lymphoma, mesothelioma, mouth cancer, multiple myeloma, nasopharyngeal cancer, neuroendocrine tumours, non-hodgkin's lymphoma, nose and sinus cancer, oesophageal cancer, ovarian cancer, pancreatic cancer, prostate cancer, retinoblastoma, skin cancer (malignant melanoma), skin cancer (non-melanoma), stomach cancer, testicular cancer, thyroid cancer, uterine cancer, vaginal cancer and vulvar cancer.

In 2002 the Malta National Cancer Registry has issued a report which detailed the most common sites and types of cancers that were diagnosed in Maltese people between the 1998 and 2000 period. In line with the findings of the Malta National Cancer Registry the most common types of cancer on our Islands are breast cancer, bowel cancer, lung cancer, prostate cancer, uterus cancer and ovary cancer. The findings correlate well with those found in the UK on the matter. As a matter of fact in the UK, the most common types of cancers are breast cancer, prostate cancer, lung cancer, bowel cancer, bladder cancer and uterine (womb) cancer.

In an interesting article called "Spiritual Needs of Patients with Chronic Diseases", Arndt Büssing and Harold G. Koenig detail some intriguing spiritual needs which patients suffering from chronic diseases normally would present to their spiritual caregivers. The intercultural approach they used in their studies gives a profound insight of these needs. For instance, US cancer patients would like to be helped in overcoming fears (51%), finding hope (42%), finding meaning in life (40%), finding spiritual resources (39%), or identifying someone to talk

"Although the chaplain is not a therapist or a counsellor, he is a faithful companion who journeys with the patient in good times and in bad"

to about finding peace of mind (43%), meaning of life (28%), and dying and death (25%). Another qualitative study carried out among French patients who are struggling at the end of their lives the subsequent issues were singled out: reinterpretation of life, search for meaning, densification of the connection to the world, to loved ones and to oneself, control, vital energy, ambivalence to the future, confrontation with death, and relationship to transcendence. When dealing with hospice cancer patients, family was the most frequently cited need (80%), while attending religious services was the most frequently cited unmet need.

Speaking from a Korean context patients with cancer identified the following spiritual needs: love and connection, hope and peace, meaning and purpose, relationship with God, and acceptance of dying.

German patients suffering from chronic pain diseases and cancer looked for religious needs (enrolling praying, participate at religious ceremony, reading religious/spiritual books, turning to a higher presence), need for inner peace (enrolling patients' wishes to live at places of quietness and peace, beauty of nature, finding inner peace, talking with other about fears and worries, devotion by others), existential needs (in terms of reflection and meaning in life and suffering, dissolve open aspects in life, talk about the possibility of a life after death), and actively giving (which addresses the active and autonomous intention to solace someone, to give away something from yourself, and turning to others).

As K. Galek and K.J. Flannelly pointed out in their paper called "Assessing a patient's spiritual needs", it is a known fact that faith can greatly help a patient to experience love and belonging, meaning and purpose, hope and peace, the sacred, appreciation of beauty, morality and ethics, resolution and death. Faith's relevance in the lives of patients can be particularly detected when it is not present.

For instance, in a study done by A.L. Williams, called "Perspectives on spirituality at the end of life", it was found that patients who have no faith are an easy prey to spiritual despair (alienation, loss of self, dissonance). On the other hand those who are open to the experience of the sacred are more open to spiritual work (forgiveness, self-exploration, search for balance), and spiritual well-being (connection, self-actualization, consonance).

My pastoral experience at Mater Dei Hospital continually informs me that hospital chaplaincy is, indeed, a powerful instrument of how cancer can be approached from a Christian point of view. Since chaplaincy at the clinical setting is about addressing spiritual and religious issues it is highly important that I, as a hospital chaplain, need to be equipped to face any kind of situation. The first thing I normally do is to let patients talk. A French proverb says presents the ministry with the sick as "to heal sometimes, to remedy often, to comfort always". Letting the patients talk is vital so that they can unload their frustrations, fears and anger. Life experience at the hospital taught me that even religious people can harbour anger against God which, unfortunately, can obstruct them from experience that much-needed peace they crave for. Dying in peace is a goal a terminally ill patient should aspire for.

