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MALTA NURSING AND MIDWIFERY JOURNAL

Malta Union of Midwives and Nurses

No.70 - Marzu 2016

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contents

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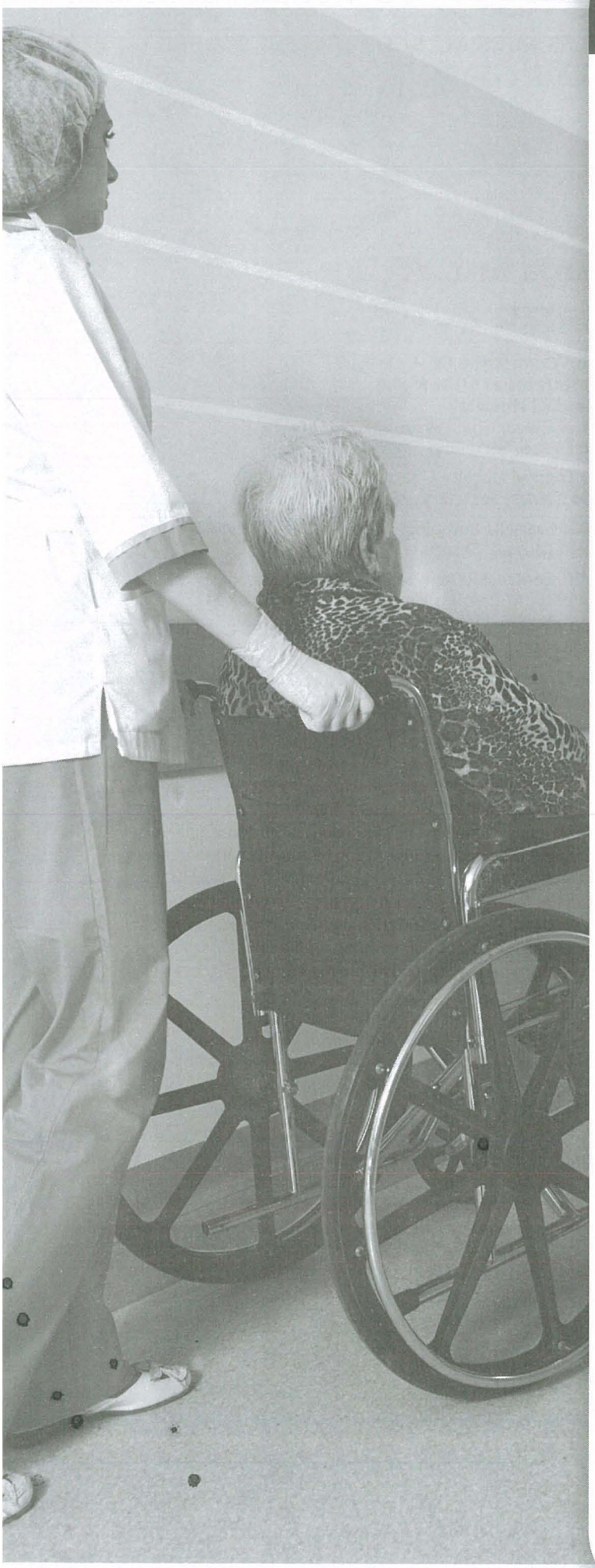


Safe staffing levels

Our Hospitals lack safe staffing guidance or policies and because there is a relationship between staffing and safety, we are jeopardising our client's well-being or quality of patient care. In fact if one had to monitor or do a study on nurse/midwife staffing levels and aspects of patient care, one would find an increase in patient incidents such as slips, trips and falls. Adding Staff Nurses to units has shown to eliminate almost 1/5 of all hospital deaths, and a reduction of relative risk of adverse patient events (Kane).

For example, studies in the UK show that when registered nurses are at 50% of the total nursing staff, the number of slips, trips and falls are at their highest. Where qualified nurses made up more than 65-70% of staff, the number of slips, trips and falls on wards are reduced by 70% and continued falling the more nurses were employed.

Each ward/area of nursing must have a well worked out risk assessment tool with a standard evaluation of maximum and minimum staffing within that section. There will always be situations where the planned level of staffing becomes inadequate due to unforeseen patient need or change in circumstances or staff sickness. Staff staffing is not about saving money; it is about setting a minimum nurses-to-patients ratio.

So why not legislate specific ratios? While we respect all attempts to address the staffing issue, we have real concerns about the establishment of fixed nurse-to-patient ratio numbers in our state hospitals. While such legislated numerical ratios seem to offer a concrete solution and may appear to be a good fit for some workplaces, many variables - factors including intensity of patient need, level of experience of nursing staff, layout of the unit, and level of ancillary support, are key to establishing the right nurse-patient ratio for any one unit.

A hospital whistle-blower should be in place for the protection of Nurses and Midwives and others who may file a complaint regarding staffing. Hospitals should be held accountable on such matters. There should also be public reporting of staffing in hospitals.

To be fair legislated ratio approach has its downside too. For example it treats nurses as "numbers" rather than recognising them as professionals with a say in the care that they provide. There might be other concerns such as the lack of assurance that the "minimum" ratio does not become an average, or worse, a maximum level of care as time progresses; and there might be no flexibility to revise legislated ratios to ensure that they can be adjusted to meet staffing needs and concerns over the years, and not just in the moment.

At present we only depend on collaborative efforts with regards to safe staffing, but MUMN needs to keep a close watch on instances of unsafe unbalanced staffing. This would definitely be of benefit to our hospital, our nurses and our patients.

President's message

Dear Colleague and Member of the MUMN,

Will 2016 be perfect? Of course not, but I hope that we will learn together. I am sure our professions will face many challenges in this coming year. How we respond to these challenges will be the measure of our organisation. The ultimate test of a leader is not what you are able to do in the here and now, but instead what continues to grow long after you are gone. As we began 2016, your union is excited about the possibilities of what we, as MUMN members, can accomplish collectively. As health care professionals, we are certainly facing challenges: patient acuity and numbers are increasing; we are an older workforce; new technologies are constantly evolving; and with the high patient-to-nurse ratios or with the never ending caseloads, we can't take a break — let alone lunch. The list of challenges is endless, and it involves different members of the MUMN. Ongoing meetings are held through sound industrial relations and effective social dialogue. We are also holding meetings with Dr. Mizzi, Mr. Fearne and with the CEOs of each respective department, to foster cooperation and to create an enabling environment for the realization of the objective of decent work at the national level. Our endeavour in the coming months, will be working to find new ways to meet the challenges we are facing every day in each respective department. We, as MUMN, are a vast storehouse of knowledge with a willingness to help. Collectively we are powerful!

Reflecting on the work we did during the past two months, I can say that through the dynamism of the union, we achieved a lot. In January, the educational committee together with the Mater Dei Hospital PaSQIT Team organised a Conference on 'Patient Safety'. This conference provided an inspirational setting to meet, learn and share knowledge in our common mission to improve the quality and safety of care for patients. During the last few weeks the MUMN together with the Board and Management of St Vincent De Paul Facility announced the project kick off of the Continuous Improvement Project on the residence. The aim of this joint project is to proactively find new work methods and best practices in pursuit of meeting the ever changing needs of the residents. The initiative will span a five month period, and will focus on the patient demand levels relative to the levels of dependency, with emphasis on age-related frailty and dementia. The study will look into the required aids that facilitate nurses' work and increase comfort for the elderly. In February, we also carried out a training needs analysis of our members. Today's work environment requires employees to be skilled in performing complex tasks in an efficient, cost-effective, and safe manner. Through the completion of this successful training needs analysis, you helped us identify what kind of training is needed
– thanks to all those members that completed the study! The results of this training needs analysis help us put the training resources to good use. As a union we kept working on the industrial aspect of the organisation. There are several objectives of good industrial relations and your union responsibly and diligently make sure to develop harmonious relations. In the past months the MUMN was negotiating two sectoral agreements for two professions that it represents. The MUMN also asked for the sole recognition of the physiotherapists.

The MUMN's strategic initiatives focus on advancing the professions it represents; advocating for safe practice and safe care; creating a culture of inquiry, learning, and collaboration; and expanding and fortifying our membership. The future of the MUMN depends on our ability to adapt and change. This sometimes means creating discomfort. This means not doing the same things we did in the past. This means taking risks but carefully considering the outcomes. Risk taking is unpredictable, uncomfortable, and uncertain — at times a scary business. At the core of risk is fear; the fear of failure, fear of success, fear of looking like a fool, or fear of seeming ignorant. So why would anybody want to take a risk? Perhaps because it leaves us open to new ideas, opportunities, and experiences. As an organization and as individuals, it is important that, in order to grow and thrive, we confront the challenges that occur when change is necessary and have the courage to move forward through fear. All change and innovation involves some sort of risk and challenge. Your union will continue to revise and redesign how we do things as an organisation.

I recently recalled reading a book 'First things First' by Stephen Covey. It led me to think about my career and my life. I remembered that as soon as I finished my midwifery studies, I was asked to help recruit members in the newly established MUMN. That was exactly 20 years ago. Next September we will be celebrating the twentieth anniversary – we will be giving further information on the celebrations. I am passionate about my profession, my career and the trade union work in a way I never could have imagined. We all have days when we wonder what we were thinking when we choose our profession. The fact that we are still here means that at some point in our career we had that passion. The MUMN together with the professions it represents has too much to give to others who need the care, comfort, and skills that we provide. We should never give that up. Until next time.

Best Regards,

Maria Cutajar, MUMN President

Kelmtejn mis-Segretarju Ġenerali

Sena ilu ġie elett Kunsill ġdid tal-MUMN u niftakar li l-akbar żewġ sfidi li kellu quddiemu kienu n-nuqqas ta' soddod u nuqqas ta' nurses. Mhux għax problemi oħra ma kienx hemm tafux, però dawn kienu fl-opinjoni tiegħi l-aktar tnejn li kienu diffiċli biex issib soluzzjoni għalihom.

Irrid nistqarr li dwar il-problemi tas-sodod jidher li qed jinstabu s-soluzzjonijiet meħtieġa però dwar in-nuqqas ta' *nurses* għadna 'l bogħod. Għalkemm din il-ġimgħa konna nvoluti f'laqgħa li ser twitti t-triq biex università Ingliża tibda toffri l-*courses* tan-*nurses* minn Ottubru li ġej, il-frott ta' din l-inizjattiva jibda jidher erba' snin oħra. Imma għall-inqas inkunu bdejna nindirizzaw parti mill-problema.

Il-parti l-aktar importanti li jrid jimbarka fuqha l-Gvern u li hija l-aktar waħda li tagħti r-riżultati meħtieġa hija li toffri pakkett ta' kundizzjonijiet ta' xogħol u salarji attrajenti lin-*nurses* peress li dan joħloq *platform* sod għaż-żgħażagħ li jkunu se jħallu s-siġġijiet tal-iskola, lesti li jagħżlu karriera tagħhom. Barra minn hekk in-*nurses* li qed jaħdmu llum tkun qiegħed tatihom kuraġġ li, għalkemm fil-maġġoranza tagħhom qegħdin jaħdmu f'kundizzjonijiet ta' xogħol ħżiena, xorta jħossu li dak li qed jagħmlu mal-marid qiegħed ikun apprezzat mill-Gvern.

L-MUMN ilha tipprepara għal dawn l-aħħar sitt xhur dokument interessanti ħafna li jinkludi numru sostanzjali ta' proposti li se jitressqu quddiem il-Gvern fil-ġimgħat li ġejjien bil-għan li jintlaħaq Ftehim Settorali ġdid.

