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MALTA NURSING AND MIDWIFERY JOURNAL

Malta Union of Midwives and Nurses

No.71 - Ġunju 2016

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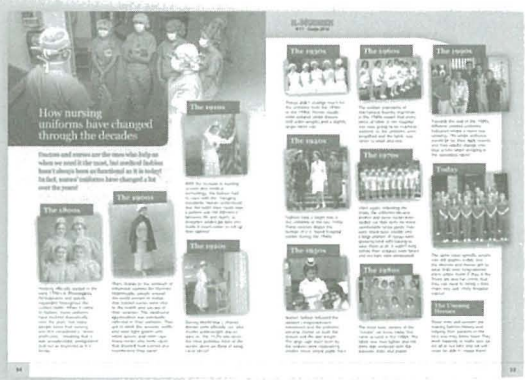

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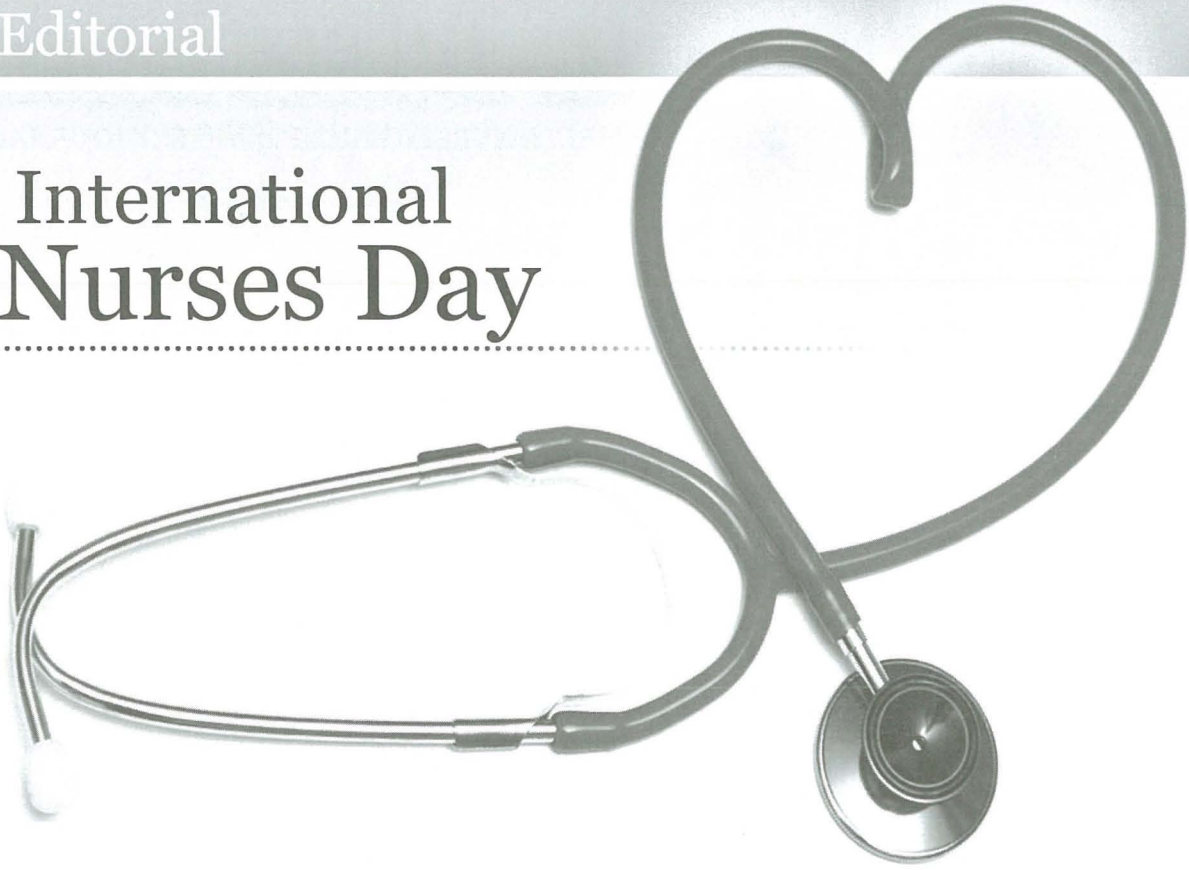
International Nurses Day



International Nurses Day is an international day celebrated around the world on 12th May of each year, to mark the contributions nurses make to society. The International Council of Nurses (ICN) has celebrated this day since 1965. In January 1974, 12th May was chosen to celebrate the day as it is the anniversary of the birth of Florence Nightingale, the founder of modern nursing. Each year, ICN prepares and distributes the International Nurses' Day Kit. This kit contains educational and public information materials, for use by nurses everywhere.

The IND theme for 2016 was: Nurses: A Force for Change: Improving health systems' resilience.

Nursing is the largest health care profession in the world and nurses are the key of achieving the Millennium Development Goals (MDG). Nurses are well-trained and educated for maintaining the health and wellness of the patients through all the aspects like psychosocial and social aspects.

Nurses have deep practical knowledge of delivering best health care services. National Nurses Associations, like MUMN, play an important role in making nurses well informed, advised, encouraged and supported to deliver better work. In fact MUMN works with the government and non-government organisations to strengthen the health care systems as well as to create conditions maximising the nurse's contribution.

Nurses and nursing are also subject to growing pressures, including regular reviews and reorganisations, coping with changes to service delivery and models of care, expanding scopes of practice and enhanced expectations of what a nurse workforce should achieve. Nurses, along with other health care staff, also experience physical and psychological stress caused by long working hours. The experience of increased stress and difficult workplace environments contributes to increased sickness rates and poor staff retention. The resultant staff shortages can put additional pressure on the remaining staff.

Nurses' resilience comes into play when considering different aspects to strengthen and improve health systems such as: Maintaining the individual nurse's health and well being; prioritising the development of the nurse's personal resilience and supporting the development of their co-workers' resilience; considering ways in which the nurse can actively work with patients, carers and communities to improve their understanding of how to improve their abilities to self-care and influence the development of services; developing nurse's skills to demonstrate the positive impact that high quality nursing has on outcomes and developing nurse's health systems thinking by making strong networks across the system.

On the other hand our employers must ensure PPE for health care staff; support health and well-being of health care staff; provide employees with learning opportunities; ensure a system of critical incident review is in place and establish place disaster plans. Policy makers must support all the above.

Through our involvement in decisions for health systems' strengthening we can promote positive practice environments which will in turn result in improved health systems' resilience and health outcomes. Nurses must play an integral role in leading change. With redesigned health systems and full participation of nurses in policy, we will be better equipped to provide quality care for all, even in times of difficulties.

President's message

Dear Colleagues,

Three months have passed from the last issue of 'Il-Musbieħ' and here we are again. When I was preparing for this issue's address, I was reflecting on the work that MUMN did during this time. Suddenly, I recalled seeing a post made by a nurse on the social media. The post was a reflective account of an experience he had during one of his duties as a nurse. Instantly, I thought most of us as health care professionals can recall different experiences. Something should be done with these reflections, these should be shared, as sharing is learning, and by this we can improve the professions – and the care we offer. This is because reflecting on care is a great way to improve it.

University applications for study programmes will soon be with us, and a fair number of our colleagues will be applying for various courses, to broaden their knowledge and enhance the professions. Whilst wishing them luck we should consider that health care professionals around the world are engaged in innovative activities on a daily basis; activities motivated by the desire to improve patient care outcomes and the need to reduce costs to the health system. We live in a world that is constantly changing. Such is our reality, our challenge and our opportunity, to make a significant difference to our patients and clients. We have never been in a better position to do so. Expert knowledge and the research findings that underpins this knowledge are at the heart of many of our new roles, as well as the basis for traditional health care. But it is the combination of innovation and vitality that allows our work to take flight. The need for innovative solutions has never been greater as health care environments globally struggle to provide equitable, safe and effective health services, while at the same time containing costs. Within today's context of scarce resources, continuous change and expanding knowledge, innovation is truly an expectation. The business sector and governments are among those investing heavily in this area. We must invest too – to advance our practice, and improve care and outcomes.

May is over but this month is in the heart of MUMN as on the 5th and 12th, together with our international counterparts we celebrate the Midwives' and Nurses' Day respectively. On these days we celebrate the work that midwives and nurses do. Like previous years the MUMN in collaboration with the Ministry of Health launched the marketing campaign for nursing. Although the success of this campaign arrives in September, the MUMN works hard throughout the year so that the nursing profession will be marketed as a career and a profession. Through the campaign potential nursing students will have all the information needed about the nursing profession – from the nursing programs and specialties to career opportunities and more.

From an industrial relation point of view, I can say that during the past 3 months the group committee members together with the MUMN council were busy indeed. Our meetings with members at their respective workplace are still being held regularly – and from the members' feedback this is a successful initiative. The MUMN administration together with the group committees is also having regular industrial meetings with the administration/management of each respective entity. During these meetings the MUMN is particularly engaged in defending the members' direct interests in the workplace, primarily by means of collective bargaining, where all stakeholders involved will negotiate through social dialogue. It is only when these negotiations break down or do not provide satisfactory results, that we as a union declare disputes. On the 31st May, the MUMN filed a judicial protest against the government for not offering recognition to physiotherapists. As a union we asked the Public Administration Human Resources Office to give the physiotherapy profession the proper recognition, particularly given that the absolute majority of the physiotherapists in the public service sector are members of the MUMN. Recently, the MUMN also declared industrial dispute with the health department over working conditions of its members working at Mount Carmel Hospital and Mater Dei Hospital. The level of skill and responsibility required to do our job has never been greater. High workloads and short staffing mean that we are working harder than ever before. The goodwill that brought us into the profession is not limitless, and skills that we use every day deserve recognition.

As I informed you in the March issue, this year we'll be celebrating the 20th Anniversary of the MUMN. During September, we have some exciting activities taking place to ensure we celebrate the achievements MUMN gained throughout these years. So stay tuned as we'll be keeping you posted. I'm sure you all agree that such achievements were possible through the hard work and support of all of us. The MUMN council cannot thank our group committees and members enough – your extraordinary efforts are continuing to make a difference to our professions and therefore the lives of the many people who we care for.

Till we met again, I hope that you will enjoy your summer and find time to enjoy the warm weather and the longer days of sunshine!

Best Regards,

Maria Cutajar - MUMN President

Kelmtejn mis-Segretarju Ġenerali

Ftit tal-ġranet ilu, waqt li konna qed induru s-swali niltaqgħu mal-meḿbri, ġiet *nurse* fuqi u fakkritni li diġà għaddiet sena minn meta ġie elett Kunsill ġdid tal-*union*. Għalija dan il-perjodu qisu ilu tliet snin!

F'din is-sena ma waqafniex milli nipprovaw intejbu l-kundizzjonijiet tax-xogħol tal-membri tagħna kemm b'mod individwali kif ukoll fuq livell kollettiv. Barra minn hekk komplejna nassistu lill-membri tagħna fil-każijiet ta' dixxiplina madwar l-isptarijiet kollha fejn nistqarr li hija xi ħaġa rari li membru minn tagħna jinstab ħati ta' xi akkuża miġjuba kontra tiegħu.

L-aspett finanzjarju huwa importanti daqs il-kundizzjonijiet tax-xogħol. Infatti l-MUMN ma qagħditx tistenna li jasal il-Ftehim Settorali tan-*nurses* u l-*midwives* biex laħqet numru ta' ftehim li jtejbu l-qagħda finanzjarja ta' dawn il-professjonisti. Però huwa pjaċir tiegħi li ninfurmakom, li fil-ġranet li ġejjin l-MUMN se tressaq għad-diskussjoni mal-Gvern, il-pakkett komplut li jwassalna għall-Ftehim Settorali ġdid għan-*nurses* u l-*midwives*. Dan il-pakkett se jkun wieħed ambizzjuż però biex insolvu n-nuqqas ta' *nurses* f'pajjiżna jinħtieġ li jittieħdu deċiżjonijiet kuraġġjużi. Nispera li l-Gvern issa jgħaddi mill-paroli għall-fatti. Nistennew u naraw!

L-MUMN bdiet ukoll tinnegozja mal-Gvern żewġ Ftehim Settorali oħra importanti li jirrigwardaw l-ECG Technicians u s-Social Workers. Għalkemm nistqarr li f'kull Ftehim kien hemm il-problemi inizjali sakemm irrankajna, nista' ngħid li issa qed noqogħdu u ħa naqbdu nirrankaw.

Aspett li jinkwetani huwa dak tas-Saħħa u s-Sigurtà. Dan l-aspett ma jingħatax l-importanza li jixraqlu. Il-Gvern, l-awtoritajiet, kif ukoll il-*management* rari tismagħhom jitkellmu fuq dan l-aspett ħlief meta tinqala' xi diżgrazzja. Is-settur tas-saħħa huwa nieqes b'mod totali minn dan l-aspett ħlief għal xi punt 'l hemm u 'l hawn biex nidhru li qed nagħmlu xi ħaġa! Nappella lil kulħadd sabiex nieħdu dan l-aspett b'mod aktar serju għaliex hemm fin-nofs il-ħajja tagħna lkoll.