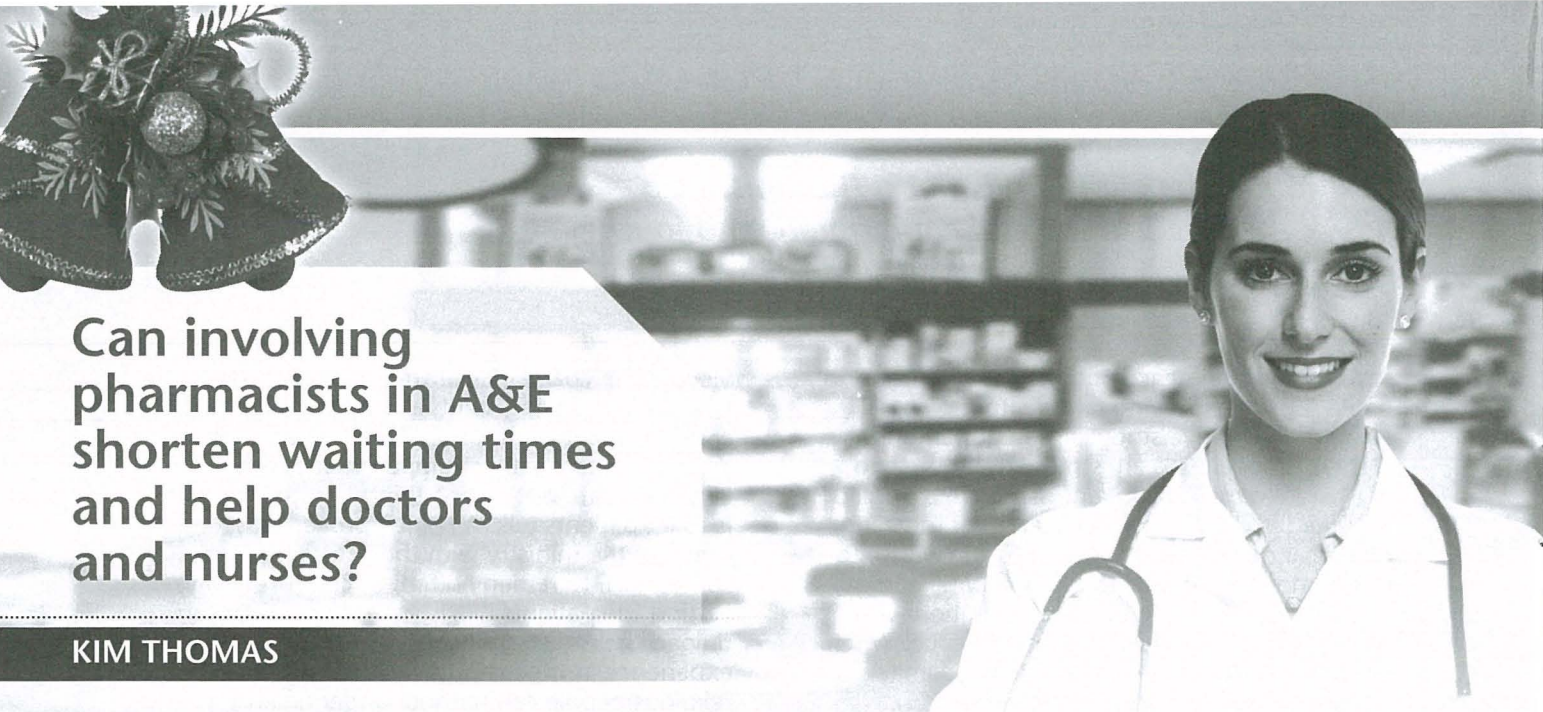
Although the chaplain is not a therapist or a counsellor, he is a faithful companion who journeys with the patient in good times and in bad, in all periods of sickness until death separates him from the person he is spiritually caring for. When he wisely and intuitively uses the sacraments and the Bible these can impart healing on the patient. How many times cancer patients thanked me for anointing them, hearing their confession and praying with them?