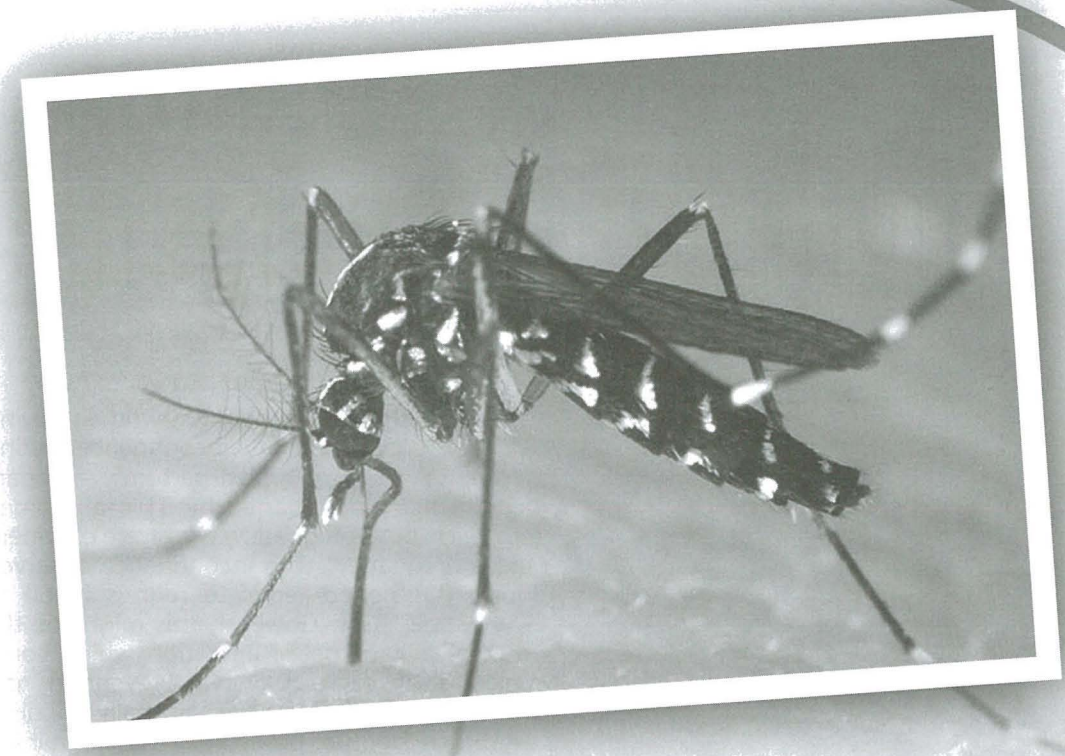
Ftehim importanti li din il-Union laħqet mad-Dipartiment tas-Saħħa huwa dwar l-i*Staff Nurses* li għamlu l-*conversion course* fejn is-snin li ħadmu bħala Enrolled Nurses ser jiġi rrikkonoxxut nofsu. Din kienet waħda mill-punti li l-Kunsill ġdid tal-Union beda jaħdem fuqha mill-ewwel u rnexxielu jsib soluzzjoni tajba għal kulħadd.

Fil-ġranet li ġejjin sejrin nippubblikaw il-formoli sabiex jiġi elett *Group Committee* ġdid tan-*nurses* fl-Isptar Mater Dei. Kull min hu interessat għandu japplika għaliex huwa indispensabbli li jkollna *Group Committee* b'saħħtu u effettiv. Ir-responsabbiltà ta' dan il-*Group Committee* jkunu n-*nurses* li jaħdmu fl-MDH minbarra dawk in-*nurses* li jaħdmu fid-Dipartiment tal-Emerġenza u fil-*Main Operating Theatres* peress li f'dawn iż-żewġ postijiet tax-xogħol għandna żewġ *Group Committees* ħabrieka ferm.

Nixtieq nfakkar li din is-sena, eżatt fid-19 ta' Settembru, l-MUMN ser tiċċelebra l-20 sena anniversarju minn meta twaqqfet. Il-*Group Committee* responsabbli mill-Attivitajiet qed iħejji programm interessanti ħafna għal dan il-perjodu. Aktar informazzjoni titħabbar 'il quddiem.

Għal llum ser ikolli nieqaf hawn għax malajr jiġbduli widnejja minħabba l-ispazju. Nieħu l-opportunità biex nawgura l-Għid it-Tajjeb lilek u lil għeżież tiegħek.

Colin Galea, Segretarju Ġenerali



Nurses are first point of care, education and community resilience to Zika virus

Geneva, Switzerland, 10 February 2016

As the largest group of health professionals in the world, and the first point of care for many, nurses are key to educating patients on prevention and risk of the Zika virus and providing care to those who need treatment.

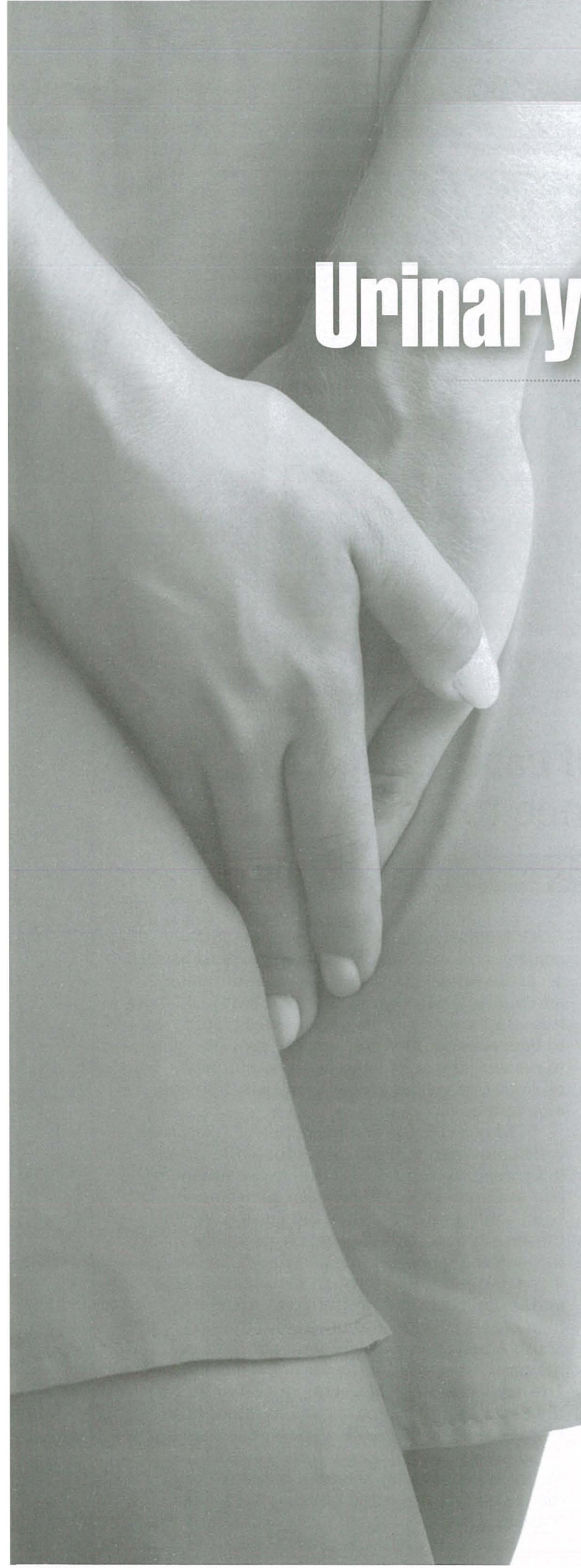
The International Council of Nurses (ICN) recommends nurses in infected countries to advise patients to protect themselves against mosquito bites through the use of insect repellants, bed nets, window and door screens, and covering exposed areas of skin. In addition, any containers, such as flower pots, buckets, etc. that many contain water where mosquitoes can breed, should be removed. In non-affected countries, ICN advises nurses to ask whether their pregnant patients have recently travelled to infected countries and to advise them against travel to those areas.

"With nurses providing the majority of primary health care in most countries, it is important they are aware of the risks of the virus, the ways to prevent its spread, and when testing and treatment are needed," said Dr Frances Hughes, ICN's Chief Executive Officer. "While the Zika virus disease is usually relatively mild and requires no specific treatment, this recent outbreak and the risk it poses to pregnant women have caused widespread concern."

Dr Hughes added, "To reduce fear and anxiety, it is important for communities to have access to up-to-date and accurate information and nurses are the key vehicle of delivery of this information. Nurses are also well placed to educate and offer psychosocial support to reassure the public and build community resilience, as well as ensure early detection and intervention."

In May 2015, the first infections of Zika virus were confirmed in Brazil. Since then, the virus has spread to over 13 countries in the Americas, and in Cape Verde, Africa.1 Cases have now been confirmed in the USA and Europe. While the virus is transmitted to people primarily through the bite of an infected Aedes species2, it can also be spread through blood transfusion and sexual contact. Unfortunately, there are many cases in Brazil and other countries in South America, in which a pregnant mother has passed the virus on to her unborn child. The news channel, Al Jazeera3, reported that the Brazilian Minister of health has announced that there are over 4,000

suspected and 400 confirmed cases of microcephaly among newborn babies with many strongly suspected of being caused by the Zika virus.



Post-Partum Urinary Incontinence

Almost half the number of women giving birth, experience urinary incontinence during pregnancy and/or post-partum[1]. Urinary incontinence was reported by 31% of women with a first-time-pregnancy, who were continent before pregnancy[2]. The incontinence observed during this period tends to regress in 60 to 80% of the cases. However, this might be the result of a light pelvic alteration which could cumulate at each delivery[1]. Prevention and treatment of incontinence normally involves recommendation of pelvic floor muscle training during pregnancy and after birth[3,4]. However, it is also important that such persons use good quality continence devices which are adequate for urinary incontinence as well as for absorption of blood, to help improve their quality of life during this period.

Urinary incontinence is the loss of bladder control. Symptoms can range from mild leaking to uncontrollable wetting. Most bladder control problems happen when muscles are too weak or too active. Stress incontinence may happen if the muscles, that keep the bladder closed, are weak. Hence, there may be accidents when one sneezes, laughs or lifts heavy objects. On the other scenario, urge incontinence or overactive bladder, takes place when bladder muscles become too active. One may feel a strong urge to go to the bathroom when she has little urine in the bladder[5].

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

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

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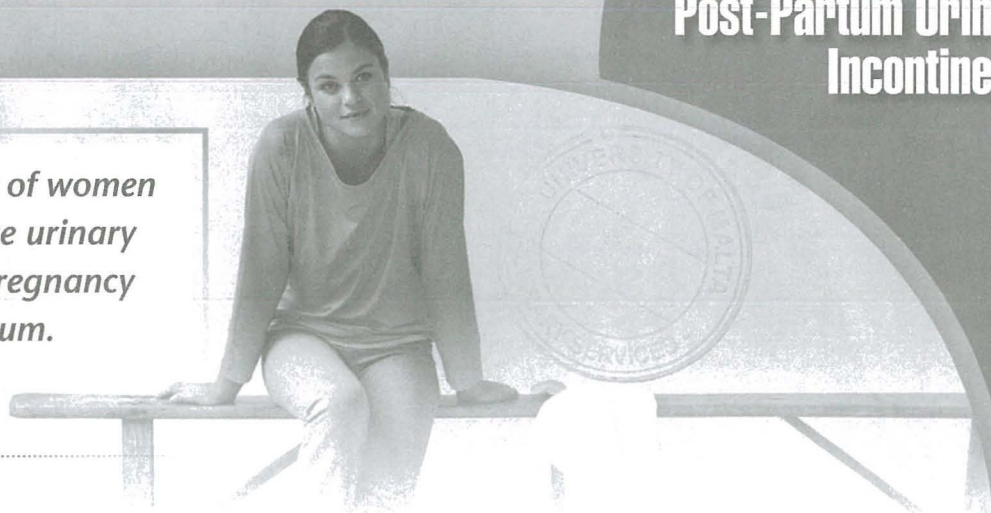

Good quality continence devices are able to provide:

- **A Perfect fit** since they are anatomically shaped to fit closely and safely to the body. Friction from clothes or continence devices is one of causes of groin rash[6]
- **Discretion** having an odour neutralizer, are not bulky, and do not rustle on movement
- **Security & Reliability:** through the use of a system that locks wetness away quickly & safely, through the use of super absorbent gels in the core. This is important when considering that frequent incontinence, constant exposure to moisture, the use of occlusive continence devices, and decreased mobility may put a person at a higher risk for Incontinence-Associated-Dermatitis[7].
- **Integrity of device** without tear during use
- **Comfort** through the use of air-permeable materials similar to normal underwear. In contrast to occlusive materials; semi-permeable materials enable the circulation of air and consequently allow heat exchange for a balanced skin climate. Reduction of heat and sweat build-up, enhance skin comfort and support prevention and reduction of skin redness and irritations[6,7].
- **Skin friendliness** through the use of skin-friendly materials which are less likely to cause skin sensitivities. Constant contact with possible allergenic materials may cause Contact Dermatitis[6]. Hypoallergenic and dermatologically tested products offer the best possible guarantee of reliably preventing allergic reactions.
- **Anti-bacterial and skin protective effect** by using materials, which are in continuous contact with the skin, that keep a slightly acidic pH[7]
- **Suitability to absorb blood** is especially important after birth, in order to cater for heavy vaginal bleeding

Choosing the right continence device to address a person's needs will lead to the achievement of cost-effectiveness through better use of the products' potentials, thus avoiding excessive consumption and waste. Not all continence devices are indicated for absorption of blood as well as for urinary incontinence. However, these are available on the market, and are not necessarily the most expensive devices. The advantages achieved when using such good quality products are: better comfort, substantial savings in laundry costs, less skin problems and a better value for money. The Nurses'/Midwifes' input, in recommending the right continence device to their patients, is of utmost importance, since they are able to understand the necessary features built into such products, in order to lower health associated risks. This results in the promotion of a better quality of life for their patients coping with incontinence.