Din is-sena l-MUMN se tiċċelebra l-20 sena anniversarju mit-twaqqif tagħha - 19 ta' Settembru 1996-2016. Huwa xieraq li niftakru f'dan il-jum b'mod speċjali u nagħtu ġieh li dawk kollha li taw is-sehem tagħhom biex l-MUMN hija dik li hija llum. Il-Kunsill tal-Union iddeċieda li jikkommemora dan l-anniversarju billi jorganizza ġimgħa ta' attivitajiet li jkopru l-*ispectrum* kollu. Aktar dettalji jitħabbru 'l quddiem.

Dan ix-xahar se jiġi elett Group Committee ġdid għall-Isptar Mater Dei fejn jirrigwarda n-*nurses* inġenerali. Nappella li kull min għandu għal qalbu l-impjieg tiegħu biex japplika f'dawn in-nominazzjonijiet li se jkunu ppubblikati dan ix-xahar.

Għal darb'oħra erġajna organizzajna kampanja biex inħajjru ż-żgħażagħ jagħżlu l-karriera fin-*nursing*. Għalkemm inqbadna ftit fin-nofs bil-kontroversja tal-*billboards*, fejn fl-aħħar mumenti kellna nbiddlu l-istrateġija kollha, nista' ngħid li kienet l-aħjar kampanja sa kemm ilha tiġi organizzata. Ir-rispons huwa wieħed inkoraġġanti ħafna li jagħmlilna kuraġġ li nkomplu ninsistu fuq il-vjaġġ li qbadna flimkien 15-il xahar ilu.

Għal-lum se jkolli nieqaf hawn. Nixtieq nieħu din l-opportunità biex nawgura lilek u lil dawk għeżież tiegħek sajf ta' mistrieħ, hena u saħħa.

Colin Galea, Segretarju Generali

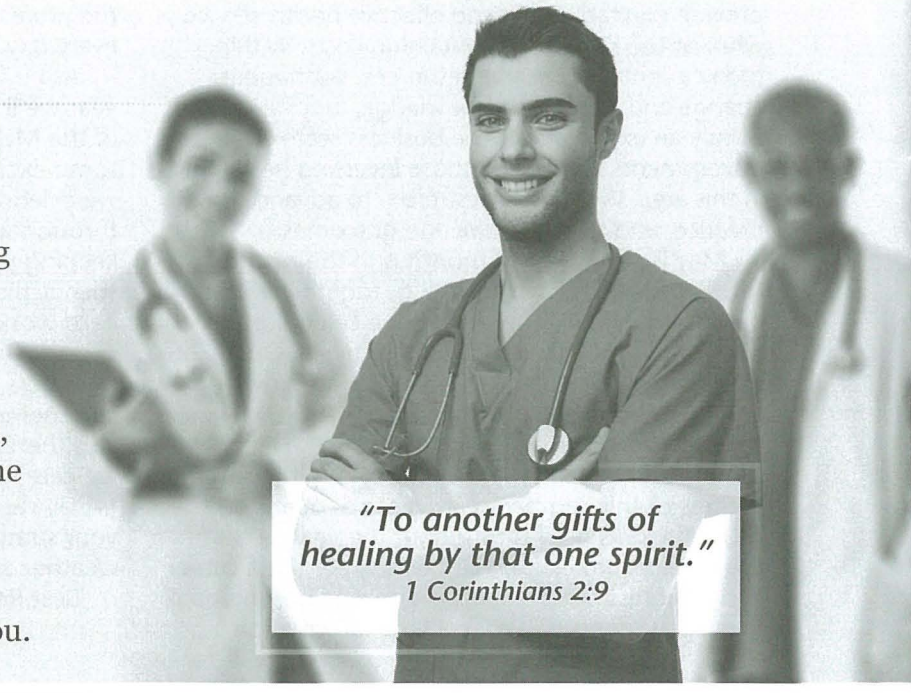
Dear Nurse

You soothe the aches of human pain, and serve in love and not for gain.

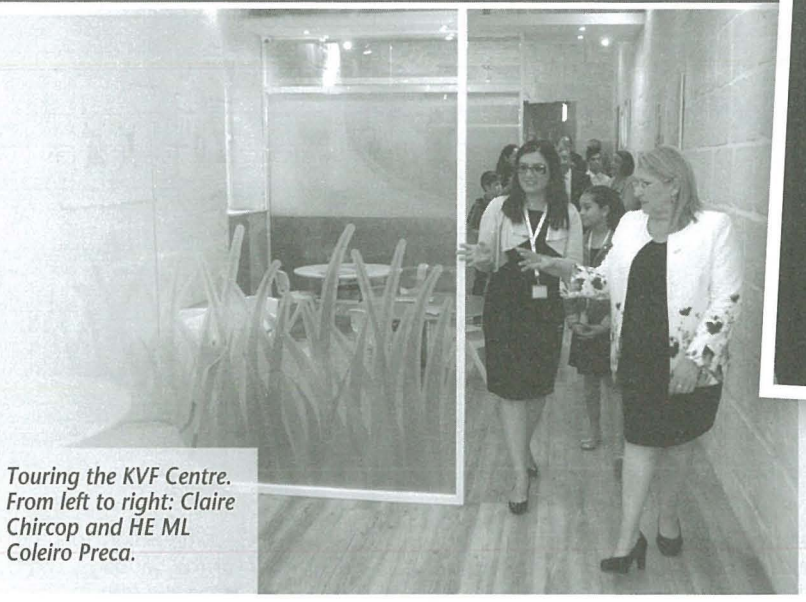
You lovingly do the kindly deed, attending to the hurting one in need. You place your hand on the fevered brow and bring comfort to the longing one now.

You cheer the soul through its body's woe, and minister Jesus everywhere you go. The touch of a nurse with a heart so true, the Great Physician is working through you.

Thank You.



The Karl Vella Foundation



Touring the KVF Centre. From left to right: Claire Chircop and HE ML Coleiro Preca.

(Top) Cutting the ribbon. From left to right: Claire Chircop - Chairperson, Christine Vella - Karl's daughter, Rosemary Ann Vella - Karl's widow, HE ML Coleiro Preca - President of Malta and Samuel Vella - Karl's son.

Following the untimely passing of Karl Vella, a voluntary organisation was set up in May 2014 to extend Karl's legacy of generosity and to be of assistance to the local community by providing support to children in families disrupted by long term or serious illness or injury. The objective of the KVF is to ease the pressure on parents by providing an environment for their children where they can feel safe, looked after, and focused on, despite the family trauma being experienced in the background.

The Karl Vella Foundation Centre was inaugurated in 2015. The premises are welcoming and childfriendly, designed to create a 'home away from home' for the children receiving support. The interior is a haven of safety and security for the receivers of our service.

Children are registered with the Karl Vella Foundation through a process of referral. Any health professional who is overseeing the invalid in the family will be able to refer children to the Karl Vella Foundation. A specially appointed committee will vet all the applications and register the children accordingly. Referral forms may be accessed from our website www.karlvellafoundation.org

During term time, the support given to children aims at preventing them from falling behind in their school work, by providing teachers and LSAs to assist them with homework where needed. As all parents are aware, even just one month of distraction can sometimes allow a child to fall behind for a whole year. Some children just cannot cope with their homework on their own.

Besides help with homework, other volunteers will also be on hand to do extracurricular activities, or simply sit and read, or lend a listening ear. The inviting chillout area allows children to relax in a very welcoming seating area, where they will be encouraged to do arts & crafts, play, or watch a favourite DVD or read a book.

The best intentions in the world may still permit a child to feel isolated and afraid, and sometimes even guilty that something they may have said or done has caused the ailment in the invalid. The volunteers of the Karl Vella Foundation have been trained to look out for, and recognise any underlying signs that the child may manifest, and psychological assistants are on hand should the child need help to cope with the situation. Before any level of interaction with a psychological assistant takes place, permission will be sought from a child's parent.

Presently, the KVF Centre opens twice a week between 2.30 and 6.30 p.m. Very soon we will be extending this to a third session as well.

All the support provided by the Karl Vella Foundation and its volunteers is free of charge, and we rely on the benevolence of the general public to keep the service going. As we enter the second phase of the building project, and the transformation of the lower floor from stables into the ground floor of the premises, we encourage everyone to share the information about the Karl Vella Foundation to help raise awareness.

If you are interested in helping out, please visit www.karlvellafoundation.org where you can discover various ways you can assist the Foundation. We are always on the lookout for volunteers, or people to organise small fundraising activities among their own group of friends, so if you feel you can help in some way, do not hesitate to get in touch.

Donations are always welcome and can be made either via SMS (50617913 - €4.66, 50618803 - €6.99 or 50619242 - €11.65) or through the Bank, (APS Bank Account # 20001489503, APSBMTMT, IBAN: MT85APSB77 12700776232000148950 3). Cheque donations should be made out to Karl Vella Foundation and posted to P.O. Box 22, Mellieħa.

Compression bandaging

in Venous Leg Ulcer Treatment

Compression Therapy is a strong therapy which can promote venous leg ulcer healing, and enhance a person's quality of life[1, 2]. Persons suffering from chronic venous insufficiency are predisposed to develop venous leg ulcers, due to impairment of the blood return circulation system, to the heart[3]. The squeezing effect of compression onto the leg, results in reduced oedema and improved venous blood flow towards the heart[1].

The amount of compression required during treatment, is generally based on the patient's morbidities and ability to tolerate treatment. Treatment of venous leg ulcers generally involves application of sub-bandage pressures >40mmHg. Sub-bandage pressures, vary according to posture, movement of patient and also bandage application techniques[2]. The **resting pressure** is the pressure exerted by a bandage or stocking, onto the treated leg, while the patient is resting. This tends to be lower than the **working pressure**, which during exercise, results from expansion of the calf muscle against the stiff resistance created by the bandage[2]. This effect, improves the actions of the calf muscle pump, to pump blood back, from the leg towards the heart[4].

Advantages in the use of Compression Bandages: Although hosiery or intermittent pneumatic compression devices are available to induce compression, bandages are most often used to achieve this effect[1]. The European Wound Management Association Position Document 2003 promotes the use of compression bandages, as treatment of choice, over the use of compression stockings since the use of bandages results in a significant effect on deep venous blood return, when compared with elastic compression stockings. Such hosiery exert their primary effect on the superficial vein system. Inelastic bandages may therefore be more effective in patients with extensive deep vein reflux[4]. During the use of compression devices, it is very important to avoid further damage to the wound bed and the surrounding skin, and to ensure that the pressure applied is evenly distributed. Hence, the use of compression stockings is also impractical in patients at high risk of pressure damage and those with large ulcers or high exudate levels, since no padding can be applied underneath. Self application of compression stockings is also often difficult, even if an application device is used[1].

Bandage Materials and features: The pressure created by a bandage mainly depends on the tension of the material, the number of layers applied and the shape of the leg. Tension is dependant on the amount of stretching of the bandage during application. Sustainability of this tension depends on the elasticity of the bandage material; which is the ability of the material to return to its original length on decreasing applied tension.

Elasticity directly depends on the composition of the threads and the method of construction of the bandage. High compression bandages are usually classified according to their amount of extensibility, or their ability to stretch. Although non-stretch materials, such as those used in Zinc Paste bandages are available; the most common materials used are short-stretch, for minimally elastic or extensible bandages; and long-stretch, for highly elastic, extensible bandages[2].

Long-Stretch bandages are able to accommodate expansion or contraction of the leg circumference during exercise or due to reduced oedema, with minimal changes in sub-bandage pressures[2, 5]. Long-stretch bandages, sustain high pressure for long periods of time, even whilst the patient is resting[5]. However, a high resting pressure may not be suitable for such patients[1], as it might interfere with the supply of blood to the extremities in patients with arterial problems.

Short-Stretch cotton bandages are able to create high working pressures during exercise, and low resting pressures[2]. They are less able to accommodate changes in leg circumference and retain their rigidity against the calf muscle, thus improving the action of the calf muscle pump. During rest, the sub-bandage resting pressure is quite low, and hence short-stretch bandages are also considered safer in patients with moderately impaired arterial circulation[5].

Multi-layer compression systems have been found to be more effective than single layer compression systems. The concept of multi-layering is that compression is applied in layers, thus achieving an accumulation of pressure[5]. Such systems may be simple, using only 2 layers of the same type of bandage; or complex including both short and long stretch bandages[2].

Hypo-allergenic bandage materials: Contact sensitivity is very common in patients with venous insufficiency[8,9]. It affects 40–82.5% of patients and has major implications on patient management[7,8]. Allergic contact dermatitis to rubber or synthetic rubber components in compression stockings or bandages, is frequently seen[8,10] and occurs in 11–15.6% of patients with chronic venous leg ulcers[7,8]. Besides the effect on skin integrity, allergy greatly affects patient compliance to treatment; as on application, itching, skin redness and a burning sensation is often considered as an allergy to the stocking/bandage, and usually leads to discontinuation of treatment[11]. Hence, it is of utmost importance that materials used for compression devices are hypo-allergenic.

Patient Compliance makes an integral part of any treatment. It can be enhanced by encouraging patients to take an active role in their treatment. It often depends on patient motivation, which can be affected by issues originating from the health condition itself, such as social isolation; or treatment discomfort, which might range from pain or inhibition of regular activities such as work or entertainment. Education of patients and relatives is very important, to gain their compliance[5].