Pamela Rose Williams suggests 17 inspirational bible verses in order that cancer patients would find in them peace, courage, comfort and deliverance from the negative feelings they go through during their period of illness. She classified them under four headings: (1) God is big: Comfort and Rest for the Restless: Deuteronomy 31:6; Psalm 138:3; Proverbs 3:5-6; Matthew 11:28-29; and 2 Corinthians 1:3-4; (2) God is Faithful: Calm for the Anxious: Psalm 18:6; Psalm 33:20-22; Philippians 1:6; Philippians 4:6-7; and 1 Peter 5:6-7; (3) God is Trustworthy: He Has a Plan for You: Ecclesiastes 3:1; Jeremiah 29:11; John 14:1-3; and (4) God is hope; Even When it Seems Hopeless: Romans 8:16-17; Romans 8:24-25; Romans 8: 38-39; and 1 Peter 1:3.

The last prayer I would like to mention in facing Christianly the dreadful enemy of cancer is the Divine Mercy Chaplet. Sustained by Jesus' own promise that at the hour of death He would defend every dying person's soul where this Chaplet is said because His unfathomable mercy envelops that soul (see Diary, 811), I seek to pray this powerful prayer with the family of the dying person. Experience has all the way been showing me that both the dying person and his/her family receive the comfort they really need at this critical moment for their family.

Cancer is a dreadful enemy. Yet, let us resist it by being firm in our Christian faith! (1 Pet 5: 9).

Fr Mario Attard OFM Cap



Can involving pharmacists in A&E shorten waiting times and help doctors and nurses?

KIM THOMAS

Accident and emergency departments are nearing crisis point, but evidence suggests that some of the pressure comes from patients who want to avoid having to wait for a GP appointment. Could pharmacists reduce the burden by helping to treat A&E patients suffering relatively minor conditions?

This is the question that Health Education England (HEE) hopes to answer through a national project. The aim, says Matt Aiello, special projects manager, transformation, at Health Education West Midlands, is to find out whether pharmacists can be a "relevant and viable part" of the A&E team and, if so, what kind of training they would need.

A pilot in the West Midlands, looking at 782 patients attending A&E in three acute trusts between April 2013 and August 2014, was encouraging. It found that 39.8% of patients could have been dealt with by a pharmacist with advanced clinical practice training skills, while an independent prescribing pharmacist could have dealt with another 5.1%.

The national project collected data from 48 trusts in England between 2 March and 3 April this year. Each trust introduced a pharmacist into the A&E department tasked with evaluating a random selection of approximately 400 patients – 18,229 in total. As well as recording details about their complaint and demographic data such as age and sex, pharmacists had to indicate the most appropriate person totreat the patient: a community pharmacist; an independent prescriber pharmacist in A&E; an independent prescriber pharmacist in A&E with advanced clinical skills training; or a doctor.

The data is being reviewed by independent clinicians and pharmacists, and a report on the results will be published later this month. Sandra Gidley, chair of the Royal Pharmaceutical Society's English Pharmacy Board, thinks there is a strong case for involving pharmacists in A&E: "Pharmacists are at the moment largely underutilised within A&E departments. If the results from West Midlands are replicated widely in HEE's national pilot, it will be overwhelming evidence of the profound impact an enhanced role for pharmacists can have."

Pilot project looking at 782 patients found 40% could be treated by a pharmacist with advanced clinical practice training skills

Two possibilities are likely to be considered. Some pharmacists would receive training (part-time, over six months) as independent prescriber pharmacists, enabling them to prescribe medication for patients without consulting a doctor.