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

Global Work Migration

Crisis and Opportunity in the Nursing Profession

In an attempt to address nursing shortage within the United State, healthcare organizations are increasingly resorting to recruitment of foreign nurses. While this recruitment practice has led to increased staffing levels within the United States, it simultaneously creates nursing shortages in less developed countries. In an effort to counter this inherent ethical dilemma, the nursing profession, health care organizations and government legislators are engaged in developing approaches that can facilitate a "win-win" outcome characterized by adequate nurse staffing levels in both developed and developing countries.

The shortage of nurses occurs on a global scale with fluctuating levels dependent on labour market conditions. There exists economic push and pull factors in the developing and developed countries respectively. Factors include the level of income, availability of employment opportunities and working conditions. It is in this multifaceted context that recruitment by developed countries takes place. Studies show evidence of the resultant "brain drain" and negative economic impact on developing countries. Long-term considerations on the impact of global nurse migration raise ethical questions pertaining to "human rights, global injustice, global policy for fair wages paid, and quality health care outcomes."

Two major factors contributing towards nursing shortage within the United States are an ageing nursing workforce and the lack of nurse educators. Nurses are opting to remain in the workforce for higher salaries related to the labour market rather than returning for advanced degrees needed to become instructors to the next generation. The long term impact is less availability of seats in nursing schools, and fewer enrolled/graduating nursing students to replace the aging workforce. Utilizing immigrant nurse labour force is a stopgap solution, especially when one considers the often partisan and volatile legislative process impacting migration policy and trends.

Two major stakeholders – the American Nursing Association (ANA) and the American Hospital Association (AHA) – are in favour of restricted employment of immigrant nurses. While this stance can be contentious as self-serving, both entities are valid in their observations that this approach is offers a "short term solution which does not address the core issues driving the problem within the United States." Both entities raise valid objections to wealthier countries luring and/or poaching nurses Page 9 of 12 from less developed (often underserved) countries. The ANA's insistence on adherence to guidelines aimed at protecting immigrant nursing workforce seem prudent given constant changes in immigration policy which can occasionally render foreign workers in limbo.

Nursing shortage exists across national boundaries making it possible for rich nations to "poach" nurses from other poorer countries. This "promulgates a circle of poverty and despair in locations where hope exists in the guise of quality health care, something which is often lacking." Adopting an international cooperative strategy to resolve the nursing shortage can allow for a positive-sum environment for all. Based on the game theory, this approach emphasizes increased educational and funding opportunities (in all countries) allowing for an increase in the applicant pool, subsequent decrease in employee poaching and thus a positive-sum outcome across national borders. All stakeholders must choose to engage in genuine cooperative behaviour for lasting change to occur.

Source: Muslin I, Willis WK, McInerney M, Deslich S. Global worker migration: Crisis and opportunity in the nursing profession. J Health Man. 2015; 17(1): 1-10.

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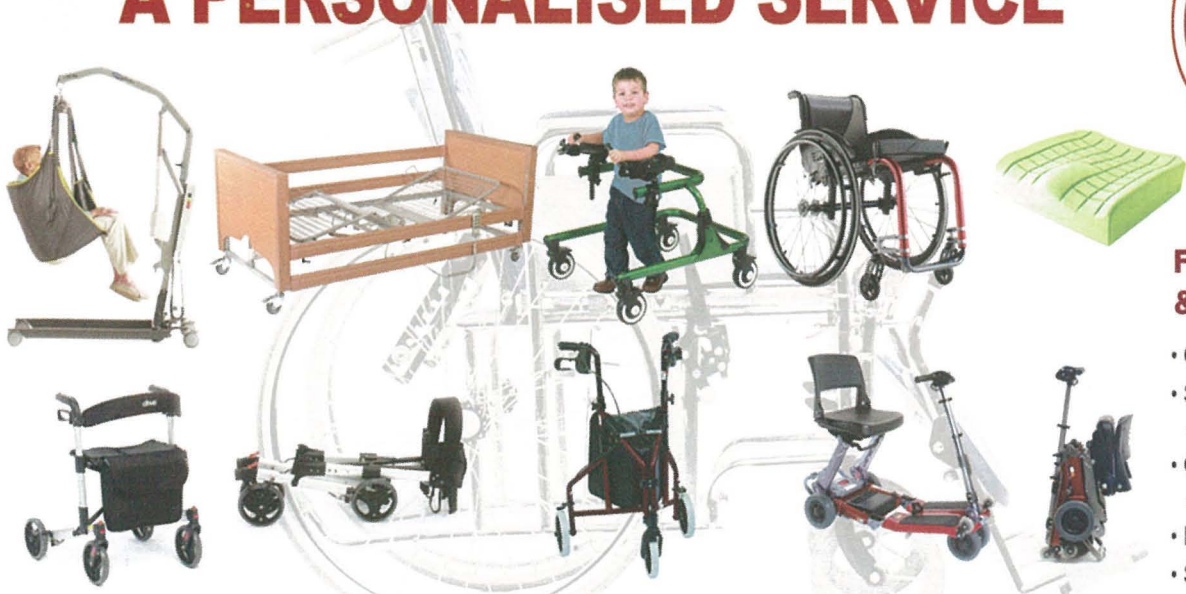

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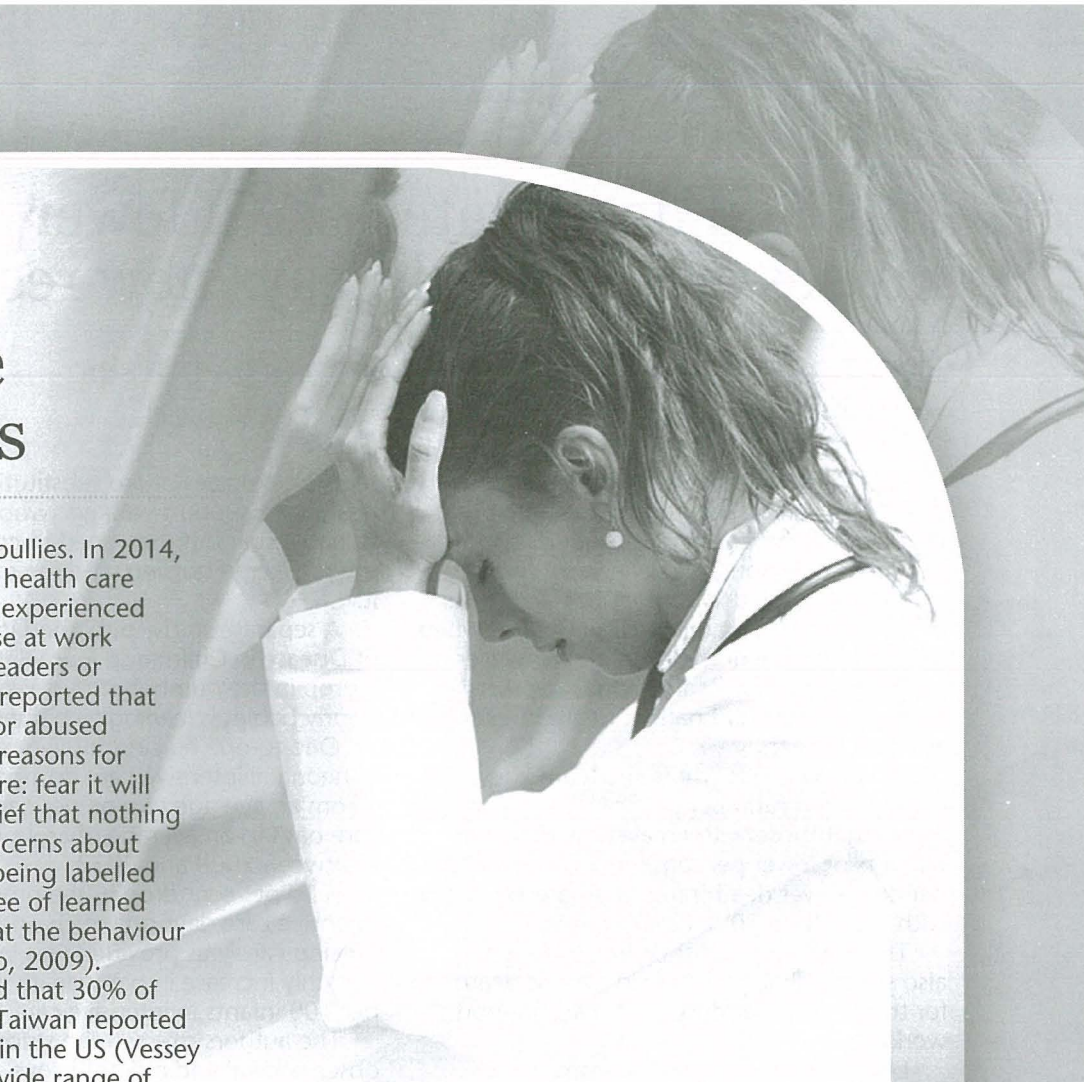
Children are not the only bullies



Children are not the only bullies. In 2014, 25% (NHS, 2015) of the health care professionals in the UK have experienced harassment, bullying or abuse at work from their managers, team leaders or other colleagues. Only 37% reported that they were bullied, harassed or abused at work (NHS, 2015). Some reasons for underreporting of bullying are: fear it will make matters worse; the belief that nothing would be done about it; concerns about confidentiality, concerns of being labelled a trouble maker and; a degree of learned tolerance that may imply that the behaviour is acceptable (Mistry & Latoo, 2009).

Pai and Lee (2011), found that 30% of their sample of nurses from Taiwan reported being bullied. Other studies in the US (Vessey et al., 2009) also showed a wide range of staff being bullied in the workplace. Sa and Fleming (2008), reported that 1 in 6 nurses were bullied in the previous six months.

But what is bullying? And how is it different from harassment? Bullying is an "offensive abusive, intimidating, malicious or insulting behaviour, or abuse of power conducted by an individual or group against others, which makes the recipient feel upset, threatened, humiliated or vulnerable, which undermines their self-confidence and which may cause them to suffer stress. Bullying is behaviour which is generally persistent, systematic and ongoing" (Centre for American Nursers, 2008). Harassment is an unwanted behaviour that offends, humiliates or intimidates a person, and targets them on the basis of a characteristic such as gender, race or ethnicity (Power, 2013).

Bullying creates a toxic work environment which will benefit almost no one. Victims may feel isolated from other team members and they might dread going to work. Self-esteem decreases and self-doubt can suppress their initiative and innovation.

Victims of bullying may suffer stress-related health problems, such as anxiety, depression, lack of sleep, weight changes, and substance abuse. Other staff members might feel stressed as well because they will be wondering if they will be the bully's next victim.

The health care professional is not the only victim; bullying affects the patients as well. Teamwork, communication and collaboration are all affected by bullying. When a manager purposely assigns too heavy a patient load, or does not provide assistance when needed, the patients' safety might be threatened and errors that might be fatal to the patients may occur. Nurses who have been bullied might be more reluctant to ask questions and are most of the time afraid to speak up to help their patients.As a result of bullying some nurses quit and may leave nurses without adequate experience or knowledge to recognize and act quickly on potential patient problems.

Bullying in the caring profession has become the norm and therefore it is difficult to accept that it is a problem. Therefore it is very important that professionals learn what bullying is and how to be able to stop the oppression.It is also important that experienced nurses remember what it was like to be a new nurse and to make an effort and welcome new nurses to make them feel part of the group. Actions speak louder than words and therefore if you ever experience bullying report the incident and if you see someone being bullied help the person in any way possible to make them feel better. In case you've been bullied Psychological Help is found to be very effective in dealing with the negative effects of the action.

Dragan Donkov
Employment Services Coordinator
Richmond Foundation

Hospital death rates rise if fewer nurses are on wards, says new research

Research suggests the drive to replaces nurses with less qualified staff should be reviewed

Death rates are higher on wards with fewer nurses, according to research that suggests the drive to replaces nurses with less qualified staff should be reviewed.

Experts studied 137 acute hospital trusts in England and found lower death rates when there were more nurses working. However, hospitals with healthcare support workers in higher numbers had patient death rates seven per cent higher.

Of the 31 trusts where the team knew the exact staffing ratio per patient, the researchers found that those with an average of six patients or fewer per registered nurse had 20 per cent lower death rates compared to trusts with more than 10 patients per nurse.

The findings, published in BMJ Open, also show a slight increase in patient deaths for trusts with the most healthcare support workers.

Lead researcher Jane Ball, from the University of Southampton, said: "At best, healthcare support workers make no difference, but at worst a higher level of support workers is linked to an increased risk of death during a hospital stay. "The heavy reliance on support workers at the expense of registered nurses puts patient safety at risk. That's a situation that can lead to more patients dying during their hospital stay."