Patients should be advised about the importance of:
- Wearing flat comfortable shoes that allow flexing of ankle joint
- Exercise such as walking, if possible participate in a rehabilitation programme
- Adequate skin care
- Proper care of compression bandages[1]

Contra-indications and precautions: Compression therapy should be used with caution, since incorrect application of compression can lead to serious consequences. Strong compression in patients with arterial insufficiency, neuropathy, cardiac disease, or intolerance to compression material may be unsafe or painful[1, 5]. Prior to treatment, a Doppler test should be carried out to calculate the ankle brachial pressure index (ABPI), in order to evaluate arterial perfusion. In patients with cardiac failure, compression may be dangerous, as it induces rapid shifts of body fluids, which increase the pre-load of the heart. In patients with neuropathy, the risk of pressure damage underneath the bandages increases, since the protective response to pain is absent[5].

Cost-effectiveness ensures that scarce resources available for health-care; are used in the best possible way to achieve the greatest improvement in the health-related quality of life of patients[6]. Budgetary constrains, stress the importance of presenting evidence of cost-effectiveness[6]. Evidence shows that treatment of patients with venous leg ulcers, with a multi-layer compression system in combination with normal wound-care, incurs less weekly costs. It is estimated to be 44% less expensive than usual wound-care alone. It is also more cost-effective than usual wound-care, since the majority of venous leg ulcers heal prior to 52 weeks of treatment with compression[6]. An ideal cost-effective compression system should:
- Be clinically effective to provide evidence based treatment
- Provide sustained clinically effective levels of compression for about a week
- Enhance and support the function of the calf muscle pump
- Use bandaging materials which are non-allergenic, in order to avoid risk of allergy
- Be easy to apply and easy to train patient or carer to apply
- Conformable and comfortable, to aid patient compliance
- Long-lasting, in order to enhance cost-minimisation due to re-use of bandages[5]

Innovative 2 layer compression bandage system, using 2 bi-elastic 100% cotton short-stretch bandages has been recently developed. Bi-elasticity of the bandage is achieved through the weave structure of the bandage. Such a system is as effective as complex multi-layer systems in achieving high working pressures and low resting pressures. Additional advantages of this system include:
- the use of normal shoes, since it is not as bulky as 3 or 4 layer systems, the circumference of the bandaged foot will not increase much, thus fitting the shoes that the patient regularly uses
- more comfortable for patients to wear during warm weather due to lighter, air permeable, skin-friendly cotton material enhancing better quality of life and also compliance
- Due to the bi-elastic properties of bandages, these conform better to leg contours to distribute the pressure more evenly, hence providing also easier application
- These bandages are able to regain their full elasticity after washing, resulting in a cost-minimisation impact on healthcare institutions due to their re-usability

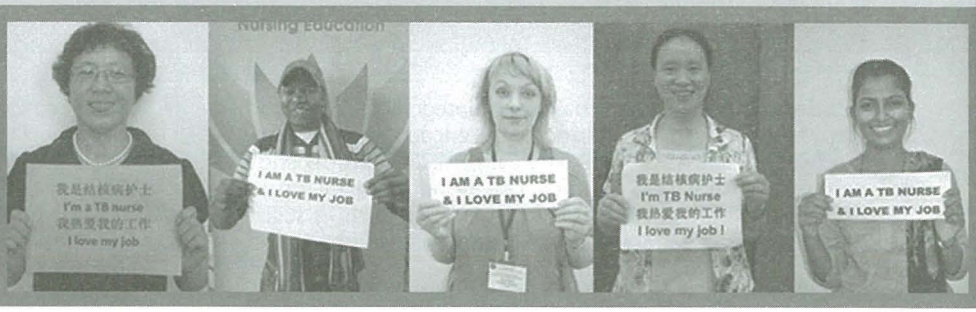
In the treatment of leg ulcers, compression therapy has been used since the time of Hippocrates[5]. Compression can dramatically reduce the amount of oedema and pain and promote healing of venous leg ulcers. Success directly depends on the use of the right materials and application technique[4]. Preventive measures include the long-term use of compression bandaging, since sustained compression prevents recurrence of oedema and results in a lower incidence of ulcer recurrence. A high level of compression is associated with a lower incidence of ulcer recurrence. Medical professionals involved in the care of such patients, should be capable of choosing and applying the appropriate compression system according to individual patient needs[1]. A high healing rate of up to 70% of ulcers within 12 weeks can be reached, and if complimented with an ulcer recurrence preventive programme, it can greatly improve the quality of life of such patients and decrease the burden of venous leg ulcer disease on healthcare systems[5].

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

References:

1. World Union of Wound Healing Societies (WUWHS). A consensus document. London: MEP Ltd, 2008. Principles of best practice: Compression in venous leg ulcers.
2. Clark M. European Wound Management Association Position Document 2003. Compression bandages: principles and definitions.
3. Columbia University Medical Center, Department of Surgery, New York, USA. Vein Program. Available: http://cpmcnet.columbia.edu/dept/cs/vein/venous_leg_ulcers.html Accessed: 06/09/13
4. Partsch H. European Wound Management Association Position Document 2003. Understanding the pathophysiological effects of compression.
5. Marston, W; Vowden, K. European Wound Management Association Position Document 2003. Compression therapy: a guide to safe practice.
6. Franks PJ; Posnett J. European Wound Management Association Position Document 2003. Cost-effectiveness of compression therapy.
7. Tavadia S, et al. Allergic contact dermatitis in venous leg ulcer patients. Contact Dermatitis. 2003. Available: http://www.ncbi.nlm.nih.gov/pubmed/12868967 Accessed: 09/05/16.
8. Cravo M, Gonċalo M, Figueiredo A. "Allergic contact dermatitis to rubber-containing bandages in patients with leg ulcers". Contact Dermatitis 2008. Available: https://www.deepdyve.com/lp/wiley/allergic-contact-dermatitis-to-rubber-containing-bandages-in-patients-sWWTMXPl6X Accessed: 09/05/16.
9. Jankicevic J , Vesic S, Vukicevic J, Gajic M, Adamic M, Pavlovic MD. "Contact sensitivity in patients with venous leg ulcers in Serbia: comparison with contact dermatitis patients and relationship to ulcer duration". Contact Dermatitis 2008. Available: http://www.ncbi.nlm.nih.gov/pubmed/18154556 Accessed: 09/05/16.
10. Mizuno J , In-Nami H. "Allergic contact dermatitis to synthetic rubber, neoprene in compression stockings". Masui. 2011. Available: http://www.ncbi.nlm.nih.gov/pubmed/21348260 Accessed: 09/05/16.
11. Valesky EM; Kaufmann R; Meissner M. "Contact allergy to compression stockings: Is this possible?" Phlebologie –Stuttgart 2014. Available: https://www.researchgate.net/publication/275514677_Contact_allergy_to_compression_stockings_Is_this_possible Accessed: 09/05/16.

Geneva, Switzerland, 24 March 2015



Nurses reaching the 3 million finding, treating & curing Tuberculosis

TB FACTS

- 9 million new cases of TB in 2013
- 1.5 million deaths due to TB in 2013
- 480,000 new cases of multidrug-resistant TB (MDR-TB)
- More than 3 million women develop TB each year and more than 500,000 will die of TB
- 550,000 children developed TB in 2013 with 80,000 deaths
- 1.1 million patients living with HIV developed TB in 2013 - TB/HIV co-infection rates are as high as 70% in some countries

The International Council of Nurses-Lilly TB/MDR-TB Project is training nurses in order to reach the 3 million people with tuberculosis who go undiagnosed and untreated.

Nurses play a critical role in improving case detection, getting patients on appropriate treatment, providing ongoing support to patients and improving treatment outcomes. The ICN-Lilly TB/MDR-TB Project has trained more than 1,900 nurses in 18 countries to strengthen the global nursing capacity in the prevention, detection, care and treatment of tuberculosis and multidrug and extensively drug-resistant TB (M/XDR-TB). These nurses have in turn rolled out the training to over 96,000 nurses and allied health workers.

In 2013, 9 million new cases of TB were diagnosed globally, but the World Health Organization (WHO) estimates that an additional 3 million people go undiagnosed and untreated. Many of those missed will either die or be placed on inappropriate treatment – while most will not be treated and continue to infect others in their communities. Furthermore, nearly half a million will be diagnosed with MDR-TB which is more difficult and more expensive to diagnose and treat. TB remains the second leading cause of death due to a communicable disease and is a leading cause of mortality among women of reproductive age. Major efforts are needed to close this gap and nurses on the front lines play an important role in finding, diagnosing, and treating these patients.

The ICN-Lilly TB/MDR-TB Project trains experienced nurses working mainly in the TB and HIV fields, who then cascade information to their colleagues in local health care facilities as well as in the communities they serve. The TFT courses are run in countries with a high burden of TB and MDR-TB where the ICN has a strong working relationship with the national nurses association. The ICN TB/MDR-TB Project is currently running in the Russian Federation and China – two countries greatly affected by TB and MDR-TB - as well as six other countries in sub-Saharan Africa (Ethiopia, Lesotho, Malawi, Swaziland, Uganda, and Zambia). Find out more about the project on www.icn.ch/tbproject.html.

Not only do the nurses trained through the TFT courses train other nurses, health care professionals and members of their communities, they also change their practice and improve the care and services provided to patients. The training provides much needed knowledge on all aspects of TB/MDR-TB but, just as importantly, it empowers and gives the nurses the confidence to improve their practice and to assess their current practices and environment against best practices in TB care and develop plans to address the identified gaps.

One nurse from South Africa said this about the training,

• continued on page 26

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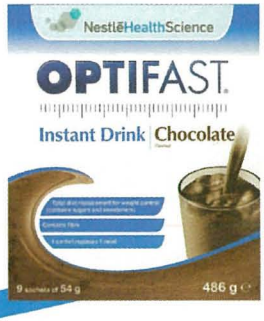

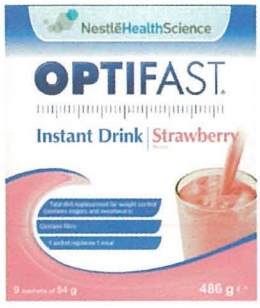

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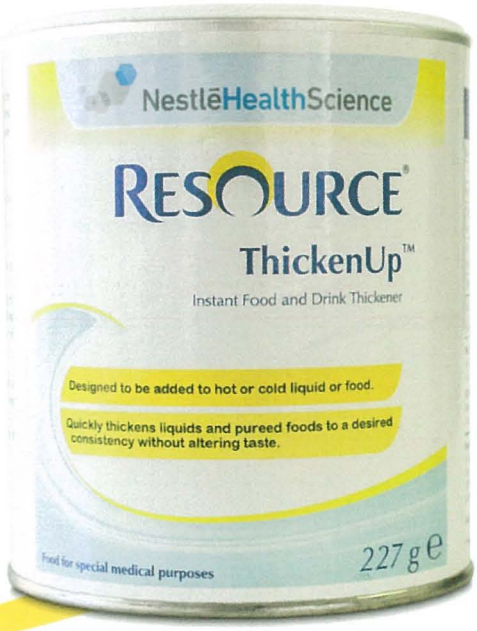

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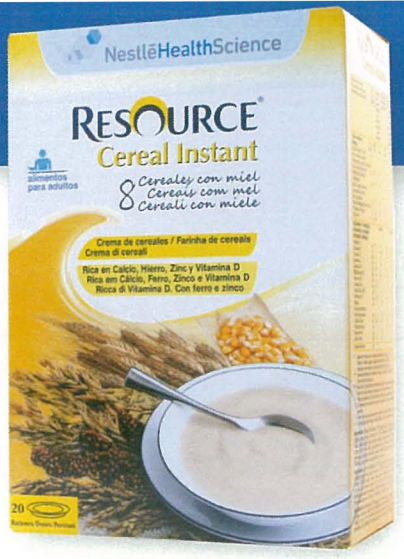