The more advanced role would require an independent prescriber pharmacist to have additional training in clinical diagnosis and minor injuries and ailments. David Terry, director of the pharmacy academic practice unit at Aston University, Birmingham, and evaluation lead on the project, says that currently there is an oversupply of pharmacy graduates and that the excess "might over time be channelled to provide health services in a different way".

Some A&E departments have already seen first hand the benefits pharmacists can bring. Earlier this year, Norfolk and Norwich University hospital, which took part in the HEE pilot, also ran its own pilot scheme over six weeks to introduce pharmacist services to A&E. Gemma May, pharmacist team leader for medicine, says that the biggest benefit came from the support pharmacists gave clinicians in prescribing the correct medicines.

Doctors surveyed at the end of the pilot, says May, felt that pharmacists had "helped in management of patients both within A&E and those admitted into hospital in terms of sourcing medication, which meant they were able to administer drugs quicker". The pharmacists were also "able to provide medicines-related advice there and then which they could act on". The trust has since introduced the service permanently, employing four pharmacists and two pharmacist technicians in A&E.

Addenbrooke's hospital in Cambridge, which took part in the national pilot, has had a pharmacist in A&E during normal working hours for five or six years. Victoria Heald, lead pharmacist for emergency admissions, says that her role includes making sure that the most cost effective and clinically effective drugs are prescribed.

Between December last year and March this year, the hospital introduced a pharmacist into A&E

in the busier evening hours. An important part of the work has involved medicines reconciliation: a high proportion of A&E patients are already taking multiple medicines, or high-risk medication such as warfarin, and the pharmacist made sure that a new prescription didn't conflict with existing medication.

Heald believes it brought both efficiency and patient safety benefits: "Because the doctors had that information given to them, they didn't have to spend half an hour trying to work it all out. And fewer things seemed to go wrong with medicines while we had the pharmacists there."

If the HEE report is positive, a review of pharmacists' career paths will follow, says Aiello: "Career development tends to be aligned to local needs rather than a structured training pathway nationally. So what we're trying to do is give pharmacists access to clinical training in a manner that allows them to see and treat patients as part of their normal practice."

The hope is that a pharmacist presence in A&E will reduce the burden on doctors, shorten waiting times and improve patient safety. As one Addenbrooke's doctor wrote after this year's evening hours pilot: "It is difficult to overstate the value of pharmacists' input and review at the point of admission. This is important for patient safety and may contribute to a decrease in breaches of the four-hour waiting time in the emergency department."

PRESS RELEASE

One-third of British people born in 2015 'will develop dementia'

Alzheimer's Research UK warns that Britain's ageing population could lead to a national health crisis

One in three people born this year will develop dementia, according to new figures. The Alzheimer's Research UK charity warned of a "looming national health crisis" as the population ages.

It called for greater efforts across the globe to help develop new treatments. Dementia affects 850,000 people in the UK, resulting in the loss of brain cells. The most common type is Alzheimer's disease. Early symptoms include problems with memory and thinking. As the disease progresses, people can experience difficulty with walking, balance and swallowing.

Alzheimer's Research UK said age was the biggest risk factor for developing dementia. As people live longer than ever before, the numbers with dementia will rise. The latest analysis, commissioned by the charity and carried out by the Office ofHealth Economics, was released to mark World Alzheimer's Day. It showed 27% of boys born in 2015 will develop the condition in their lifetime, alongside 37% of girls. Previous research from the same team has estimated that the development of a drug that could delay the onset of dementia by five years would cut the number of cases by a third.

Dr Matthew Norton, head of policy at Alzheimer's Research UK, said: "It's wonderful news that each generation is living longer than the last, but it's important to ensure that people can enjoy these extra years in good health. "Dementia is our greatest medical challenge and, if we are to beat it, we must invest in research to find new treatments and preventions.