She said that introducing new roles - such as the nursing associate role announced by the Government in December - must be evaluated for their effect on patient safety.

Janet Davies, Chief Executive of the Royal College of Nurses, said: "The evidence is a clear warning about the impact on patient care and outcomes if we are to have too few registered nurses or are substituting them for healthcare support workers [who] are highly valuable staff but they need to complement the registered nursing workforce - not replace it."

A separate study, published in the Archives of Disease in Childhood journal, found that a drop in the number of nurses caring for poorly babies is leading to higher death rates.

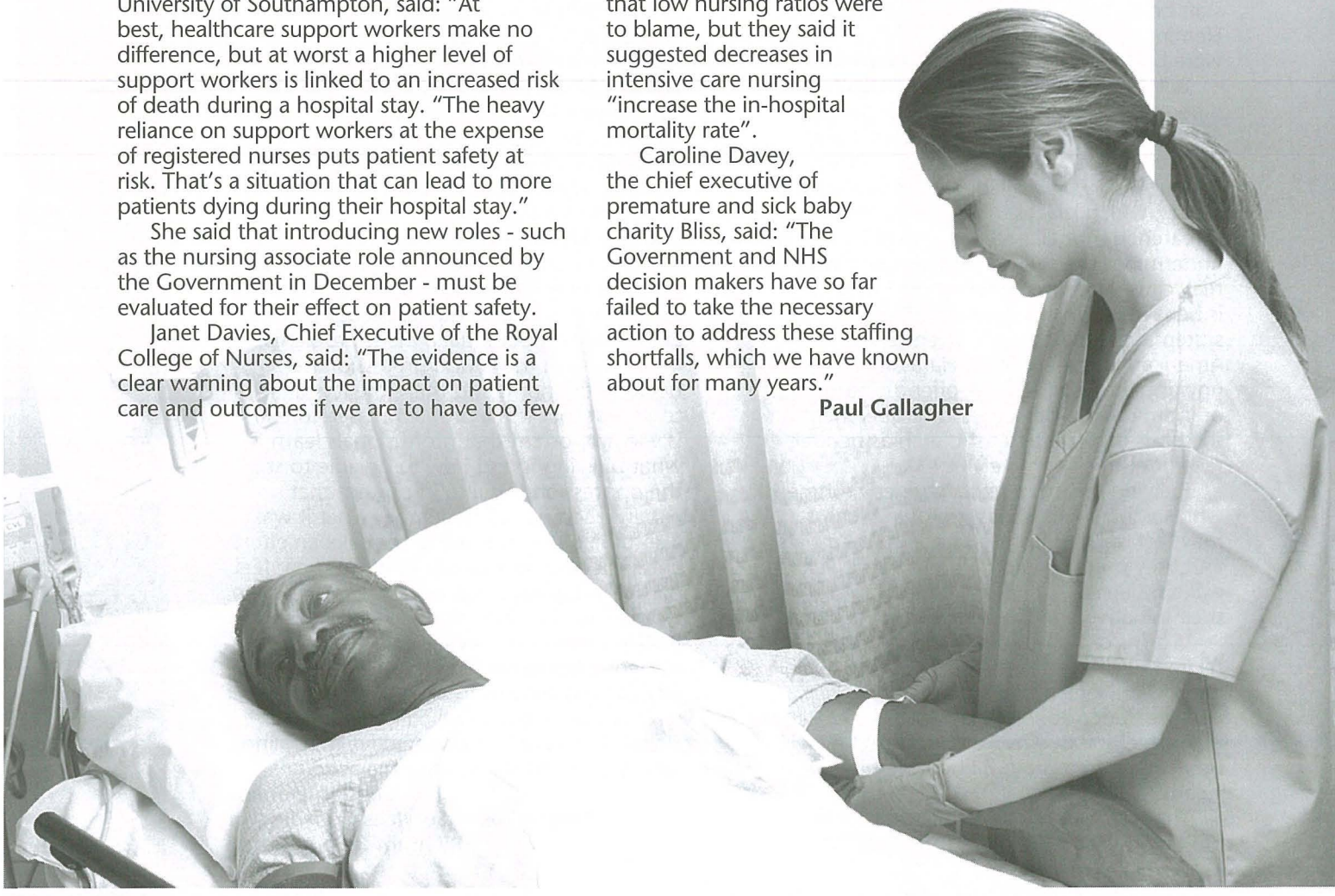
One-to-one nursing for very sick babies in neonatal intensive care dropped by a third - from an average of nine per cent intensive care days to an average of around six per cent - between 2008 and 2012.

A 10 per cent drop in the proportion of intensive care days on which one-to-one nursing care was provided was linked with a monthly increase in baby death rates of 0.6 per 100 infants in intensive care.

The authors stressed the study was observational and did not prove that low nursing ratios were to blame, but they said it suggested decreases in intensive care nursing "increase the in-hospital mortality rate".

Caroline Davey, the chief executive of premature and sick baby charity Bliss, said: "The Government and NHS decision makers have so far failed to take the necessary action to address these staffing shortfalls, which we have known about for many years."

Paul Gallagher



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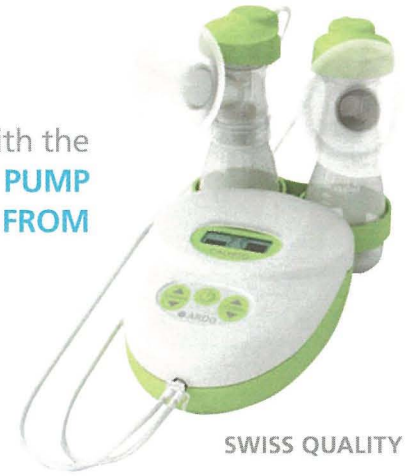

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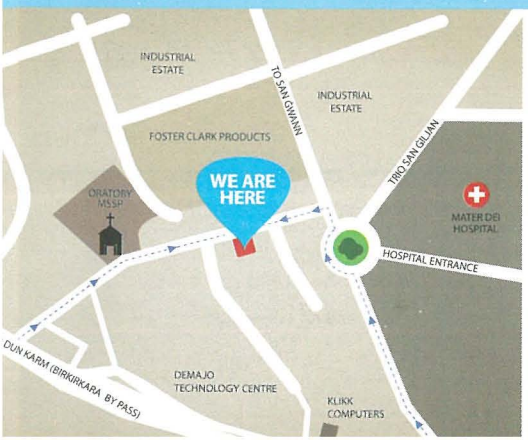

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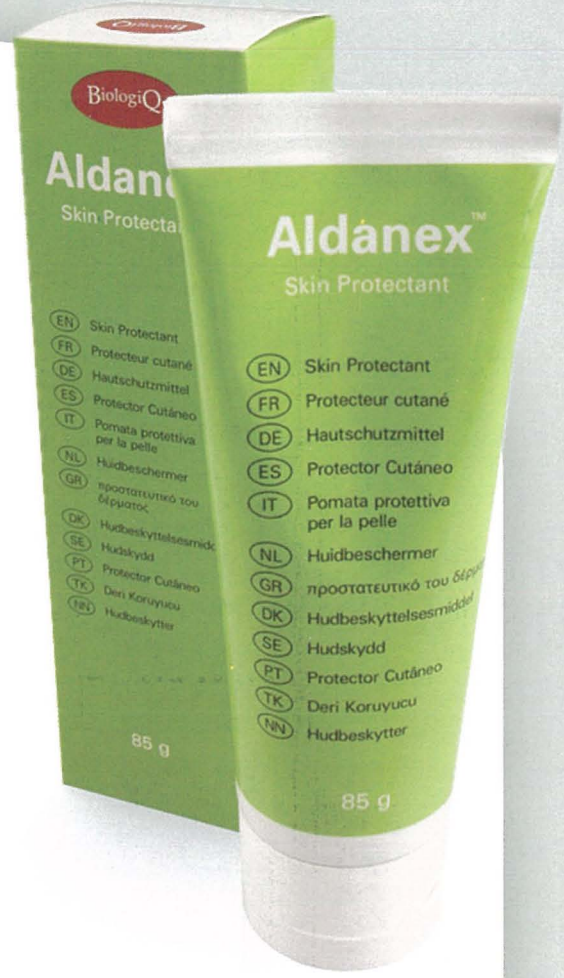
Aldanex™ bridges the gap between preventive skin care and therapeutic wound care



Incontinence is a major problem for healthcare systems worldwide. Roughly half of all institutionalized elderly patients suffer from incontinence; urinary, faecal or both. The results are all too familiar to care professionals everywhere: skin irritation, reddening, inflammation, infections and excoriations, all symptoms of Incontinence Associated Dermatitis (IAD).

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*Up to category 2

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from our diary...

MUMN 1996
Malta Union of Midwives and Nurses

Our Financial Secretary and Administration Committee Member George Saliba was elected as the European Regional Board Member of the Commonwealth Nurses and Midwives Federation. In this photo George Saliba is seen with the General Secretary of CNMF.

The MUMN Pensioners Group Committee during the Annual Christmas Party.

MUMN organised a Blood Donor Activity at St. Vincent de Paule through its Group Committee with the collaboration of Management.

Michael Cini Charge Nurse at the Day Care Unit in Gozo General Hospital won the Worker of the Year Award at GGH.

Josette Parnis Deputy Charge Nurse at the Renal Unit won the Role Model of the Year during the national ceremony of the Premju Haddiem tas-Sena 2015.

MUMN organised a very interesting conference – Safe Practice within the Clinical Environment.

MUMN organised its Christmas Dinner at the Xara Lodge. It was really great!

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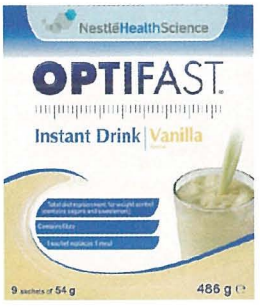
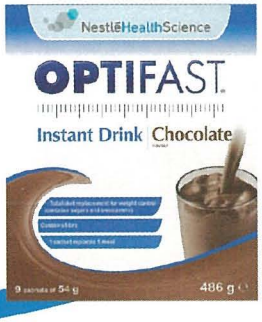
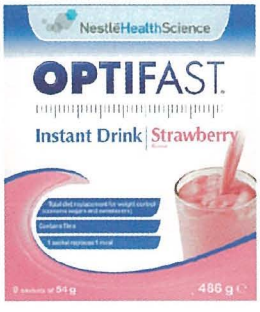


- Total diet replacement for weight control (contains sugars and sweeteners)
- Contains fibre
- 1 sachet replaces 1 meal





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Available from all leading pharmacies.

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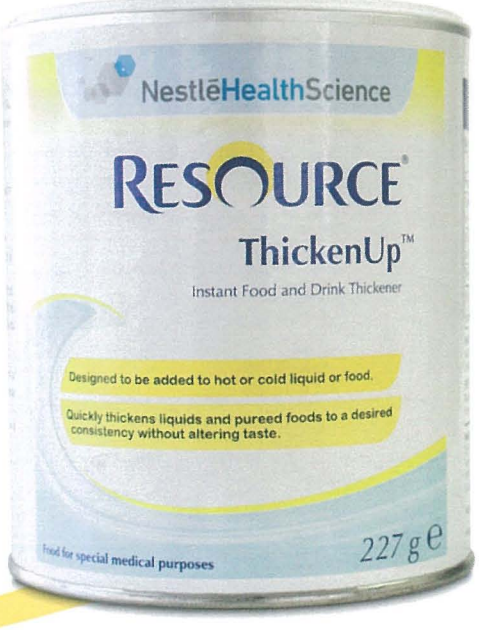

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1.5 kcal/ml (303 kcal per bottle)

11.2 g protein per bottle

Available in 5 flavours: Vanilla, Chocolate, Strawberry & Raspberry, Apricot and Banana.
Available from all leading pharmacies.

NestléHealthScience

RESOURCE® Diabet Plus

Nutritionally complete high protein food for special medical purposes, with fibres.

High Protein 18g*

High Energy 1.6 kcal/ml (320 kcal*)

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*/200ml.

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How does it work?

Meals are replaced with Optifast® VLCD™, which is designed to restrict energy intake, whilst still maintaining a healthy nutrition. Reducing the amount of calories (energy) you take throughout the day means that your body will start to draw energy from its own fat stores.

Each sachet provides 200Kcal of energy and is nutritionally complete. This means that each sachet provides carbohydrates, high quality protein, fat, and all the essential vitamins and minerals required to support normal body function. Depending on the specific needs of the user, Optifast® VLCD™ may be used as a total diet replacement or as a supplement to a calorie controlled diet.

- **Optifast® VLCD™ as a Total Diet Replacement**

  This program is suitable for individuals with a BMI >30 and must be used under medical supervision. Patients with type 2 diabetes, hypertension or a BMI >35 must be monitored carefully.