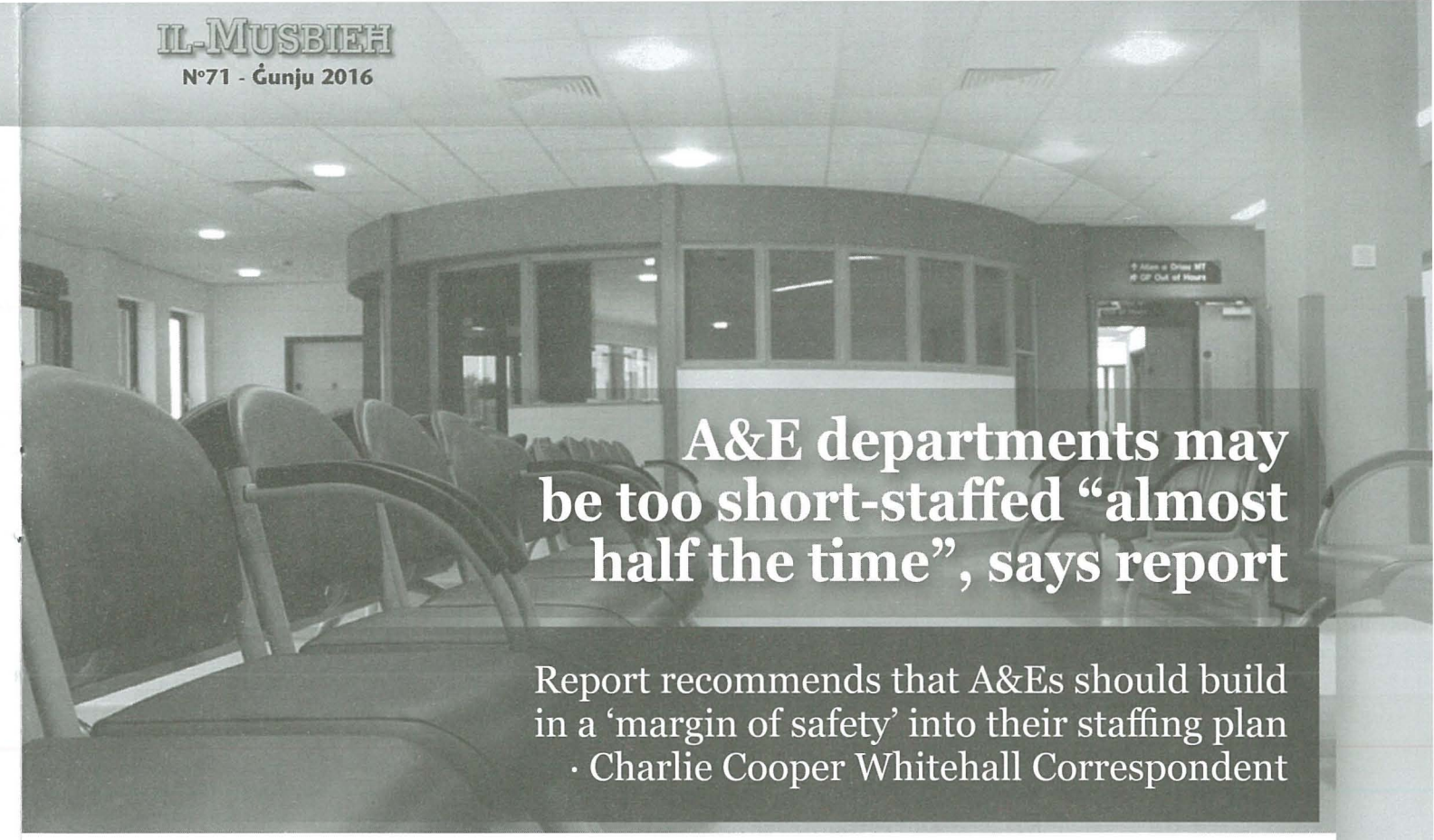
Resource® Cereal Instant is an instant food powder which is prepared from 8 different cereals together with honey. The product can be used either as a breakfast or as a tasty snack that provides wheat, corn, rice, oats, barley, sorghum, rye and millet. When reconstituted with liquid, Resource® Cereal Instant provides a smooth, homogeneous cereal that may be recommended for the dietary management of people with mastication and swallowing difficulties. Patients that suffer from moderate to severe dysphagia or with poor oral phase abilities and reduced ability to protect their airway, may consume this product. Resource® Cereal Instant may also be recommended to patients that suffer from neurological problems, post-operative treatment, and disease related malnutrition as well as for individuals that would like to consume a low sodium breakfast cereal.

Administration and dosage

Resource© Cereal instant may be easily prepared by gradually adding 30-35g of powder (equivalent to 3 leveled tablespoons) to 200ml of warm or cold milk. The mixture should be stirred well until all powder dissolves completely. Resource© Cereal instant may also be reconstituted with water as well as juice depending on the calorie content desired. Food texture may be adapted to the patients' needs by adding more or less liquid. Cocoa, instant coffee, cinnamon as well as vanilla may be added to Resource© Cereal instant to reduce taste fatigue and offer the patient alternative flavours.

Other recommendations

Resource© Cereal instant may also be used as a healthy breakfast or snack for anyone who is on a low sodium diet, as the salt content of this product is very low and exclusively due to naturally present sodium. This product may be consumed by all those individuals that would like a quick and healthy low sodium breakfast that is fortified with vitamins and minerals. In fact, Resource© Cereal instant provides a good source of vitamins B1, B2, B6, B12, Niacin, and Pantothenic Acid. These are all vitamins required to release energy from food and to help maintain the normal functioning of the nervous system. Resource© Cereal instant is also a good source of folic acid and iron that are essential for normal cell division and in the formation of blood cells as well as a good source of calcium, a mineral required to maintain bone and teeth health. Individuals with no swallowing difficulties may also add fresh fruit such as banana, strawberries and peaches to Resource© Cereal to add texture and enjoy a healthy start of the day!



A&E departments may be too short-staffed "almost half the time", says report

Report recommends that A&Es should build in a 'margin of safety' into their staffing plan

· Charlie Cooper Whitehall Correspondent

A&E departments may be too short-staffed to cope with demand "almost half of the time", according to a suppressed report by patient safety experts.

Experts at the National Institute for Health and Care Excellence (NICE) called for the NHS to introduce minimum nurse-to-patient ratios on A&Es last year, but the report was never published and NICE'S research was controversially suspended.

Ministers and NHS chiefs faced accusations at the time that they were seeking to hide the scale of the staffing crisis in the NHS and water down recommendations for more nurses that would have come at a huge cost to the Government.

In a copy of the NICE guidance, obtained by theHealth Service Journal after frequent requests for its publication were denied, experts say that A&E staffing levels set according to historical patient demand leave emergency departments unprepared to cope with frequent surges in demand.

The report recommends that A&Es should build in a "margin of safety" into their staffing plans, even if this meant they were overstaffed during quiet periods.

The Royal College of Emergency Medicine endorsed the findings, saying that "most" A&E departments have "insufficient nursing staff to deal with predictable patient attendance patterns".

Despite his emphasis on improving patient safety in the NHS, Jeremy Hunt, the Health Secretary, has rejected calls for minimum nurse-to-patient ratios. The Royal College of Nursing said it was "concerning" that the financial cost of alleviating the shortages "may have been a factor in the decision to scrap" NICE's research.

However, officials in the Department of Health said that the NICE report was an unofficial document, indicating that it should not be considered as guidance by hospitals. Research on safe-staffing has transferred to the new arms-length NHS regulatory body, NHS Improvement, and will be completed later this year, a DH spokesperson said.

But Dr Clifford Mann, president of the Royal College of Emergency Medicine, said that not only were A&Es understaffed half of the time, they were often "as much as 50 per cent" short of the numbers required.

"This guidance from NICE highlights what is self-evident on a daily basis in UK A&E departments. Most have insufficient nursing staff to deal with predictable patient attendance patterns," he said, adding that the guidance should be formally published and that hospitals should consider it.

The number of A&E attendances has increased by 35 per cent between 2003 and 2015.

Donna Kinnair, director of nursing, policy and practice at the Royal College of Nursing said: "These guidelines were put together by experts, looking at strong evidence who found a very clear relationship between the number of registered nurses and patient care.

"The evidence for the importance of having the right number of nurses, and the right ratio of nurses to health care assistants, would have led to new recommendations and guidance on the safe range of nurse staffing levels.

"These recommendations would have exposed shortages, and this would have had financial consequences. It is concerning that these consequences may have been a factor in the decision to scrap this important work.

Justin Madders MP, Labour's Shadow Health Minister, said that the decision to block the findings was "deeply concerning"

"Ministers need to urgently set out how they intend to tackle the workforce crisis in the NHS and ensure hospital wards are not left dangerously understaffed," he said.

The brave nurses who supported people who underwent 'gay cures' in post-war Britain

Dr Tommy Dickinson, lecturer in nursing at the University of Manchester, explores the barbaric treatment of gay patients in hospitals - and the nurses who helped them · Tommy Dickinson

Things have changed immeasurably for the LGBT community in the UK since the repeal of the controversial and divisive Section 28 thirteen years ago – gay couples can now adopt, gay workers are protected in the workplace and they now have the right to enter into civil partnerships or marriage.

Hard to imagine then that up to as late as 1974, the British medical profession was using aversion therapies for homosexuality as a matter of course.

As the RCN celebrates 100 years of the nursing profession, it's worth pausing to remember the nursing staff who had the courage and compassion to fight back during some of the health service's darker days.

Homosexual men – and it was predominantly men – were institutionalised in British mental hospitals and given "treatment" for their "condition" – the most well-known being Second World War Code Breaker, Alan Turing. Following his arrest and prosecution for a relationship with another man, Turing was given the "choice" between a prison sentence or oestrogen treatment and died not long after. An open verdict was recorded but it's since been widely argued that the man whose groundbreaking work saved thousands of life and hastened the end of WW2, took his own life.

Whilst the majority were enduring chemical aversion therapy, the absence of protocols or medical guidelines for such treatment meant that in some cases homosexual and transsexual men were given electrical shock treatment in the most appalling of circumstances. Refused water and being forced to lie in their own vomit and faeces as matter of course, many likened their experiences to torture. But this wasn't Nazi Germany – this was post war Britain – a country supposedly entering into a new and brighter future.

Those who experienced this treatment, many of them now in their 60s and 70s, painfully recall the medical and nursing profession's complicity in it. There were, however, many nursing professionals who sought to provide compassion and caring to these battered and beleaguered men. These brave nurses show us that even in the worst of situations, compassion and kindness can still flourish.

These are nurses like Benedict Henry who I spoke to as part of my research, still vividly recalls seeing her first electric shock treatment.

She said: "I thought it was barbaric, I mean I remember thinking 'where was the treatment?' The young lad nearly jumped out of his skin with the jolt of the first shock. Then you could see it was almost mental torture waiting for the next one."

Nurses like Benedict took huge professional risks by going against the medical status quo and treating their patients as human beings. They were told not to carry out simple caring tasks like talking to the patient but many ignored the decree and did so anyway. Benedict said: "Even though we were not really supposed to, I tried to sit down with the patient and offer them support."

Mercifully, in this country, these practices have vanished. But the sad fact remains that in many corners of the globe and in countries as diverse as the United States and Uganda, persecution and discrimination still exist.

Chemical and electrical aversion therapies have by and large disappeared but they have, in some places, been replaced with psychoanalytical alternatives and herbal gay 'remedies'.

Only last year, President Obama had to speak out against the rise of conversion and reparative therapies for transgender, gay, lesbian, bisexual and queer youth in America.

Homosexual and transsexuals still face barriers to acceptance and understanding. And as long as this remains the case, we need the brave Benedict Henrys of the world not to sink into the past but to remain a solid fixture of our future.

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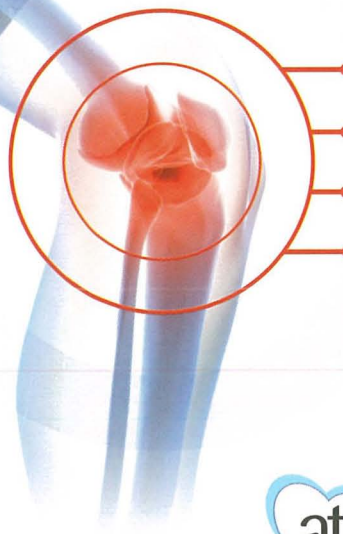

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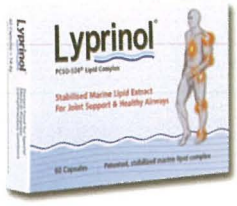

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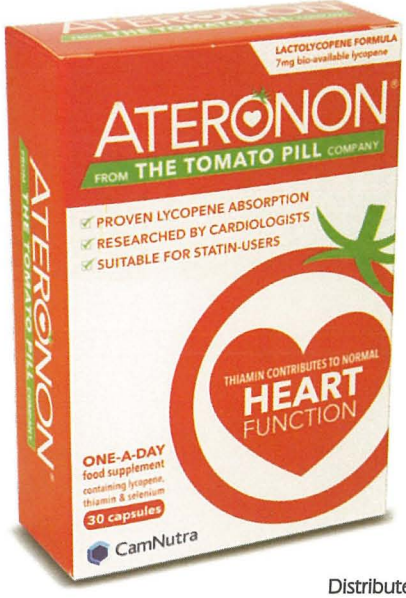

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from our diary...