"Research has the power to transform lives, and our actions now will help determine the future for children born today."

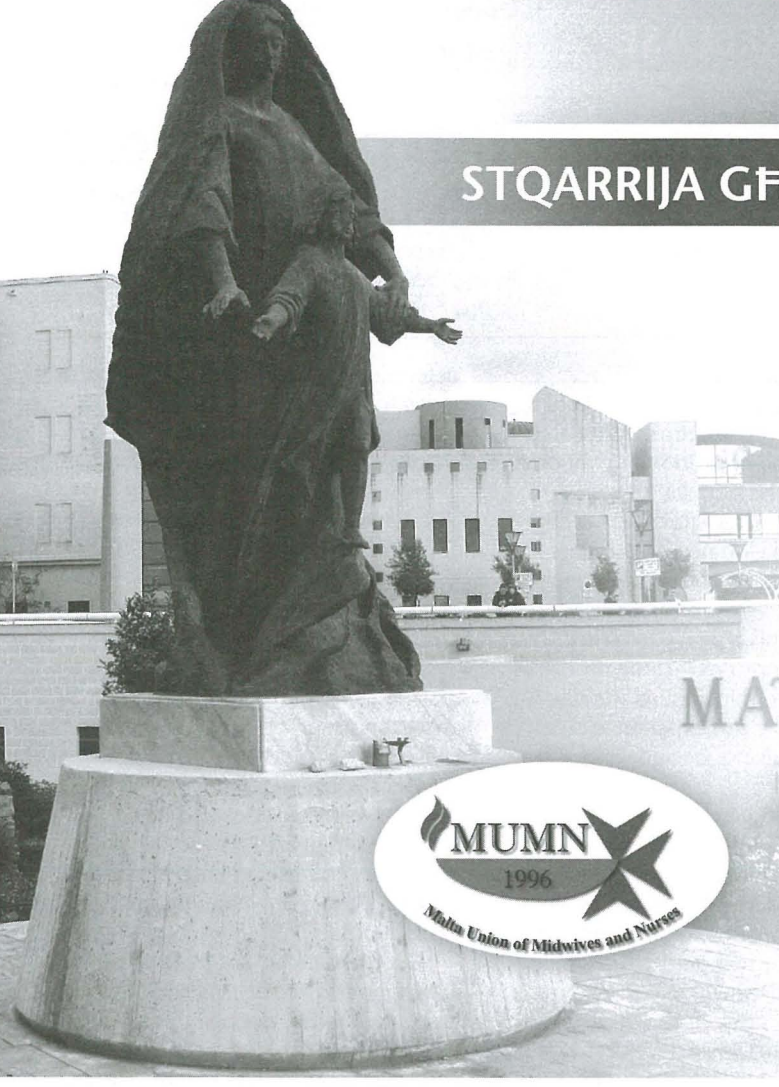
Amanda Franks, from Swindon, a champion of Alzheimer's Research UK, whose mother Cathy was diagnosed with early-onset Alzheimer's six years ago, said: "My mum was only 58 when she was diagnosed. Up until then, we had no idea this devastating disease could affect someone so young.

"Simple day-to-day tasks like making a cup of tea, getting dressed and eating soon became a huge challenge for mum.

"As a mum myself, I would dearly love to see preventions and new treatments found to defeat Alzheimer's disease and other dementias, giving hope to people now and future generations."

George McNamara, head of policy at Alzheimer's Society said: "Dementia is already the biggest health challenge this country faces. It costs the UK in excess of £26bn, which equates to £30,000 a person with dementia – more than the cost of either cancer or heart disease. Today's stark finding should galvanise the government, and us all, into action." "We urgently need long-term, sustainable research funding that is proportionate to the economic and social impact of the condition. Alzheimer's Society has pledged to put at least £100m into research into the disease over the next decade, McNamara added.