  4 sachets of Optifast® VLCD™ (800Kcal) per day are indicated as a total diet replacement for weight control. This program should be supplemented with a minimum of 2 liters of water and other calorie free drinks. Low starch vegetables can be included to supplement the diet. Once you start to achieve weight loss you may start to slowly introduce low calorie meals and use Optifast® VLCD™ as a supplement to a calorie controlled diet as shown below.

- **Optifast® VLCD™ as a Supplement to a Calorie Controlled Diet**

  This program is suitable for individuals who are trying to achieve a mild/moderate weight loss, or who are transitioning from using Optifast® VLCD™ as a total diet replacement.

  Use 1 or 2 sachets of Optifast® VLCD™ to replace breakfast / lunch /dinner. Other meals taken throughout the day should also be calorie restricted (350Kcal breakfast and 500Kcal lunch/dinner). This program should also be supplemented with a minimum of 2 liters of water and other calorie free drinks. Low starch vegetables, small portions of fruit and 1 portion of dairy can be included to supplement the diet.

Optifast® VLCD™ Product Range

- **Optifast Shakes**
  Available in vanilla, chocolate and strawberry these Optifast® VLCD™ Shakes can be enjoyed at breakfast, lunch or dinner.

Easy to prepare

Each Optifast® VLCD™ meal replacement is individually packed in sachets making it convenient to carry around with you. Simply pour the contents of one sachet into a suitable container and add 200ml of water. Stir vigorously using a fork whisk or blender and consume immediately.

Famous Nurses in history

by Liane Clores, RN

We are often lectured on the "need-to-know-people" in Nursing Schools and seminars. We try to memorize their works, but tend to forget them after handing pieces of paper to our Clinical Instructors, which turn out to be exams. But do we really understand their work and their role in nursing history? Let's get to know some of them find out what they did that made them famous and which molded nursing to what it is right now.

Florence Nightingale

Who, in the nursing profession, doesn't know the lady with the lamp? The term "nurse" is often synonymous with Florence Nightingale, who is considered as the most famous nurse of all time. Nightingale was a British nurse who worked during the 19th Century. A selfless nurse as she was, she fearlessly faced ruthless conditions in battle during the Crimean War. She was also a statistician and her devotion to reducing the deaths of British Army soldiers created some revolutionary conclusions on the existing conditions of patients. She also advocated cleanliness for all people in the hopes to reduce illness and death, thus the concept of dusting and cleaning.

Clara Barton

Also known as the "the angel of the battlefield" during the Civil War, her name is almost as closely related to nursing as Florence Nightingale. She is also the Founder of the American Red Cross in 1881, which she is known most. Being a lifelong philanthropist in the 1800's, she was shaken at the number of lives lost in the Battle of Bull Run with lack of medical supplies as one of the causes. After that, she traveled with medical teams during the war and assisted as a nurse. She had no proper medical education before her efforts in the war. Her first accomplishments were as a respected & successful school teacher

Margaret Sanger

As she is one of the most famous nurses, she is also famous for being a women's liberation activist in the world. She is an advocate of birth control & women's health which wasn't common when she was working as nurse in the early 20th century and founded the National Birth Control League which later became Planned Parenthood. She set up the 1st birth control clinic in the US and helped organize the 1st World Population Conference in Geneva in 1927.

Dorothea Dix

Also known as "Dragon Dix", she was an early US nursing pioneer-predecessor and contemporary of Florence Nightingale. She served as Superintendent of Nurses during the Civil war era and was known for her patient advocacy. She was strong supporter for the mentally ill and for prisoners thus bringing about great changes in the policies of mental hospitals. She asked the MA legislature for reforms to end the inhumane conditions of the mentally ill. However, her unfortunate nickname, stemmed from the strict rules she enforced with her staff nurses.

These are just some of the most famous nurses in history. Others areWalt Whitman, who was a famous male nurse, Mary Ann Bickerdykewho was famous for her ability to run army field hospitals, Linda Richards who was America's 1st trained nurse, Hildegard Peplau who is considered as the mother of psychiatric nursing, Madeleine Leiningerwho was foundress of the worldwide Transcultural Nursing movement and many others.

They are people who were known for their wealth or economic background, but were just simple people who have lived and have proven themselves to be selfless, dedicated nurses. Their legacy has lived on for decades and still continues to inspire people to become compassionate and professional health providers.

Haroon Siddique
Thursday 14 January 2016

Hospital A&E waiting times in England rise by a third in November

NHS England data show more than 157,000 accident and emergency patients are kept beyond four-hour target

The number of people waiting longer than four hours in hospital accident and emergency departments in England rose by a third in November compared with the same period last year, according to official figures.

NHS England data published on Thursday showed that 157,101 were kept waiting beyond the benchmark period in A&E in November, up from 117,644 in the same month in 2014. Attendances rose by 11,115 (0.9%) year-on-year.

The proportion of patients being seen within four hours at hospital A&E departments in November was 87.1%, below the 95% target.

Cancer referral and ambulance times were also missed and the number of delayed transfers was the second highest since recording began in August 2010. The statistics prompted Labour to call it the NHS's worst November ever, while the Nuffield Trust think tank said they did not bode well for the remainder of the winter.

Nigel Edwards, chief executive of the Nuffield Trust, said failure to meet the targets "now seems to have become the norm rather than the exception".

He added: "These new figures are particularly worrying given that they only cover November, when the weather was exceptionally mild and winter had not even properly begun – the fact that there have been such dips in performance so early in the season does not leave the health service in a good position to cope with the rest of winter."

Edwards said the issue of delayed transfers was rapidly becoming the biggest problem many NHS trusts face. The number of patients delayed in hospital on the last Thursday in November (5,600) was the highest since records began in 2010. The number of patients waiting longer than 62 days to start first treatment for cancer was up 14% year-on-year, with 83.5% starting treatment within 62 days, below the target of 85%.

In total, 1,729,292 diagnostic tests were undertaken in November, a 4.9% year-on year increase, adjusted for working days. But the number of patients waiting longer than six weeks for a diagnostic test was up 36% and the number waiting longer than 13 weeks was up 118%.

The NHS says the long-term trend was of greater volumes of both urgent and emergency care and elective activity.

Heidi Alexander, shadow health secretary, said: "There is a crisis in A&E, elderly patients are stuck in hospital because of a lack of care in the community, and thousands of people are waiting more than 18 weeks for operations.

"The reality is that this dramatic deterioration in patient care is a direct consequence of this government's policies. They cut older people's care in the home, meaning hospitals have become dangerously full, and cuts to nurse training places have forced hospitals to drain resources hiring expensive agency staff. The NHS is being badly let down by this Tory government and it is patients who are paying the price."

The government prefers to measure the target for 95% of people being seen within four hours against all emergency departments, not just those in hospitals. By that measure, 91.4% of patients were treated within four hours in November, compared with 93.5% in the same period in 2014.

Richard Barker, interim national director of commissioning operations for NHS England, said:"These figures for last November show frontline staff treating record numbers of patients, with particularly large increases in the number of patients getting diagnostic tests, emergency ambulance callouts, and using the NHS 111 service. We continue to treat more than nine out of 10 patients A&E patients within four hours, probably the best performance of any major western country."

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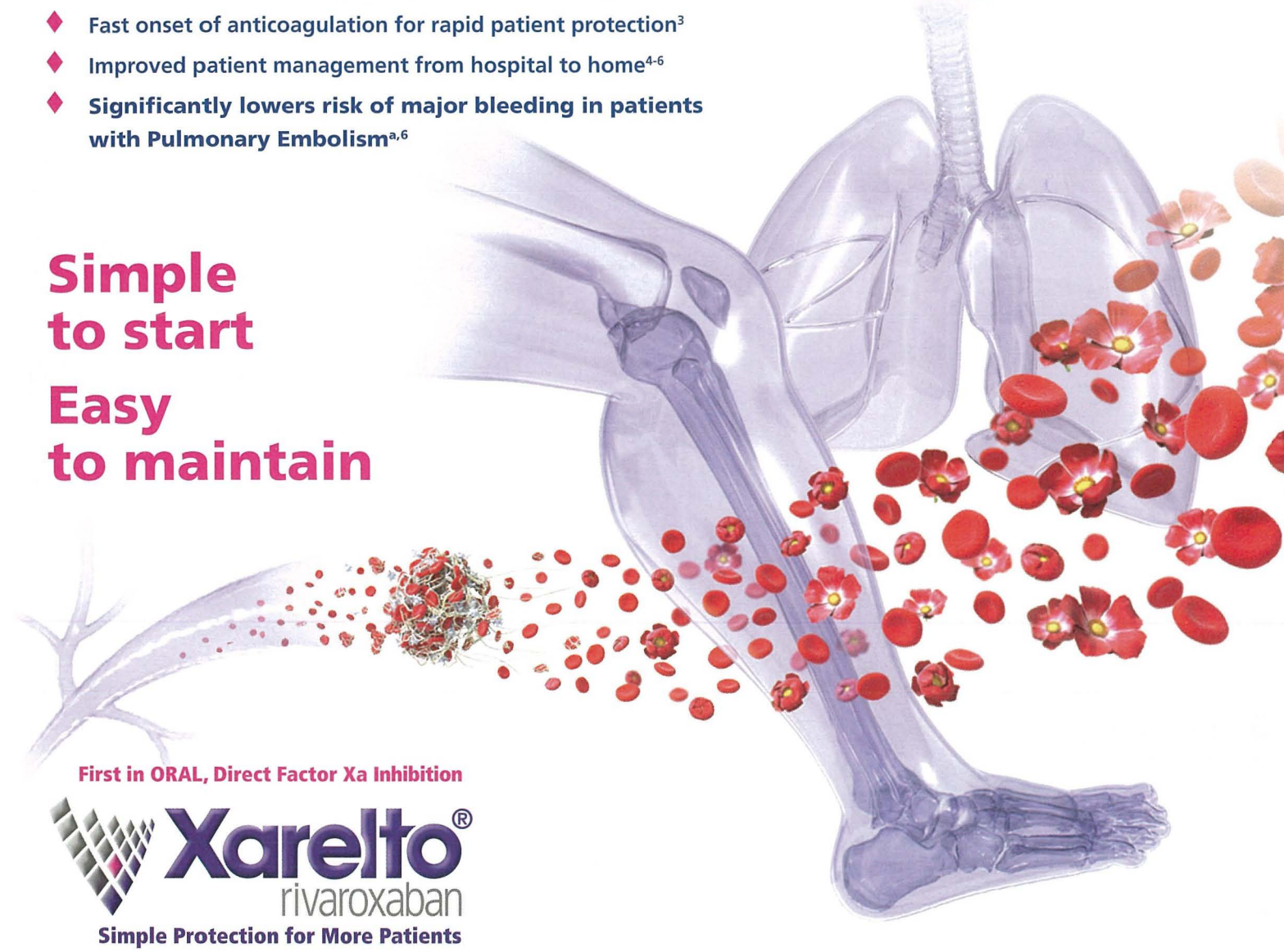

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References: 1. Enoxaparin SmPC. **2.** Warfarin SmPC. **3.** Kubitza D et al. Investigation of Pharmacodynamic and Pharmacokinetic Interactions Between Rivaroxaban and Enoxaparin in Healthy Male Subjects. Clin Pharmacol Drug Dev; published online: 15 MAY 2013. DOI: 10.1002/cpdd.26. **4.** Xarelto® (rivaroxaban) Summary of Product Characteristics as approved by the European Commission. **5.** EINSTEIN Investigators. Oral rivaroxaban for symptomatic venous thromboembolism. N Engl J Med 2010;363(26):2499-2510. **6.** EINSTEIN-PE Investigators. Oral rivaroxaban for the treatment of symptomatic pulmonary embolism. N Engl J Med. 2012;366(14):1287-1297. DVTx=treatment of deep vein thrombosis; OAC=oral anticoagulant; PEx=treatment of pulmonary embolism. **a** Compared with current standard of care (dual-drug approach of LMWH and VKA).