MUMN 1996
Malta Union of Midwives and Nurses

MUMN and the Health Minister jointly launched this year's Marketing Campaign to recruit Nurses within the Public Service

The Florence Nightingale Benevolent Fund Group Committee organised its Annual General Meeting

MUMN organised a beautiful ceremony at San Anton Palace under the Patronage of H.E. Marie Louise Coleiro Preca President of Malta to commemorate the International Days of Midwives and Nurses

MUMN filed a Judicial Protest against the Government in relation to the requested Sole Recognition for the Physiotherapy profession

MUMN's President during a Board meeting held in Malta by the European Midwives Association

The Pensioners Group Committee organised a very interesting outing for its members

MUMN's General Secretary addressed a conference jointly organised by For.U.M. and MEA

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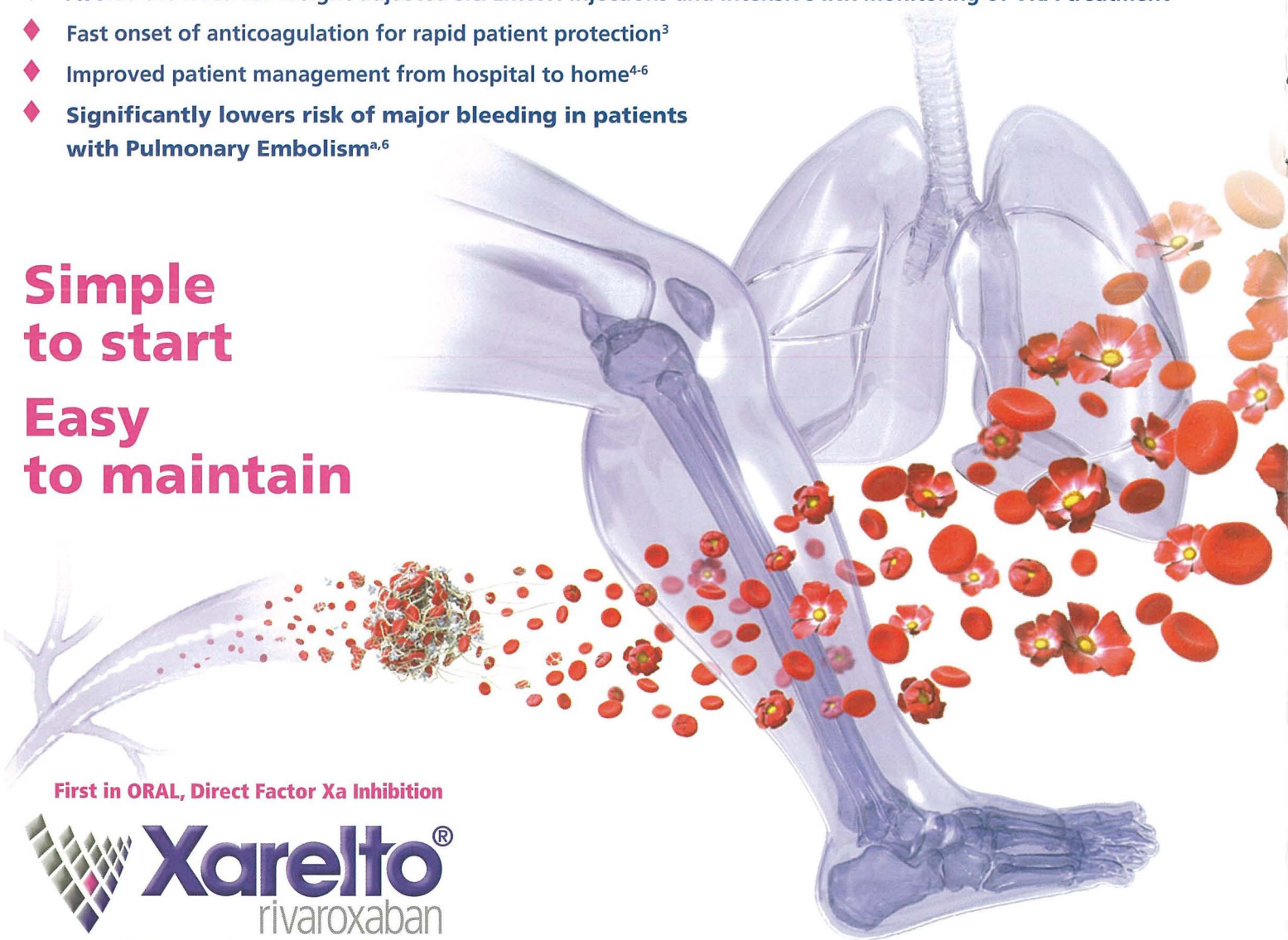

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Classification for supply: Medicinal product subject to medical prescription.
Marketing Authorisation Holder: Bayer Pharma AG, D-13342 Berlin, Germany
Further information available from: *xarelto.medinfo@bayer.com*
Version: EU/5**Xarelto 10 mg / 15 mg / 20** mg film-coated tablets.
(Refer to full SmPC before prescribing.)

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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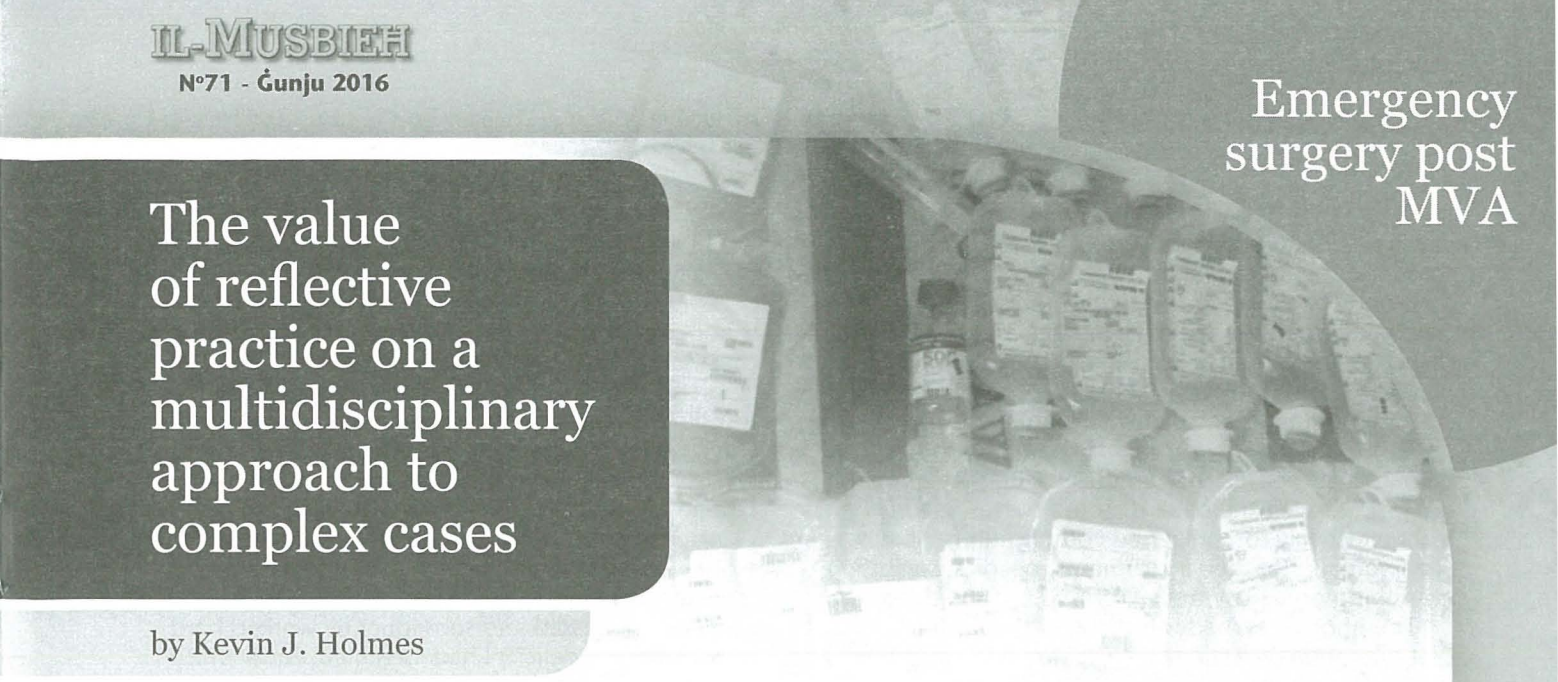


The value of reflective practice on a multidisciplinary approach to complex cases

by Kevin J. Holmes

I posted something on Facebook which was 'liked' and 'loved' by over 360 persons. It was a post meant to congratulate fellow nurses but also to subtly hint at the value of reflection and the richness of a multidisciplinary approach. Through reflection I've learnt to work with fellow allied health professionals whilst giving my best to our patients. Reflection as a tool for learning is sadly underused and underestimated. Nurses should be aware that great accomplishments are only achieved together with a multidisciplinary network.... for the word team somewhat limits our imagination to a small number of peers.

On the 12th of May I was going through all sorts of cartoons celebrating International Nurses Day when I had a couple of flashbacks. An Orthopaedic surgeon taking his shirt off in the corridor, the revolving door of Theatre 1 in St. Luke's Hospital and a swollen face; recollections of one, if not the worst night shift I remember as a nurse. I had landed in Anaesthetic Nursing at a time of two Anaesthetic Nurses per shift. My colleague Andre was covering for my shift mate and mentor, Marco. A couple of minor emergency surgeries made it a routine night shift until the call from A&E.

A young man, mid-twenties, crumpled vehicle, very bad traffic accident, currently being wheeled into the lift to be taken up to theatre. That gave us less than 2 minutes to scramble down to prepare Theatre 1. The adrenalin junkie in me was alive and kicking. I was tachycardic, trembling slightly and aware of a rush of blood to the head but thankful for those 'quiet' nights spent with my mentor, being timed mounting and unmounting fliud warming sets, going through the rapid sequence intubation drills ad nauseum, troubleshooting equipment, practicing setting up the cell salvage unit and the Level 1 pressure infusor....all in preparation for that one case, maybe, someday.

I have so many vivid details of that night. The uniform of the A&E nurse accompanying the patient was soiled with blood, oil, and something green, possibly bile. At the sight of her worn out face I was afraid for my patient. She had picked him out of a crumpled wreck with the help of the Civil Protection Department staff. She gave over whilst bagging him. Focused, she never looked at us. His vitals were a mess. His body, broken. It was time for this junior Anaesthetic nurse to prove himself, to use the armamentarium I had built.

The anesthetic team needs to be fast and accurate to keep the patient alive whilst the surgical team operates. In a jiffy the patient was transferred to the operating table where four different surgeons would operate on him. A battle against time keeping in mind the concept of primum non nocere. The Ortho surgeon was scrubbed and ready so we had to be lightning fast: positioning, securement of the airway, IV pumps, parameters, lower and under body warming. The ENT surgeon took care of his smashed nose and all that was behind but it packing it with an awfully smelling paste, trying to control the swelling which turned the patient's head to the size of a watermelon. We added more lines; another wide bore, a jugular, checked his A line. The radiographers were with us within minutes providing images to assist the Ortho surgeon in fixing his pelvis with an external fixator. Not everyone wore lead aprons because being fast is not synonymous with a 15kg apron. At the alert, 'Exposing!' those wearing an apron screened the ones without. The radiologists taking care not to expose before all were safe. The Urologist was in to check the bladder and ureters. A general surgeon had to stabilize the rest of the mess in which the spleen and bowel were due to blunt force trauma.

Looking back I so appreciated my studying and open mind. Yes, an open mind, for some lessons I learnt from colleagues who qualified after I did but been in theatre before myself. I was a clear example of a novice although having more cumulative nursing experience elsewhere and academic accreditations. "Look around you, be aware of who's doing what and where, mind that

• continued on page 26

Emergency surgery post MVA

• continued from page 25

sterile field." Adrenalin tends to narrow our vision so during the buzz of an emergency one has to constantly be aware of the surroundings. Imagine if I'm checking on the patient's urinary catheter but in so doing contaminate the sterile field compromising the patient's health further.

A lightning fast and sharp scrub nurse Tanya assisted by another two runners kept up with the demands of the surgeons whilst making sure nothing got lost.....inside the patient! Scrub nurses need to react effectively to unplanned complications whilst keeping count of their instruments, needles, swabs, everything on a busy trolley (or two, maybe three!).

The photo attached is the only one available of that operation. We laid the fluids down so we made sure to document everything including losses and dilution. Administering so many blood products meant a lot of sampling, requests and trips to the lab/blood bank. Urgency can trick us but keeping a composed manner and treating valued colleagues courteously is important. Our relationship with the colleagues at the blood bank/lab might not have been harmonious. We always demanded everything to be ready yesterday, sometimes not appreciating processes which after all are there to protect both the patients and ourselves from mistakes. Back then the cleaner was also the runner outside theatre. Charles did numerous trips to the blood bank and the lab that night and everything was flawless. The beauty of a good network!

Oh, what I haven't mentioned yet is that during that 6-7 hour operation, we took it in turns to assist the anaesthetist in Labor theatre for three emergency cesarean sections. Yes, C sections can't really wait till tomorrow. That meant that for a good 3-4 hours there was only one Anaesthetic Nurse with the MVA patient who eventually was transferred to ITU.....then it was 6.40am, time to go home and hibernate.

Today I appreciate what I learnt after that stressful night. I made it a learning opportunity for I have reflected, took notes, searched and read, focused on detail, discussed and subsequently worked hard to improve the deficits I had identified, flaws which would go uncorrected unless the going got tough and my mind was open and receptive to constructive criticism by my fellow peers. My message to you is this: I sincerely hope that this article instigates some change in attitude with regards to provision of constructive criticism and a receptive open mind to it but most importantly, the fostering of reflection in and on action as a tool to ameliorate ourselves.