"The quicker we see better investment, the sooner we will get the answers we need to develop treatments, ways of preventing dementia and ultimately a cure."



STQARRIJA GĦALL-ISTAMPA U X-XANDIR

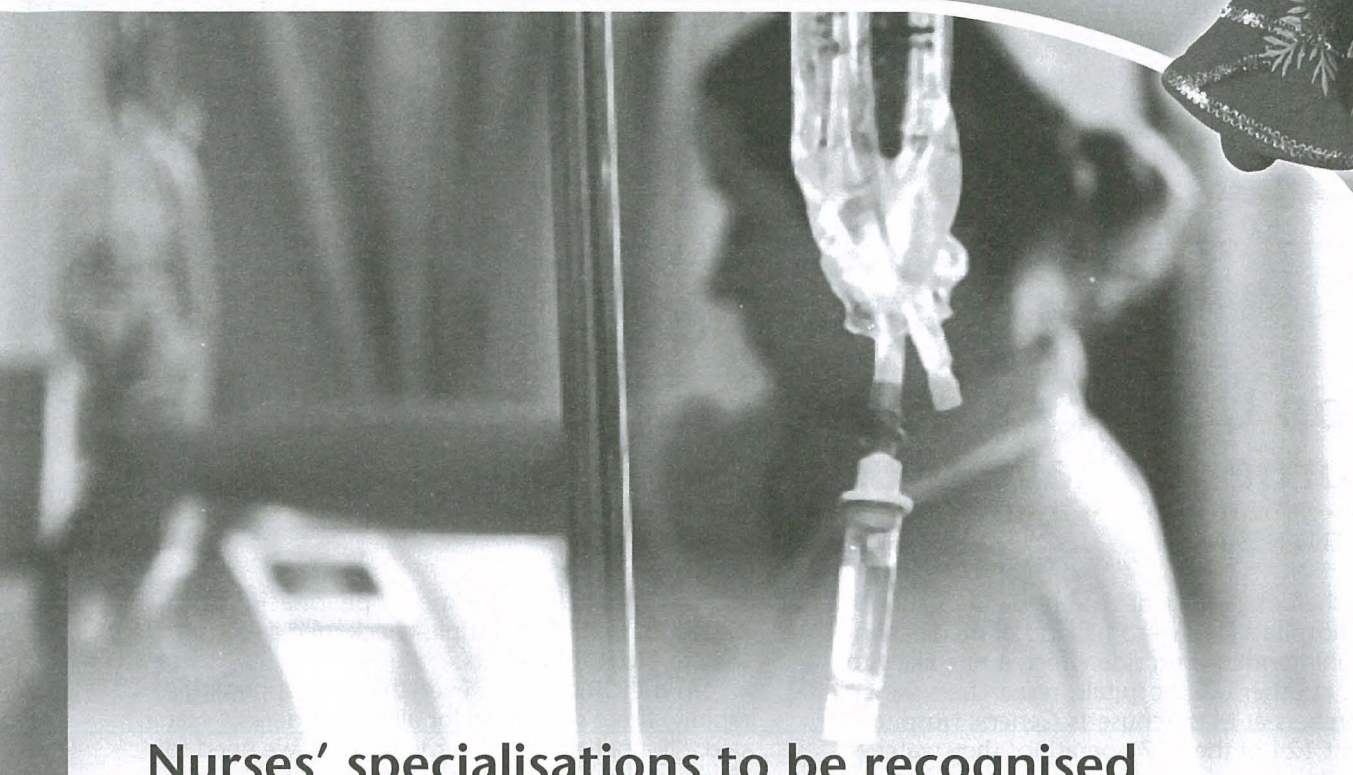
Il-Kunsill tal-Malta Union of Midwives & Nurses jixtieq jirringrazzja lin-*nurses* kollha li taw il-kura tagħhom sabiex il-pazjenti u l-qraba li daħlu l-isptar Mater Dei u fiċ-Ċentri tas-Saħħa nhar il-Ħadd, wara li seħħ l-inċident tal-karozza, irċevew il-kura li tistħoqqilhom b'kordinament mill-aqwa bejn il-partijiet kollha.