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Talba ta' ners

Illum Mulej agħtini
ftit dehen, kuraġġ u ħila
biex naqdi dmiri sewwa,
u ma nsibhiex bi tqila
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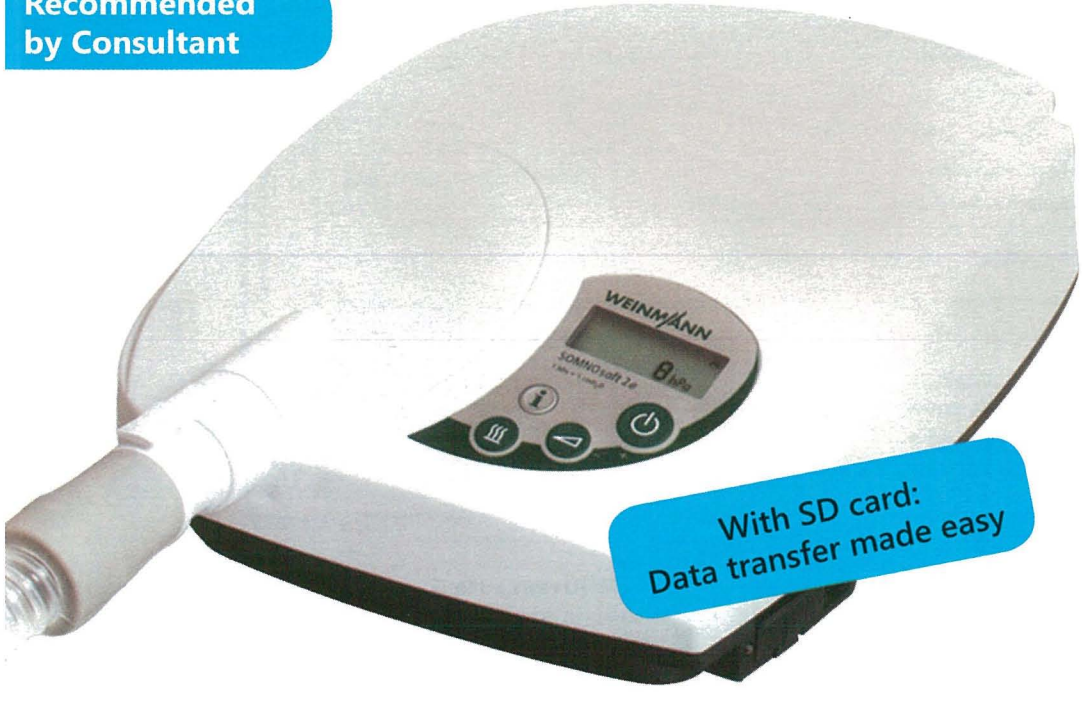

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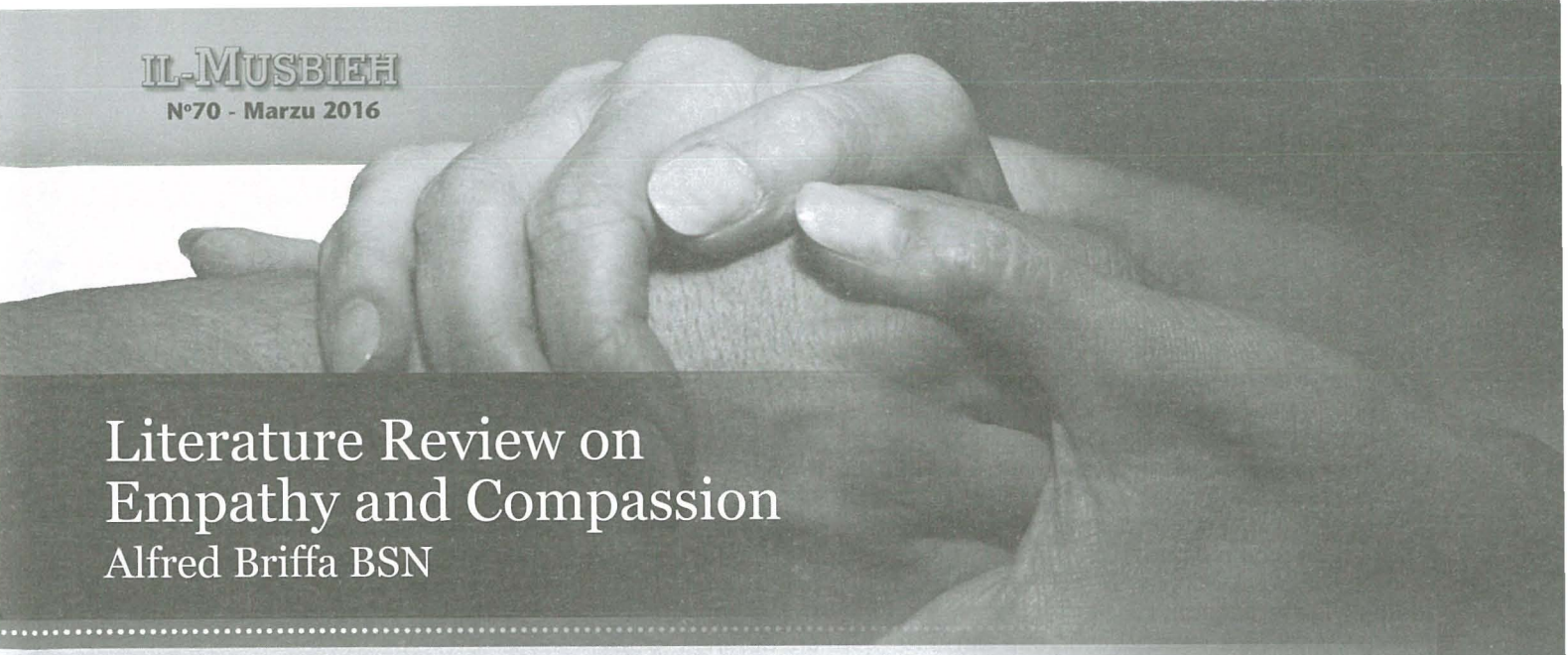


Literature Review on Empathy and Compassion

Alfred Briffa BSN

The best strategies to engage millennial nurse leaders
Written by Laura Dyrda | February 08, 2016

Nurses entering practice today need to be trained on how to become the next generation of nurse leaders. In order for that to happen, there are time-tested principles/practices that need to be observed, but the way in which those are delivered must evolve to reflect how this new class of "millennial" nurses absorbs and processes information.

"We need to teach these nurses to lead, mentor and coach," says Press Ganey CNO Christy Dempsey. "We have to do a better job at teaching them how to be leaders."

The key qualities of nurse leaders include the ability to:

1. Foster trust and teamwork
2. Model compassion and empathy
3. Provide support in the form of human, material, and emotional resources
4. Communicate effectively with patients, physicians and other nurses
5. Be visible and accessible
6. Acknowledge the complexity and the gravity of the work nurses do

Education is also important and practicing to the top of their nurse licenses will allow nurses to continue growth.

"Healthcare is a team sport; it's not something one person can do by themselves," says Ms. Dempsey. "Our patients want to see that the people who are taking care of them are talking to each other. Empathy is a cognitive attribute; it's not emotional. You have to be able to understand what someone is going through and then communicate the understanding back to them. It's really becoming a lost art."

There are some who argue empathy can't be taught, but Ms. Dempsey isn't one of those leaders. She firmly believes teaching nurse leaders empathy builds trust and allows them to lead with compassion but also based on data.

One of the most effective strategies for developing new nurse leader empathy is roll playing. Roll-playing has become an integral part of training at one Nevada hospital where nurses are asked to leave their belongings in the staff locker and then wait in the emergency room for hours. The trainers don't tell them anything about the next stage of training, just to wait until they're called.

When the nurse finally is called out of the ER, the trainers lead them to a room, pull the curtain closed and talk about the nurse from the other side of the curtain. The new nurse can hear everything going on the ED but they don't know what is happening.

"Then the preceptor comes in and says, 'this is what your patients go through every day; don't forget it'," says Ms. Dempsey. "But the training isn't a one-and-done. The patient's experience in its totality isn't something that you can talk about one time at orientation and expects the lesson to stick for a 20-year career."

Ms. Dempsey suggests talking about empathy and compassion on an annual basis and training to make sure it's second nature for the nurses. Formal ongoing education around the patient experience is crucial; this is different from patient satisfaction because the patient experience encompasses clinical, operational, cultural and behavioural aspects.

The work environment is also important for a successful organization. The nurse culture begins with leadership and can drive forward with the right attitude from the top down. Nurse leaders can practice "modelling behaviour" to encourage others and drive up the standard of care.

"We talk about purposeful rounding in our organization and we want nurses to go in to the patient rooms every hour and have a purposeful connection with their patients," Ms. Dempsey says. "If nurse leaders want nurses to sit down and make a connection with patients, you have to do that too."

One of the best ways to connect with patients is discovering something about them outside of their reason for being in the hospital. The best nurse leaders apply the same principle to their nursing staff.

"If you're a leader, it's important to know something about the staff that isn't work-related," says Ms. Dempsey. "I think it goes back to the

• continued on page 35

A suicide attempt!

Suicide! That horrible word! That word which, by itself, unveils a reality of suffering. Suicide! That word which speaks volumes about the hidden story that is overtly personified in its victims.

Suicide knows no feasts, people or status. It just hits when it wants. And when it hits it does so with a shocking mercilessness. It occurs suddenly! Unexpectedly! Reality has been constantly showing me that everyone can fall prey to this awful experience. Non-religious and religious alike. Suicide is like a professional burgular. It attacks when it is least expected of it. Even if the alarm has been on for quite sometime no one would really know when its time has come to happen. Irrespective of loads of preventive measures suicides keep happening. However, the more the suicidal incidence is on the increase the more arises the need of suicide prevention. Certainly education is a key factor in combatting suicide. Thus, as far as hospital chaplains are concerned, there is a vital need to let ourselves be educated about suicide.

Recently I have had the grace of reading an interesting article about suicide by a world-renowned expert on suicide bereavement, by the name of Joanne Harpel. The article's title is Six Things every Spiritual Care Provider Should Know About Suicide. Harpel gives nationwide guidance in the US to families and communities who are finding it extremely difficult to cope with suicide loss. Besides she is an invited Huffington Post blogger, an experienced guest lecturer and trainer at the VA National Chaplain Training Center, WHO, American Psychiatric Association as well as the American Academy of Child and Adoloscent Psychiatry. Joanne Harpel has a first-hand experience about the destating effects of suicide. She is a suicide survivor. In fact, her brother Stephen, an honours graduate of Yale, at the tender age of 26, immediately developed bipolar disorder. Unfortunately, even if he was greatly surrounded by the love of family and friends, and although every effort was spent to get for him the appropriate treatment he committed a suicide the following year.

In her article Harpel describes suicide as "stigmatized", "taboo subjected" and "tricky territory". Moreover, due to the traditional Christian cultural setting as solidified by the Catholic Church's teaching on the subject the taboo tends to have harsh judgmental undertones. Let us not forget that, according to the Church's teaching, suicide is wrong because it is contrary to the Fifth Commandment. Suicide goes against the proper love of self and the love for God, the giver of life. The Church greatly encourages us to be stewards and never masters of our own lives to the point of terminating it when we want. The person who commits suicide wrongs others by his or her act. No one can really imagine the huge pain of loss, bewilderment and grief family and friends go through. Because of these catastrophic consequences one is easily lead to believe that those who take away their lives are destined to going to hell forever. Although the Church never pronounced this judgment many people tend to believe it. Hence, there is an urgent need for appropriate education on the subject lest it hits home and finds us unprepared!

According to Joanne Harpel there are six things which chaplains should know about suicide in order that, as spiritual care providers, what they say and do become all the more relevant to survivors of suicide loss. These six points can ease more the latter's relationship with their belief system and faith community as well as help them recover their sense of equilibrium.

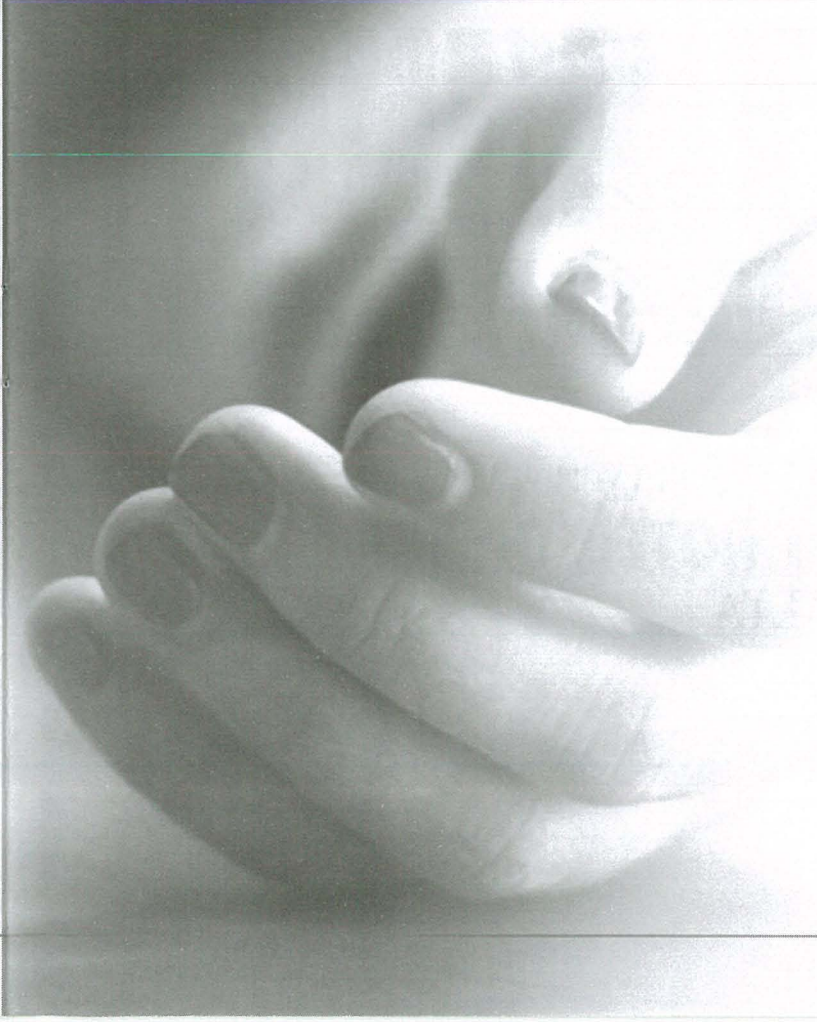
Every chaplain must realize that suicide is really a complicated issue. No one takes his/her own life for the fun of taking it. The incidence of suicide has been steadily related to mental disorder, particularly depression, bipolar disorder, schizophrenia, or substance abuse, or some combination. The immense psychological pain and complete hopelessness these illnesses bring about is extremely deleterious. As Harpel rightly explained, when a person suffers job losses, broken marriages, or receives a bad news concerning his or her healthy, "when you're experiencing those circumstances through the lens of mental illness and the accompanying distorted thinking and inability to see a hopeful future, your decision-making can become compromised, and you begin to see suicide as a viable – and perhaps the only – option".