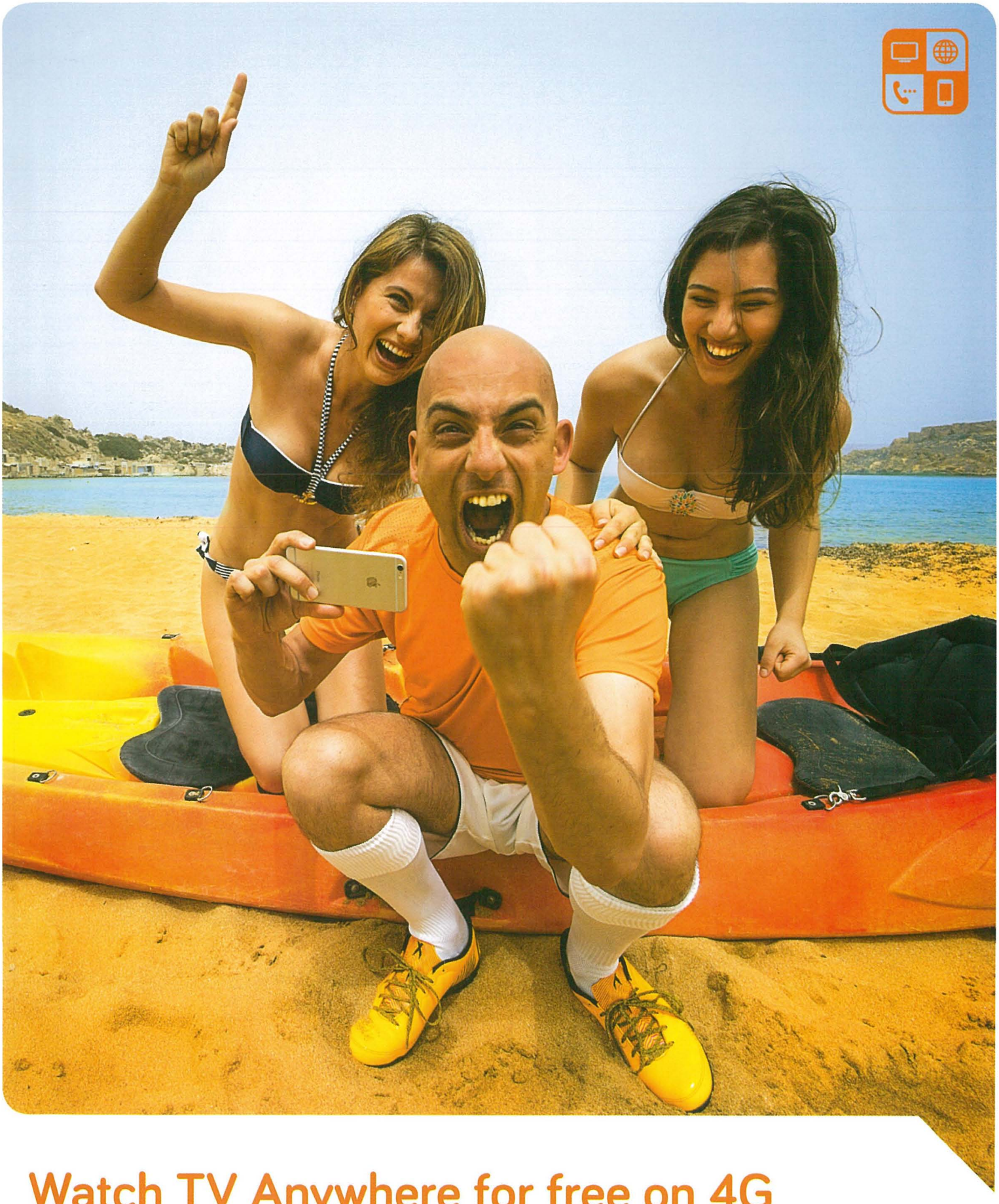
Kevin J. Holmes
Practice Nurse Urology Care & Outreach
kevin.holmes@gov.mt

Nurses reaching the 3 million finding, treating & curing Tuberculosis

• continued from page 10

"I got so capacitated that I became confident to run the TB programme smarter and more efficiently than I had previously. I now also teach my colleagues the information I acquired from the course. Now I also challenge the doctors for prescribing the treatment which is not based on the regimen which is on the national protocol. I also managed to change some of the staff members' attitude towards TB...All those patients who would be left to die, are now being diagnosed by increasing the number of people who are screened and by improved quality of specimen collected, the positive patients are now called for commencement of treatment and they are followed up. The defaulter rate has gone down."

ICN, working within the Lilly MDR-TB Partnership is committed to mobilising and strengthening nursing as the key, practical, on the ground response to address the challenges, the suffering and the spread of TB. The ICN TB Project is supported by a United Way Worldwide grant made possible by the Lilly Foundation on behalf of the Lilly MDR-TB Partnership.



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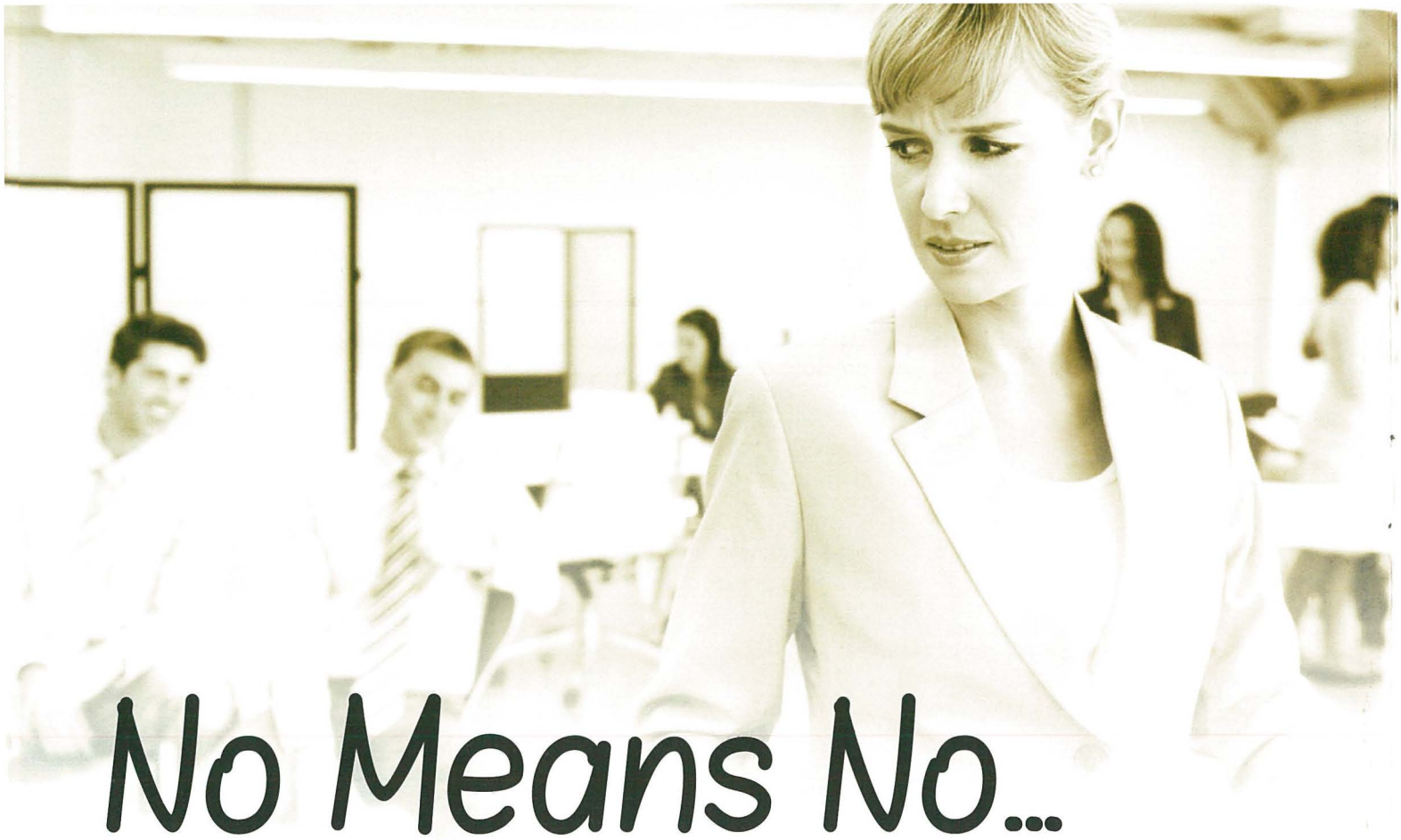


No Means No...

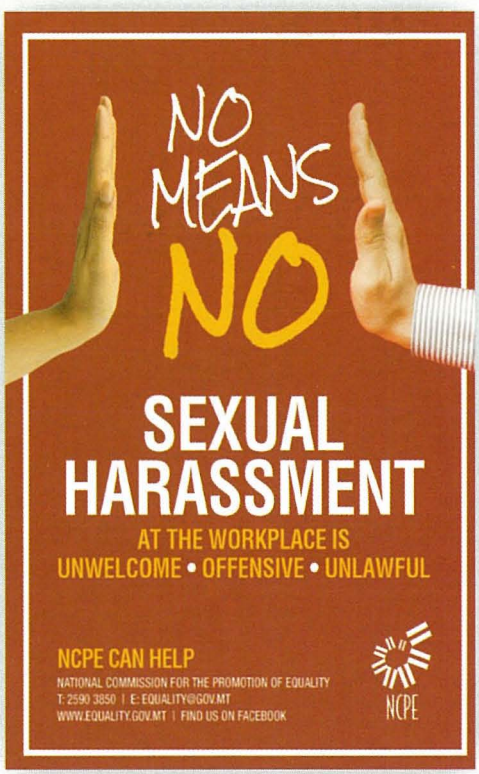
Sexual Harassment at the Workplace

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.



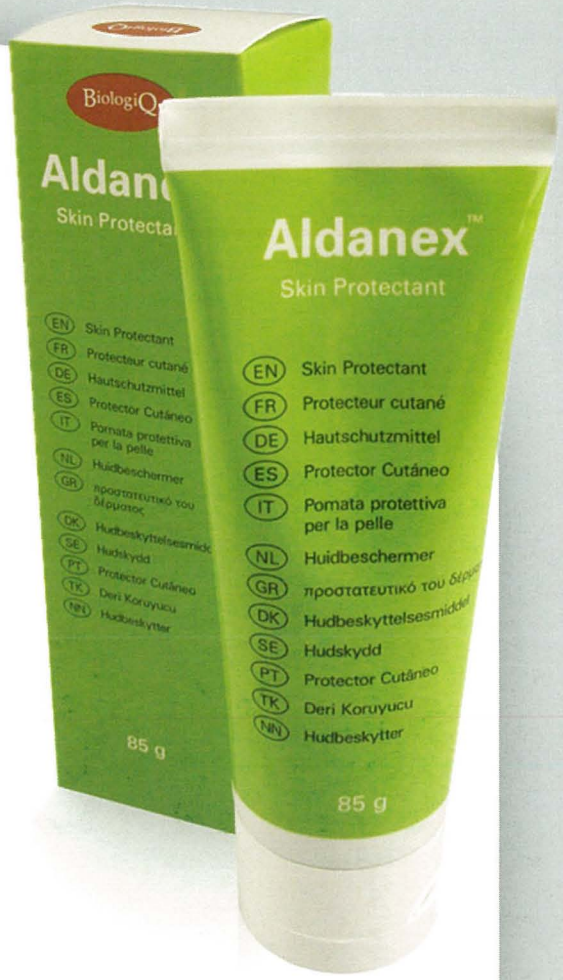
Sexual harassment may involve:

- 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

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).

The high correlation between IAD and pressure ulcers makes effective incontinence management a top priority in all care environments.

Aldanex™ has been specifically designed for the daily skin care of incontinent patients. Therefore, it represents a welcome contribution to the cost-effective prevention and treatment of moisture lesions, pressure ulcers up to category 2 and intertrigo.

Aldanex is indicated for the care of intact or injured skin associated with incontinence of urine, stool or both (IAD). It is also very effective for the prevention and treatment of pressure ulcers up to category 2 and intertrigo. Aldanex helps moisturize the body and protect severely dry skin. Other indications include partial thickness wounds, maceration of peri-wound skin and maceration/friction around drains, tubes, supra-pubic catheters, tracheostomy and nasal cannula sites.

Aldanex™ is available in leading pharmacies in tubes of 85 grams.

When people run for their life, army/police, fireman/women, health professions move into the zone of disaster!

A story of 2 nurses describes the commitment of nurses, a profession making the difference

On 22 March, we woke up early to take the train to Schuman. Kostas always walks to the EFN office, and comes near to Maelbeek metro station. Fatima takes the tram to Midi station, and then the metro to Troon, close to the EFN office. But 22 March, it was different. My train stopped suddenly in Schuman. Fatima's metro stopped far away from Troon and walked to the office. Kostas saw that Maelbeek was not as always. I started sending sms', where are you, go to a safe place! Fatima told me immediately, Gaetan (her husband) is on its way to Maelbeek for emergency nursing, as the THON Hotel EU, turned into triage hotel. Heidi called me as she followed CNN and knew I was in an extremely dangorous environment, she was so scared losing me! In the long run, we all got safely home with our PCs'. Yes! with our PCs'!, as we knew very well we would not return to Brussels the following days. We were all safe, that was the most important.

In meantine, our colleagues took over at the hot spot. Here the stories of two brave nurses, Gaetan and Maty, I believe you should read:

Maty - Works at St. Pierre hospital - Intensive Care Unit: "We lived a terrible day yesterday... We remained professional, efficient! Everything was ready to receive the victims very heavily attained, coming back from the operating room. We all stayed till the end. We needed to stay with our colleagues, our professional family. We supported each other because we couldn't reach our families. We dried our tears and worked, worked and worked... Today, I think of those who still don't have news of a family member, a friend, a colleague! Say to your beloved ones that you love them, every day...."

Gaetan – Nurse - Intensive Care/Emergency:

"This Tuesday 22 March 2016, when going to work, I was informed by the radio that an explosion had just occurred at the Brussels airport. Quickly news become worrying. Rumours of terrorist attack rise and a climate of terror falls down on the city. I am serene as regards the full assistance and medical means put in place since the Paris attacks. Less than an hour later the drama, I am informed that a new explosion took place in the metro, right in the centre of Brussels, just a step away from the European Commission. Given the extent of the disaster, I have the feeling that it is the one event too much. I take my car and drive through the city at high speed ...