L-MUMN tixtieq tirringrazzja b'mod speċjali lin-*nurses* li jaħdmu fid-Dipartiment ta' l-Emerġenza, fil-Main Operating Theaters, fis-Swali Ġenerali u fiċ-Ċentri tas-Saħħa kif ukoll lin-nurses li jaħdmu fil-Bank tat-Transfużjoni tad-Demm.

L-MUMN tixtieq ukoll turi solidarjetà sħiħa mal-familji tal-pazjenti involuti u tawgura li l-kundizzjoni ta' saħħet dawk involuti tkompli taqleb għall-aħjar.

Il-Kunsill tal-MUMN jixtieq ukoll juri s-solidarjetà kollha tiegħu mal-E.T. President ta' Malta u jħeġġiġha sabiex tkompli għaddejja bil-ħidma fejjieda u sħiħa tagħha favur il-pazjenti morda speċjalment dawk li jinħtieġu kura tal-kanċer. Bħal dejjem l-MUMN hija disposta li tassisti lill-E.T. s-Sinjura Marie Louise Coleiro Preca f'dak kollu li jkun jinħtieġ fil-ħidma nobbli tagħha favur il-morda.

Maria Cutajar
President, MUMN



Nurses' specialisations to be recognised through new framework register - Fearne

Malta Independent

The Parliamentary Secretary for Health and the Malta Union of Midwives and Nurses have agreed to start working on a structured database for specialised nurses and midwives as well as a specialisation register.

These would ensure that nurses and midwives who acquire qualifications are duly recognised.

Mr Fearne said the framework will lead to better quality workers as well as specialised care to patients. He said this was an exciting time for the country's health sector, with a number of projects announced by the government expected to lead to increased opportunities for health workers.

These included the Đ200 million private hospital in Gozo, the modernisation of St Luke's and Karen Grech hospitals in Guardamangia. This investment would not only lead to an increase in opportunities but also for a better quality service. The Gozo project would also attract medical tourism and safeguard jobs.

MUMN President Maria Cutajar praised the initiative which, she said, would improve the level of specialised nursing in Malta.

At top U.S. hospital, almost 50 percent of surgeries have drug-related error

BY LENA H. SUN

Nearly half of all surgeries at one of the nation's top hospitals involve some kind of medication error or unintended drug side effect, a rate likely to be found at other U.S. hospitals, researchers said.

Researchers at Massachusetts General Hospital found that 124 of the 277 operations they watched in 2013-2014 included at least one medication error or drug-related incident that harmed a patient. Among the most frequently observed errors were mistakes in labeling, incorrect dosages and medications that should have been given but were not.

More than one-third of the observed errors injured patients, including three life-threatening mistakes, according to the study. Two of those were caught by the operating room staff, and one was intercepted by researchers. Nobody died because of the mistakes.

The error rate is much higher than what has been previously reported but in line with rates found in inpatient wards and outpatient clinics, researchers said. There have been a few studies about medication errors in the operating room but they relied mostly on self-reported data, which typically underrepresent true rates.

The study was published in Anesthesiology and presented last weekend to the American Association of Anesthesiologists, where clinicians told the authors that similar problems are occurring at their hospitals.

"There was not a lot of surprise because everybody knew the self-reported error rates were too low," said lead author Karen C. Nanji, an anesthesiologist at Massachusetts General Hospital. "We just didn't know what the true rates were."

She added: "Medication errors are at least as high at many other hospitals. The types of errors are not unique to Massachusetts General Hospital in any way. Most of them are around common medications that are used across the board."

The medications most frequently associated with errors were propofol, a commonly used sedative in the operating room; fentanyl, a powerful pain medication; and phenylephrine, a medication given to increase blood pressure in patients with very low blood pressure.