The second factor one should take into account when dealing with suicide cases is the grieving family and friends who, most probably, shift the blame to themselves or to each other. Harpel says that "it's very common for loved ones to replay those final days over and over, desperately searching for an answer to the single most pressing question: "WHY?" They ruminate over the things they said or did (or didn't say, or didn't do) believing it's somehow all their fault. Or they angrily blame: the wife who left him, the boss who fired her, the mother, the principal, the bully, the therapist. God".

The third factor is that chaplains must be aware of their beliefs and feelings regarding

A suicide attempt!

"when you're experiencing those circumstances through the lens of mental illness and the accompanying distorted thinking and inability to see a hopeful future, your decision-making can become compromised, and you begin to see suicide as a viable – and perhaps the only – option"



suicide. Harpel advises chaplains to "educate" themselves about the subject by "simply looking at [their] faith's website;" "read[ing] contemporary religious commentary and/or some of books listed below and talk[ing] to colleagues and mentors that [they] respect. And candidly self-reflect on whether counseling the suicide bereaved is something [they] can do in good faith". Since chaplains too are limited if they feel up to it to offer authenticity coupled with, what she termed as "genuine presence", they are to "identify someone else who could step in".

The fourth factor is that the chaplains may not be completely prepared for the suicide situation. Thus, Harpel suggests that the spiritual care provider should personally and frankly ask the following questions: "What exactly about it makes you anxious? What specific situations do [I] worry [I] might face? Do you feel [my] training and experience have adequately prepared [me]? What additional information or guidance would [I] need in order to feel more fully equipped?"

The fifth factor reassures the chaplain's unique and extremely important role in suicide bereavement situations. Thanks to their ministry chaplains can be useful instruments in educating people about suicide. While they purposely refrain from being judgmental they will not fall into the trap of normalizing or glorifying it either. The chaplains' role encourages them to highlight suicide prevention in their ministry. And, most important of all, chaplains, explains Harpel, "can model both open communication about these fraught subjects and compassionate, nonjudgmental support".

Finally, chaplains are to remind themselves that suicide can be around the corner for them too! Harpel says that "more than 85 percent of us [chaplains] will lose someone we know to suicide. If you've been touched by suicide yourself, you may be caught off guard by how hard this work hits you. As a spiritual care provider it's in your nature to take care of others. Take good care of yourself, too".

The next time I shall be paged to assist family, relatives and friends of a person who would have committed a suicide attempt I would surely pray to God that I would be able to let these factors talk to, instruct, enlighten and shape my pastoral self. In her Catechism the Church teaches that "we should not despair of the eternal salvation of persons who have taken their own lives. By ways known to him alone, God can provide the opportunity for salutary repentance. The Church prays for persons who have taken their own lives" (§ 2283). May this salutary teaching reflect my non-judgmental pastoral comportment!

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10th YEAR ANNIVERSARY

Press Release 9th November, 2015

Nurses across Europe Unite to demand recognition and expansion of nurse specialist roles

European Specialist Nurses Organisations (ESNO) calls for 'transformation of nursing and healthcare workforce' to drive greater patient engagement and self-management, and to safeguard future of healthcare systems across Europe.

In an important development for the future of healthcare workforces across Europe, the European Specialist Nurses Organisation (ESNO) has launched the ESNO 2015 Manifesto – a clear call to action for governments and statutory nursing bodies to expand the availability of nurse specialists across all countries and all major areas of care, starting with formal recognition of nurse specialists both in terms of professional status and as a strategic policy priority for healthcare systems.

Speaking to delegates at ESNO's inaugural summit in Brussels, (5th and 6th November), ESNO President Ms. Francoise Charnay-Sonnek challenged governments and professional bodies to act, stating that: "We need a transformation in our health workforce if we are to cope with rising costs, the growing prevalence of chronic disease and the changing demands of more empowered generation of patients. Specialist nurses are uniquely positioned to meet this enormous challenge, yet today the issue has received little recognition at the European or national policy level. Moreover, the ESNO survey shows that specialist nurses are really interested in working in another countries Europe. But to enhance mobility of specialist nurses, to ensure safety quality of care as well as quality at work, their qualification should be automatically recognised"

Research shows that specialist nursing roles can improve patient outcomes, are likely to be cost-effective in the long-term and are widely considered to have huge potential in helping to secure sustainable healthcare systems. Anne Marie-Felton, President of the Foundation of European Nurses in Diabetes (FEND) and a founding member of ESNO stated; "Diabetes has been a major test bed of how specialist nursing can deliver regular close care supervision, in reducing the impact of co-morbidities, and in empowering patients to understand and engage in their treatment. But even in diabetes we're simply not making progress fast enough. So our choice is simple: we can have more of the same – which isn't working - or we can start to transform the way nursing works at the heart of our healthcare. We are proud to stand together with nurse specialists from all areas of practice to launch the ESNO Manifesto – it is a vital step forward for all patients in Europe."

Literature Review on Empathy and Compassion

• continued from page 31

theme of compassionate, connected caregivers. Nurse leaders acknowledge the work is difficult and foster team work to earn their employees' trust." Finally, active communication is a key component of leadership. But the type of communication is rapidly evolving as millennials enter the workspace and leadership roles. Millennials may have different values than older generations; work-life balance is very important and effective leaders understand how to pull excellence out of their team.

"There has to be the recognition that this job is hard and the nurses want a work-life balance," says Ms. Dempsey. "When we think about staffing and scheduling, we have to take that into account."

Millennials also prefer leaders not "manage" them. Instead, mentors can frame their role as helping younger nurses grow and prepare for the next stage in their careers. Developing expectations for empathy and teaching appropriate communication is necessary, especially when young nurses are treating patients in older generations.

"This is a very tech-savvy generation, but, we must teach them how to connect with other people," says Ms. Dempsey. "Thirty years ago when I went to nursing school, we practiced IVs on each other and did bath rubs on each other. We learned what was too rough, what worked and what didn't. Nurses today are taught on simulators and simulators don't usually talk, get angry or cry."

Young nurses need strong leaders who will work with them beyond just the preceptor orientation; they need mentors who will help make sure these new leaders understand their not only their job but also what effective nurse leadership looks like.

"Front line managers can make or break the experience of their staff and patients," says Ms. Dempsey. "We have to make sure they are well prepared to mentor and coach the people at the bedside."

Nursing Leadership in Primary Health Care for the achievement of Sustainable Development Goals and Human Resources for Health Global Strategies

Authors: Gail Tomblin-Murphy, RN, PhD and Annette Elliott Rose, RN, PhD

Primary Health Care and Universal Health Coverage

The classic definition for Primary Health Care (PHC) is "...essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process."

The WHO model of PHC is focused on better health for all using the following key elements: reducing exclusion and social disparities in health; organizing health services around people's needs and expectations; integrating health into all sectors; pursuing collaborative models of policy dialogue; and increasing stakeholder participation.

Universal health coverage (UHC) has become the internationally agreed objective of health and development policy. UHC aims to ensure that all people can use the promotive, preventive, curative, rehabilitative and palliative health services that are of sufficient quality, while at the same time ensuring that the use of these services does not cause financial hardship to the consumers. To this end, it is important to remember that PHC is the preferred and effective means of delivering essential health services at a cost which governments and communities can afford.

A national healthcare system is more effective when it is based on PHC encompassing a range of publicly funded essential and universally accessible and equitable health services to the population.

Strategies for Strengthening Primary Health Care

Strengthening PHC continues to be a focus of health system reform worldwide. Both peer-reviewed and non-peer reviewed papers include several key messages to improve PHC.

These include: the need for a focus on the social determinants of health; transparent and accountable funding processes; improved access to health services supported by appropriate information technology and interprofessional practice where quality and outcomes are regularly monitored. Much of the health re-design that is recommended focuses on models that embrace interprofessional education and practice with health team members who are supported to practice to full scope and who understand each other's roles. For many healthcare providers, practicing to full scope and being engaged with health colleagues, increases autonomy, improves practice satisfaction17 and improves recruitment and retention. Evidence also suggests that healthcare should be designed and delivered to support patient- and family centred health care.

Optimization of the Nursing Role in Primary Health Care

Nursing full scope practice in team-based primary care has been found to be cost effective and improves quality of care, increased patient satisfaction, access and equity, particularly in

Under serviced areas and populations. In many PHC settings, having nurses as full members of the PHC team is essential to meet the complex health and social needs of populations. PHC delivery by nurses, including nurse practitioners for acute and episodic care, chronic disease management and practice operations resulted in improved quality of care, efficiency and decreased cost.

Maximizing the benefit of nurses practicing in PHC requires a commitment to progressive policy regarding funding and public awareness, competency-based nursing and interprofessional education and the optimization of the nurses role in PHC with comprehensive process and outcome measures. Additionally, authors of a Cochrane review found that depending on the context of care, appropriately educated nurses provide care comparable to primary care physicians with similar patient outcomes.

Nurses are educated with a holistic lens so that all facets of a person's health and well-being are considered when planning and delivering care.30 With increasing focus on the social determinants of health,31 nurses are prepared to provide care based on that broader understanding of health. Nursing education also promotes developing therapeutic relationships with patients and families to fully understand their stories and life contexts in order to individualize care plans and assist people in navigating the health and social systems.

However, current models of health delivery still tend to focus primarily on the treatment of

illness, rather than focusing on other key social determinants of health. In remote communities and/or in low-middle income countries, much of the care delivered at the local level depends upon the expertise of community health workers or nursing assistants. Nurses and nursing play an important role in supporting their colleagues working in communities through advocacy, mentorship, collaboration and by recognising the important contribution of nursing assistants and community health workers in maintaining local services.

Nursing Leadership in PHC

In addition to being practice leaders, nurses at the organisational and system levels are leading strategic conversations about health system transformation in PHC. As well, national nursing associations and international organisations, such as ICN, are strong advocates for the strengthening of PHC through health system change based on the needs of populations and focused on the SDGs and UHC for all. It requires change that is evidence-informed, gender-focused and with a shift from predominantly hospital-based care to care in the community and home.