When I arrive there, it is chaos... I am just ten meters' away from the catastrophe. I decide to set up the Medical Advanced Post with the doctor who coordinates all means on the site. Hastily, we clear the tables and chairs, with the hotel staff... the first victims arrive with the firefighters... suffering of severe burns, blasted, shocked... The equipment is not yet there... the victims are laying down on the ground... and sorted according to the seriousness of their lesions... U1 U2 U3... we determine zones for every category of victims... The medical devices finally arrive... we are 4 nurses present in the medical post before the arrival of reinforcements. We put perfusions non-stop... we relieve pain with morphine... it is the same syringe for several victims... we put masks with oxygen, packs to protect and relieve burns... face, hands, body...

We are cut from the outside world... surrounded by the

police present for perimeter containment, rescue vehicles siren non-stop... We work tirelessly... there are nursing students present as first-aid workers for the Red Cross, helping us... We are all looking at each other, a smile, a wink to support each other... when is this going to finish... the victims continuously arrive... We make our maximum to coordinate the Medical Advanced Post, to relieve the victims, to bring comfort.

Personally, I did not think... I had to help... help! be a link in this assistance chain...

I only digested and realised the scale of the catastrophe in the evening, in front of television ... We talk about it amongst us... and now, it is a feeling of anger and incomprehension. And I will still be there if it would happen again... it is part of my beliefs. My training and my experience helped me to respond appropriately and proactively ..."

The day after, you do not want to listen to any news, anymore. It is all too much information. But more important are the EFN members messages, unbelievable! You feel what solidarity means. You know, understand priorities. Unbelievable!

We express our sincere thanks and gratitude to all your support and solidarity. At that moment you just feel the strength of nurses!

Thanks for all the solidarity messages!

19 January, 2016

Nurse competence and compassion must be considered 'in tandem'

Compassionate elements of nursing should be considered "in tandem" with the technical aspects of the role to ensure a good relationship with patients, according to new research.

A study, published in the Journal of Advanced Nursing, noted that UK healthcare policy had in recent years been "dominated" by the desire to focus on compassionate care – particularly in nursing.

"Technical and compassionate aspects of care... are not separate and have to be managed together"

Research paper

This had been sparked by the Francis Inquiry, which was published in 2013 on care failings at the former Mid Staffordshire NHS Foundation Trust, it added.

The study authors from Australia noted there was a perception that some nurses were unable to provide care that was compassionate and kind, as well as competent.

But their research – which looked at evidence from a range of existing studies – found both technical ability and a compassionate approach needed to be managed together.

The research paper noted nurse competence provided patients with comfort and made them feel safe. However, patients also expected nurses to display compassion as well, it said.

Meanwhile, nurses believed their ability to build a relationship with the patient relied on them being confident in their own technical abilities. Student nurses said the same.

It was also found that patients' perspectives on what creates a caring relationship was affected by their particular condition.

"Patients' expectations are that nurses are competent, compassionate and caring and can be trusted"

Research paper

One study indicated people with cancer might require more contact from nurses compared with others conditions associated with less pain and suffering.

"Nurses need to recognize that patients can and do distinguish between technical and compassionate aspects of care. These two elements are not separate and have to be managed together," said the researchers from the school of nursing at the University of Adelaide in South Australia.

"Patients' expectations are that nurses are competent, compassionate and caring and can be trusted. This set of expectations needs to be upheld," they said in their study paper.

"The evidence demonstrated that patients judge the quality of the relationship through the alignment of the explicit and implicit values demonstrated around caring behaviours and attitudes displayed by the nurse," they said.

"Effective communication strategies together with the context or care environment were also important determinants of positive nurse-patient relationships," they added.

from the Liturgy of God's Word

The Constitution on the Sacred Liturgy of the Second Vatican Council, officially known as Sacrosanctum Concilium, which was solemnly promulgated by Blessed Paul VI on December 4, 1963, had this to say about the Liturgy: "The liturgy is the summit toward which the activity of the Church is directed; at the same time it is the font from which all her power flows" (§ 10).

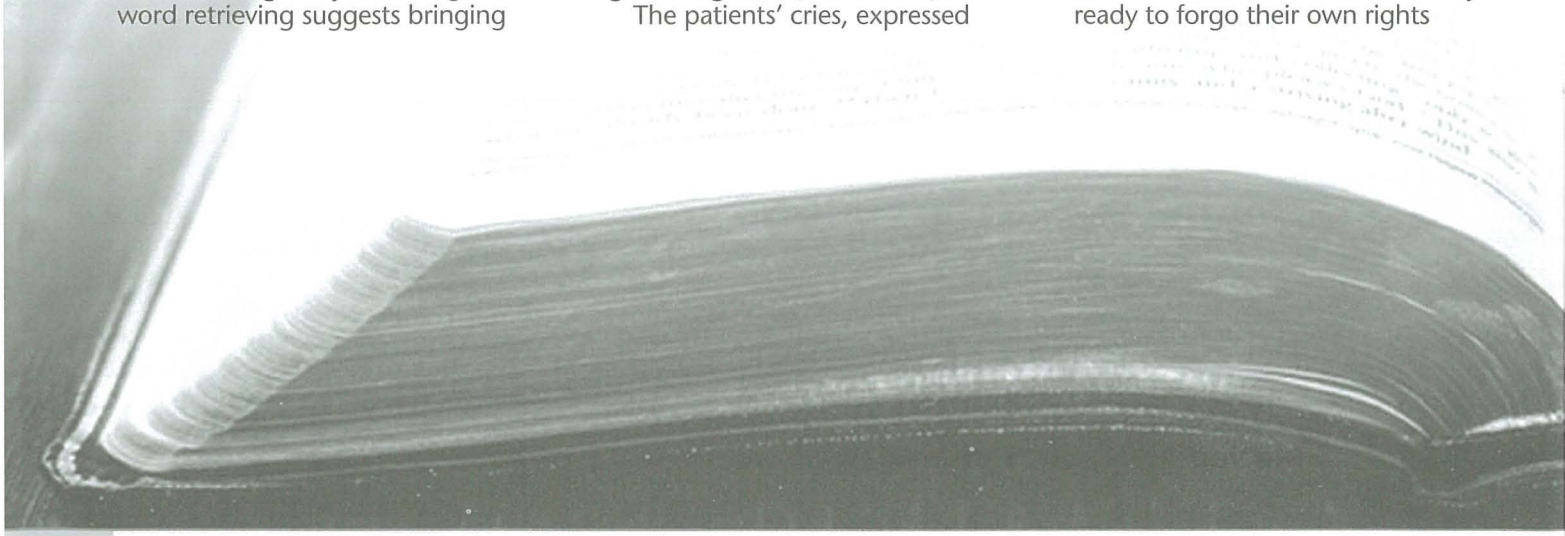
The first part of the Eucharistic celebration or the Mass is the Liturgy of God's Word. In the Liturgy of the Word we Christians assemble to thank God for God's gifts. By listening to God's Word (the Bible) we mature in our faith in order to be more conformed to the mind of Christ. The liturgy celebrates the wonders of creation and thanks God for the reality of redemption. Rather than being the celebration of what God has said the Liturgy of the Word is a celebration of what God today is saying to our hearts and souls. It is in this spirit and persepective that I intend to share with you the forthcoming reflections.

I was really touched by the readings of the fifth Sunday in Ordinary Time which were read on February 8, 2015. In the liturgical readings of the day I could see what it means to be a patient and how to respond pastorally to the sick person's needs. As I pondered on both these liturgical readings of the day together with the title of this reflection the first word that sponteneously came into my mind was retrieving. Why retrieving? The word retrieving suggests bringing back, fetching, reacquireing, recalling, recapturing, reclaiming, recovering, redeeming, repairing, repossessing, rescueing, restoring, saving and winning back. I am sure that those who are familiar with the pastoral care with the sick genuinely feel that this noble art of looking spiritually after the patients spiritual needs must itself be challenged, reformed and rebuilt continually. Let us now delve deeper into the readings themselves to see how they build up pastoral care in general, and its agent and addressee in particular.

The first reading of the day was taken from the seventh chapter of the book of Job, precisely from verses 1-4 and 6-7. The general context of the reading is that Job is wrestling with the problem of innocent suffering. The book's author is crying in his misery. He is speaking of life and death. He is spelling out his restlessness and his life's struggles. He is also affirming that he will not see happiness oncemore. As I heard this reading in Church I quickly reminded myself of the suffering our patients go through in our hospitals. In each and every suffering patient I could easily hear echoing in my ears the same words which Job uttered distressfully in his terrible illness: "When I lie down I say, 'When shall I arise?' But the night is long, and I am full of tossing till the dawn. My days are swifter than a weaver's shuttle, and come to their end without hope. Remember that my life is a breath; my eye will never again see good" (Job 7:4.6-7).

The patients' cries, expressed in this reading, helped me ask one simple question: If our patients, who are the addressees of the pastoral care we give them at the hospital, are feeling so helplessless, to the point of saying that their eyes will never again see good, how am I helping them see any good in their situation? My God-given grace of composure during the Liturgy of the Word greatly assisted me to listen more. The first part of the answer came to me from Psalm 147. In this Psalm the psalmist rightly praises the Lord because He "builds up Jerusalem; he gathers the outcasts of Israel. He heals the brokenhearted, and binds up their wounds" (Psalm 147:2-3). "The Lord lifts up the downtrodden" (Psalm 147:6). If God is so merciful to his people who are crushed with grief and despair, wounded with sorrow and shame due to their exile what am I offering as a chaplain to the patients who are undergoing the same experience of the people of God? Am I being a presence that is encouraging them to be built up once more? To find themselves after the shattering news of their illness? To be healed from their brokenheartedness? To help them bind up their wounds? To help them lift up their downtrodden spirit?

The second reading of the day was taken from the First letter of Saint Paul to the Corinthian Community. As Fr. Kevin O'Sullivan OFM explained in his book The Sunday Readings, "in this section of his letter St. Paul is encouraging his Corinthian converts to be always ready to forgo their own rights



Retrieving pastoral care

when the edification or spiritual welfare of a neighbor is at stake". The Pauline text is so telling about this forgoing for the sake of the neighbour's good! "For though I am free from all men, I have made myself a slave to all, that I might win the more. To the weak I became weak, that I might win the weak. I have become all things to all men, that I might by all means save some. I do it all for the sake of the gospel, that I may share in its blessings" (1 Cor 9:19, 22-23). My immediate self-examination of conscience has been thus: How am I really making myself available to the patients who are weak? And how my pastoral availability is deeply motivated by the self-giving ethos of the Gospel? In my pastoral work as a chaplain am I being a good news for the sick I serve? Are they being relieved from their distress the moment they come in contact with me? In other words, am I really being a blessing to the patients I daily minister to?

The final reading of the fifth Sunday was excerpted from Mark's Gospel chapter 1 from verses 29 up to 39. The disciples were struck by Jesus' authority both in word and in speech. At his command demons are expelled and bodily ailments are healed. This overtly shows that Jesus brought spiritual salvation and blessing on all people. The fulcrum of Jesus' pastoral activity was certainly prayer. From his union with the Father stemmed out his mission of going from town to town preaching the kingdom of God and his message was confirmed "by the signs that attended it" (Mk 16:20).