Researchers say the environment of the operating room is very different from that of other hospital settings, where there is time for pharmacists and nurses to double- and triple-check medications before they're given to patients.

"In the OR, because everything is happening so rapidly, there's not time for all those checks," Nanji said. "If a patient needs a medication, we need to give it in the next minute."

She and the research team observed the randomly selected operations during an eight-month period and reviewed the anesthesia records. Researchers documented every drug that was given immediately before, during and after the surgery.

They also documented any mistake in the process of ordering or administering a drug and any drug-related harm, whether or not it was caused by an error. An allergic reaction in a patient not previously known to be allergic to a particular medication was still included, for example.

One of the most common errors involved the labeling of syringes. Many medications are clear liquids, and syringes need to be properly labeled so the correct drug can be administered. Massachusetts General has a bar-code syringe labeling system, but "in our case, most errors were occurring where the bar-code scanning system was not being used," Nanji said.

On average, about 10 medications were given during an operation. The study found that some kind of error was made in about 1 in 20 medications, which equates to every other operation.

"We've never had the data to focus on errors before, and now that we have this information, we are looking at targeted interventions," Nanji said. One idea under consideration is to electronically document medications *before* they are given to patients to allow the electronic system to check for proper doses and possible drug interactions or allergies.

Patient safety advocates say it's a welcome step when hospitals conduct these kinds of studies and make the data available to the public. But the findings still took some by surprise.

"Boy, we still have a lot of work to do," said Tejal Gandhi, president and chief executive of the National Patient Safety Foundation. "If it happens at MGH, it can happen anywhere."

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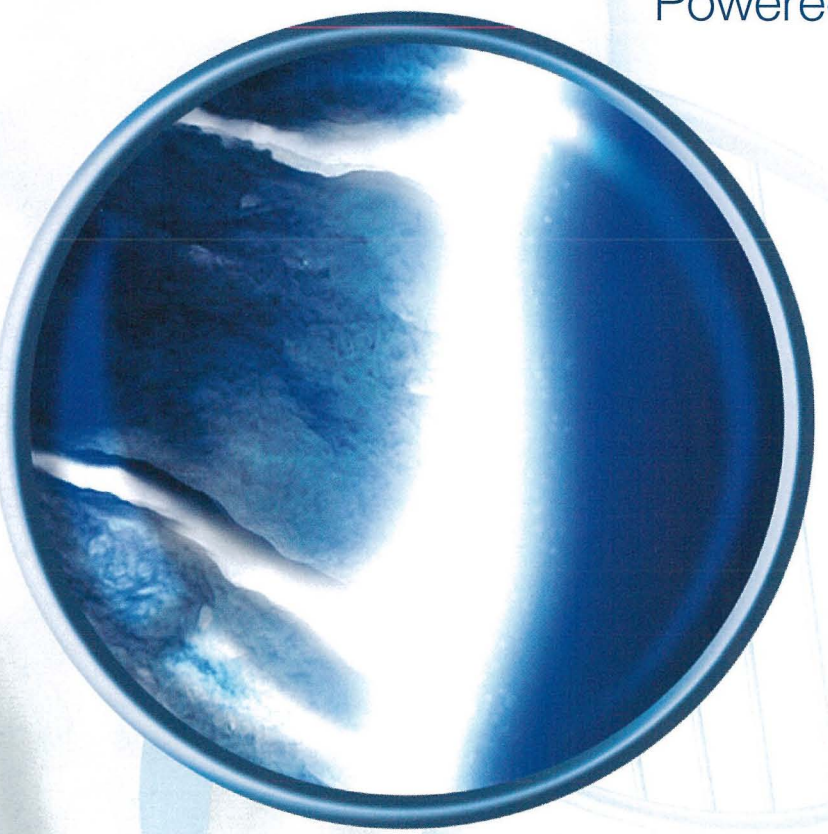

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