Primary Health Care, Nursing and the Global Strategy on Human Resources for Health

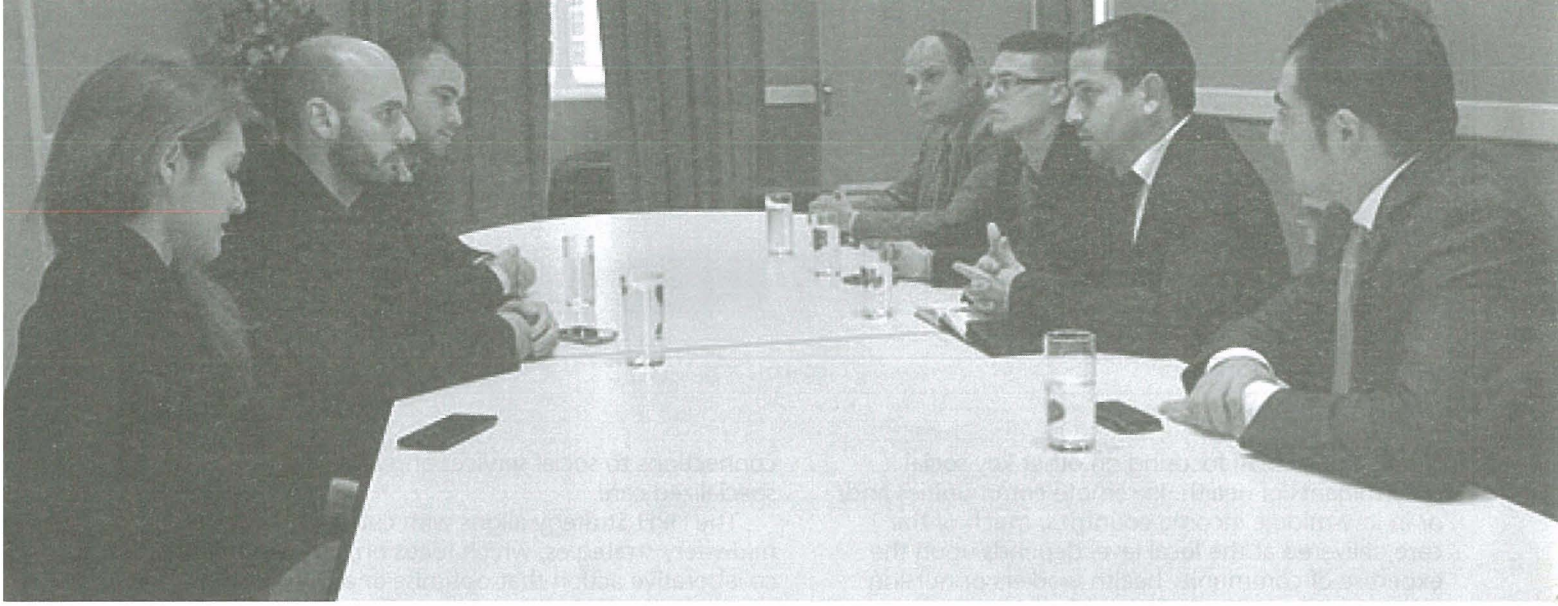
The overall vision of the HRH workforce strategy is to ensure equitable access to a skilled health workforce within a performing health system with progress towards UHC and the SDGs. Based on a broad definition of health and with the aim to provide quality health services, the goal of the strategy is to ensure that services are accessible and available but also acceptable for all people across the lifespan. Using a population, needs-based approach that is person centred and collaborative that also considers gender and safety issues for providers, the Strategy focuses on four main objectives: improving data; implementing evidence-based policy; building effective leadership and governance to support HRH; and investing in approaches that are needs-based, consider the health labour market and maximize employment and economic growth.

Generally, the Strategy recognises the importance of strengthening services and care at the local level by creating tangible targets for the redistribution of healthcare workers; the creation of infrastructure for data acquisition and sharing; economic investment in the health workforce; and institutional support for collaboration across sectors. From a PHC perspective, the Strategy focuses on attaining UHC with efficient and effective models of PHC where diversity of skill mix is paramount to meet health needs and there are clear, integrated connections to social services and advanced/specialized care.

The HRH Strategy aligns with current nursing and midwifery strategies, which focus on person-centred collaborative action that optimise and maximise nursing roles, including advanced practice nurses, to meet health needs. Such action is supported by effective policy and aimed at meeting global goals and targets such as the SDGs and UHC.

Strategies and Key Messages for Policy-setters to Strengthen PHC

- A move from a dominant, illness-focused system to one that also includes preventative services and health promotion care is required. Nursing and nurses are well positioned to lead a shift in thinking, in practice and in policy, which supports a broader understanding of health.
- Nurses and nursing are leaders both at the system level and 'on the ground' in supporting colleagues who provide PHC in remote and under-serviced areas such as the community health workers and nursing assistants in low and middle-income countries.
- Nurses practicing to full scope can provide both acute/episodic care as well as effective chronic disease management. Optimal use of nurses in PHC improves access to care, particularly for vulnerable populations, including those living in rural areas.
- In an effort to meet the SDGs for 2016-2030 and provide UHC, a diverse health workforce working in teams with the skills and competencies to meet current population health needs is required.
- As outlined in the Global HRH Strategy, global investments in the health workforce are currently not sufficient to support health or the broader social systems. Therefore, a change in the planning, education, deployment, utilization and recruitment and retention strategies for healthcare workers is needed.39 Such a change includes strengthening PHC by ensuring nurses are key care team members and leaders for health system change.
- Interprofessional education is vital to addressing the lack of knowledge providers have about other healthcare providers. It also teaches different care providers how to negotiate issues of shared scope and knowledge as well as decision-making. The key is to not only have interprofessional education programmes but also to have interprofessional practice settings to support this new way of learning about how to work together.
- Nurses and nursing are leaders at the national and global decision-making tables by supporting a strengthened PHC system that is evidence-based, collaborative, focused on the needs of people and that promotes equitable access to UHC.



Laqgħa bejn iż-żgħażagħ tal-GWU u tal-FORUM

inews 15th January 2016

Fil-Workers Memorial Building, fil-Belt Valletta, illum saret laqgħa bejn iż-żgħażagħ tal-General Workers Union (GWU) u tal-FORUM Youths, li ġiet iffurmata ftit xhur ilu.

Fl-intervent tiegħu, is-Segretarju tal-GWU Youths, Kendrick Bondin, tkellem dwar l-importanza ta' laqgħat bħal dawn. "Huwa importanti li l-Unjins isaħħu l-għaqda ta' bejniethom," saħaq Bondin, filwaqt li enfasizza fuq l-importanza li aktar żgħażagħ jipparteċipaw b'mod attiv fl-unjins.

Qal li l-unjins kollha qed jesperjenzaw nuqqas ta' żgħażagħ. Qal li s-sħubija fil-unjins ta' nies li għandhom nanqas minn 35 sena hija minima. "Naħseb li din hija problema soċjali. Il-ġenerazzjoni li tielgħa, sa minn età żgħira tqatta' ħafna waħedha fuq il-kompjuter. Għaldaqstant dak is-sens ta' għaqda li kien hawn qabel intilef," qal Bondin.

Żied jgħid li għalhekk l-unjins iridu jagħmlu kampaniji, anke b'mod kollettiv, biex iż-żgħażagħ isiru aktar konxji tal-importanza tal-unjins. Bondin saħaq li minkejja kollox, l-unjins għadhom importanti ħafna għall-ħaddiema.

Min-naħa tiegħu Graham Sansone, li huwa ċ-Ċerperson tal-FORUM Youths, qal li bħalissa d-delegazzjoni tal-FORUM Youths qed tiltaqa ma' diversi unjins.

Sansone tkellem ukoll fuq l-importanza li l-unjins jikkoperaw flimkien biex jilħqu b'mod partikolari liż-żgħażagħ. Sansone saħaq li huwa importanti li wieħed iżomm f'moħħu li ż-żgħażagħ huma ħaddiema wkoll u għalhekk għandhom ikunu konxji tad-drittijiet tagħhom.

Preżenti għal din il-laqgħa għan-naħa tal-GWU Youths kien hemm ukoll l-Uffiċjal tar-Relazzjonijiet Pubbliċi, Rachel Galea, u l-President, Andre d'Amato.

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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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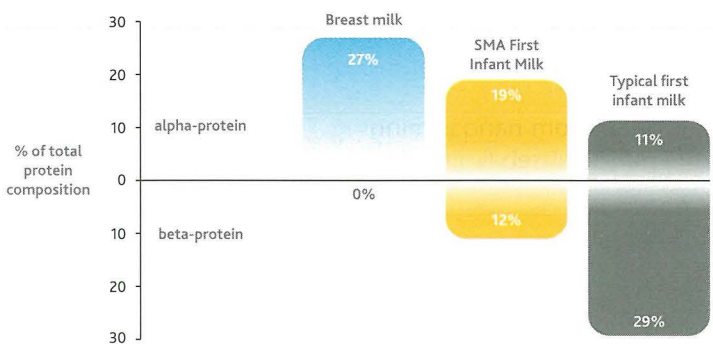

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For healthcare professional use only. Breast is best for babies.

IMPORTANT NOTICE: Breastfeeding is best for babies. Good maternal nutrition is important for the preparation and maintenance of breastfeeding. Introducing partial bottle-feeding may have a negative effect on breastfeeding and reversing a decision not to breastfeed is difficult. You should always seek the advice of a doctor, midwife, health visitor, public health nurse, dietitian or pharmacist on the need for and proper method of use of infant milks and on all matters of infant feeding. Social and financial implications should be considered when selecting a method of infant feeding. Infant milk should always be prepared and used as directed. Inappropriate foods or feeding methods, or improper use of infant formula, may present a health hazard.

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Harnessing the proven power of sodium bicarbonate to help stop bleeding gums[1-5]

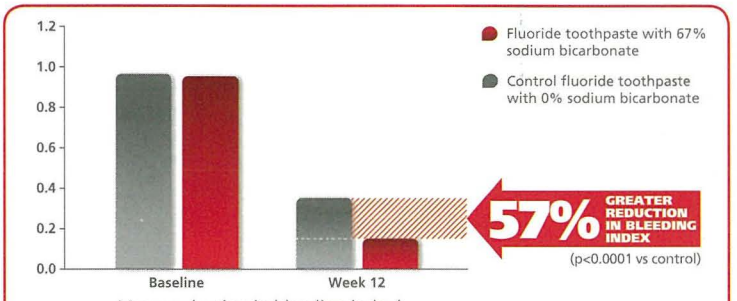
parodontax® toothpaste is unlike any other toothpaste. Its unique formulation contains 67% sodium bicarbonate. This gives **parodontax®** toothpaste a mode of action which helps disrupt the sticky polysaccharide matrix holding plaque to the teeth.[6] The result – more plaque is removed with brushing.[4,5,7]

See the benefit after just 60 seconds[8]

After just 60 seconds of brushing with toothpaste with 67% sodium bicarbonate, patients start to gain the benefit, with a 23% greater plaque reduction compared with a non-sodium bicarbonate toothpaste.[8]

parodontax® toothpaste reduces bleeding significantly more than a non-sodium bicarbonate toothpaste[4,5]

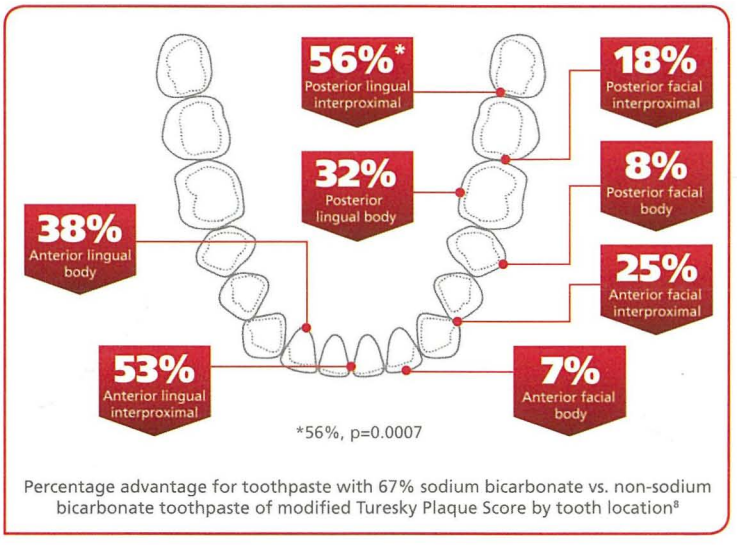
You know that when you see bleeding on probing, something needs to be done. Recommend **parodontax®** toothpaste as part of your advice to patients for their ongoing oral care routine to combat bleeding gums and help keep those gums healthy.[4,5]



Mean reduction in bleeding index[4]

parodontax® toothpaste even helps in areas hard to reach with a toothbrush[8]

When your patients brush their teeth, those hard-to-reach areas are where plaque builds up the most. So, it is comforting to know that **parodontax®** toothpaste shows the greatest advantage in plaque reduction in these hard-to-reach areas.[8]



Percentage advantage for toothpaste with 67% sodium bicarbonate vs. non-sodium bicarbonate toothpaste of modified Turesky Plaque Score by tooth location[8]

References:

1. Ghassemi A, *et al. J Clin Dent* 2008;19(4):120–6.
2. Thong S, *et al. J Clin Dent* 2011;22(5):171–8.
3. Data on file, E5931015, January 2011.
4. Data on file, RH01530, January 2013.
5. Data on file, RH01763, October 2013.
6. Data on file, Physical disruption of oral biofilms by sodium bicarbonate: an in vitro study, January 2014.
7. Data on file, RH01455, November 2012.
8. Akwagyriam I, *et al.* Poster 174485 presented at the International Association of Dental Research, Seattle, Wash. March 2013.

CHML17CHPDX/0002/15c

Recommend **parodontax®** toothpaste. Twice daily use.