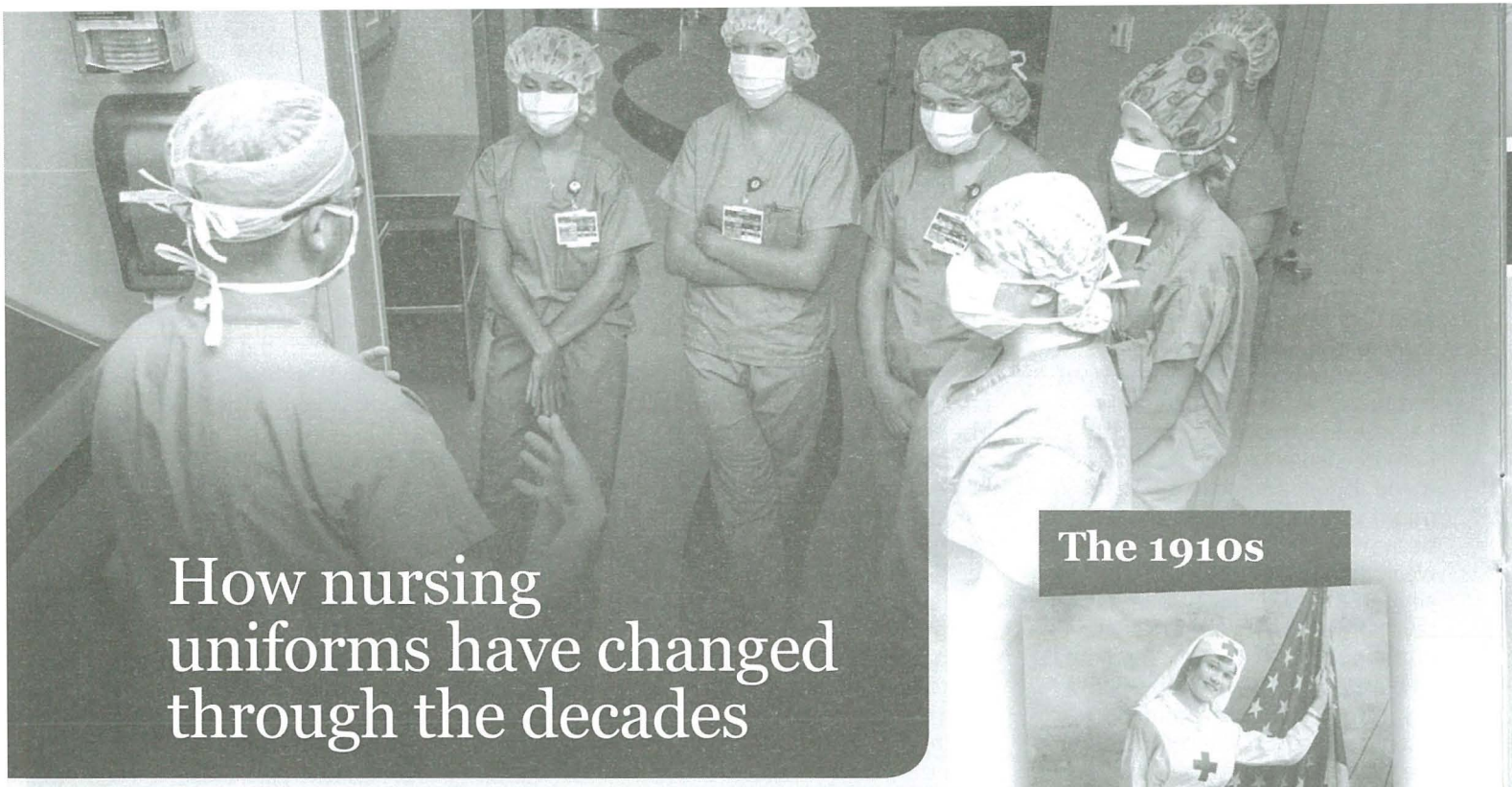
This powerful reading challenged me on various counts. The first detail that made me deeply reflect was the way Jesus healed Simon's mother-in-law who laid sick with fever. Mark says that Jesus "came and took her by the hand and lifted her up, and the fever left her; and she served them" (Mk 1:31). Do I approach the patients I serve or do I remain spiritually and emotionally distant from them? The second detail centres on Jesus' relationship with the demons. Mark recounts: "That evening, at sundown, they brought to him all who were sick or possessed with demons. And the whole city was gathered together about the door. And he healed many who were sick with various diseases, and cast out many demons; and he would not permit the demons to speak, because they knew him" (Mk 1:32-34). Do I realize that by listening; praying with; and administering the sacraments to patients; especially those of the Anointing of the Sick, Confession, and the Eucharist, I am letting Jesus casting away from the patients the demons of fear, frustration, helplessness, anger, and guilt?

"this noble art of looking spiritually after the patients spiritual needs must itself be challenged, reformed and rebuilt continually"

Mark also says that "in the morning, a great while before day, he rose and went out to a lonely place, and there he prayed" (Mk 1:35). Is my pastoral care with patients based on my intimate relationship with God? Is prayer my foundational value of being a chaplain? Does prayer feature in my personal and pastoral life as a service that I not only offer to others but is, first and foremost, my very spiritual breathe, in that it defines who I am and do as a chaplain? Finally, at the constant demand from others, Jesus replies: "'Let us go on to the next towns, that I may preach there also; for that is why I came out.' And he went throughout all Galilee, preaching in their synagogues and casting out demons" (Mk 1:38-39). Am I aware that true prayer drives me to be available more to various patients who are direly in need of having someone listen to them? Encourage them? And, in the process, be freed from any evil tendencies that are crippling their mind, body and spirit?

From this interesting experience I heartily conclude how God' word "is a lamp to my feet and a light to my path" (Ps 119:105) both as a person consecrated to God as well as a hospital chaplain. It does help me understand my pastoral role as someone who is chosen from the crowd to serve the crowd in need.

Fr Mario Attard OFM Cap



How nursing uniforms have changed through the decades

Doctors and nurses are the ones who help us when we need it the most, but medical fashion hasn't always been as functional as it is today! In fact, nurses' uniforms have changed a lot over the years!

The 1800s

Nursing officially started in the early 1700's in Philadelphia, Pennslyvania and quickly expanded throughout the United States. When it came to fashion, nurse uniforms have evolved dramatically over the years. Not many people know that nursing was first considered a "street profession," meaning that it was unsupervised, unregulated and not as respected as it is today.

The 1900s

Then, thanks to the outreach of influential women like Florence Nightingale, people around the world started to realize that trained nurses were vital to the health and success of their societies. This newfound appreciation was eventually reflected in their uniforms. They got to ditch the servants' outfits and wear light gowns with white aprons and cloth caps. Many nurses also wore capes that showed how trained and experienced they were!

The 1910s

With the increase in nursing schools and medical technology, the fashion had to cope with the changing standards. Nurses understood that the faster they could treat a patient was the difference between life and death, so designers added pockets and made it much easier to roll up their sleeves!

The 1920s

During World War I, chunky dresses were officially out, and shorter ankle-length dresses were in. The 1920s was when the most primitive form of the nurses' dress we think of today came about!

The 1930s

Things didn't change much for the uniforms from the 1930s to the 1940s. Nurses usually wore collared white dresses (still ankle-length) and a slightly larger fabric cap.

The 1940s

Fashion took a larger role in the uniforms of the late 1940s. These women depict the fashion of U.S. Naval hospital nurses during the 1940s.

The 1950s

Nurses' fashion followed the women's empowerment movement and the uniforms became shorter on both the sleeves and the skirt length. The large caps once worn by the women were replaced by smaller, more simple paper hats!

The 1960s

The sudden popularity of mechanical laundry machines in the 1960s meant that every piece of fabric in the hospital was now going to be machine-washed. So the uniforms were simplified and the fabric was easier to wash and iron.

The 1970s

Once again, reflecting the times, the uniforms became shorter and some nurses even traded out their skirts for more comfortable white pants. Hats were made even smaller and a large portion of nurses were growing tired with having to wear them at all. It wasn't long before their requests were heard and the hats were eliminated!

The 1980s

The most basic version of the "scrubs" we know today first came around in the 1980s. The fabric was now lighter and the dress was replaced with the separate shirts and pants!

The 1990s

Towards the end of the 1990s, different colored uniforms indicated where a nurse was working. The white uniforms would be for their daily rounds and they would change into blue scrubs when assisting in the operating room!

Today

The same color-specific scrubs rule still applies today, but the doctors and nurses get to wear their own long-sleeved shirts under them if they'd like. There are also fun prints that they can wear to bring a little cheer into sad, chilly hospital rooms!

The Unsung Heroes

These men and women are making fashion history and helping their patients in the best way they know how! They work tirelessly to make sure we are all at our best and we will never be able to repay them!

1887 Nursing Job Description

Flickr | Boston Public Library

Whether you're a new nurse or a seasoned nurse, it's always intriguing to take a look back at the history of the nursing profession.

This list illuminates the day-to-day tasks and regulations pertaining to the life of a nurse in 1887 – before routine charting was even invented.

In addition to caring for your 50 patients, each bedside nurse will follow these regulations:

1. Daily sweep and mop the floors of your ward, dust the patient's furniture and window sills.
2. Maintain an even temperature in your ward by bringing in a scuttle of coal for the day's business.
3. Light is important to observe the patient's condition. Therefore, each day fill kerosene lamps, clean chimneys and trim wicks.
4. The nurse's notes are important in aiding your physician's work. Make your pens carefully; you may whittle nibs to your individual taste.
5. Each nurse on day duty will report every day at 7 a.m. and leave at 8 p.m., except on the Sabbath, on which day she will be off from 12 noon to 2 p.m.
6. Graduate nurses in good standing with the director of nurses will be given an evening off each week for courting purposes, or two evenings a week if you go regularly to church.
7. Each nurse should lay aside from each payday a goodly sum of her earnings for her benefits during her declining years, so that she will not become a burden. For example, if you earn $30 a month, you should set aside $15.
8. Any nurse who smokes, uses liquor in any form, gets her hair done at a beauty shop or frequents dance halls will give the director of nurses good reason to suspect her worth, intentions and integrity.
9. The nurse who performs her labors [and] serves her patients and doctors faithfully and without fault for a period of five years will be given an increase by the hospital administration of five cents per day.

A nun who is believed to have been the oldest person in Malta has died aged 107

TIMES OF MALTA

Sister Lidia (Giuseppa) Formosa of the Sisters of Charity was born in Victoria on March 12, 1909. She joined the congregation 84 years ago and served as a nurse in different hospitals around Malta.

During World War II she worked at the Central Hospital in Floriana and then continued with her work as a nurse at St Vincent de Paul Residence for the elderly.

For the past few years she lived in the Sisters of Charity convent in Balzan.

Xi jferraħni

Ikollna nammettu; li drabi il-ħajja,
il-morr iddewwaqlek, toffrilek it-tlajja.
U aħna dan kollu, narawh u nħossuh,
u nagħmlu minn kollox sabiex intaffuh.
U f'nofs dit-taqbida kemm sejjer iddum,
tissielet, tipprova, titħabat kuljum?

Min jgħaddi il-ħajja idur bil-marid,
jaf jogħtor f'mixjietu, bla ma jkun irid.
Għax jekk toqgħod tkejjel jew tiżen f'miżien,
il-keffa tan-niket se tegħleb maż-żmien.

'Mma hemm ħwejjeġ oħra narawhom hawn biss,
min jifli ftit sewwa iħosshom ta' spiss.
Fil-għajn jidhru ċkejkna, u jagħmlu ħoss ftit,
'mma l-keffa l-imniżżla taf fl-għoli iżżid.

Jien rajt fuq wiċċ xwejjaħ sabiħa tbissima,
kif kont ħdejh mas-sodda u tajtu tislima.
Ilmaħt tgħib il-weġgħa tal-kbir abbandun,
kull darba li nersaq, maġenbu inkun.

Intbaħt b'min ftit jara, inkella biss ċpar,
illum qed igawdi il-ġmiel ta' dawl ċar.
Rajt min għex f'silenzju ġie s-smigħ mogħti lura,
biex jisma il-ħsejjes ta' ġmiel in-natura,
Rajt għadam jinagħqad, jissaħħaħ bil-mod,
u jerġa ir-riġel fuq l-art jirfes sod.
Rajt lura is-saħħa iżżur par idejn,
li kellhom kundanna ta' użu ta' xejn.
Rajt ġrieħi li wasslu għal ħafna tbatija.
Ftit ftit rajthom jilbsu, bil-laħam mimlija.
Il-qalb illi waqfet u tbattlet mid-dmija,
mill-ġdid qegħda tħabbat bil-ħajja mimlija.
U lura jiħmaru bil-lewn il-ħaddejn,
li kienu ġa sfaru b'tal-mewt id-difrejn.

Min jista ikejjel il-ferħ ta' dik l-omm,
li lura f'ħoġorha lil binha iżżomm.
Minn ħalq marda kiefra fil-ħin ġie imfejjaq,
u tkeċċa minn darhom kull niket u dwejjaq.
Familja magħquda li kienet fit-tmiem,
mill-ġdid issa darhom imseddqa bis-sliem.

Jien rajt ħjiel it-tama minfejn kienet għabet.
Rajt tgħammar il-paċi fejn qatt ma instabet.
Rajt jaħrab id-dubju, il-biża u d-dieq,
u l-qalb li inqasmet fi tnejn, terġa tfieq.

Dan seħħ għaliex aħna li hawn attendejna,
id-dmir mitlub minna mill-qalb morna qdejna.
Wettaqna il-ħidma li ġejna afdati;
Li ngħinu u nħobbu lil min qed ibati.

U kif jibda' jidlam u d-dar nerġgħu lura,
nifirħu għax tajna mill-qalb l-aqwa kura.
Dan hu il-ħlas tagħna ta' jum fuq saqajna;
li bl-akbar imħabba, aħn' għinna kemm stajna.
U konna mqar spalla għal min fit-tiġrib,
wiżinna 'l min mgħattan taħt toqol salib.
Erfajna 'l min mgħarraq, bla nifs, ħassu fgat,
għinnih isib riġlu mill-ġdid fuq il-blat.

Għalhekk.....
nitolbu lil Alla jkattrilna il-ħlewwa,
biex dak illi nwettqu ikun biss l'hu sewwa.
U nifhmu xi grazzja messitna, x'fortuna,
li nistgħu innaqsu mqar xewka f'kuruna.
Li nimsħu id-dmija, nixxottaw id-dmugħ,
nitimgħu u nmantnu lil min hu bil-ġuħ.
Lil min ħalqu niexef, tazz' ilma nagħtuh,
lill-għeri inlibbsu, fil-kesħa nsaħħnuh.
U saqaf niprovdu lil min qalbu nfniet,
għax daru inbiegħet biex jirtu l-ulied.
U nishru maġenbu f'dan l-akbar dulur,
għax minn tant qrabatu ħadd lilu ma jżur,

Dan hu li jqajjimni filgħodu minn kmieni,
biex nara lix-xwejjaħ xi ftit aktar ħieni,
u lilu nwassallu minn qalbi t-tislima,
u lili jħallasni b'ta' wiċċu t-tbissima.
Dan hu li jferraħni f'ħidmieti kuljum,
u n-ngħas itajjarli, w mis-sodda inqum.

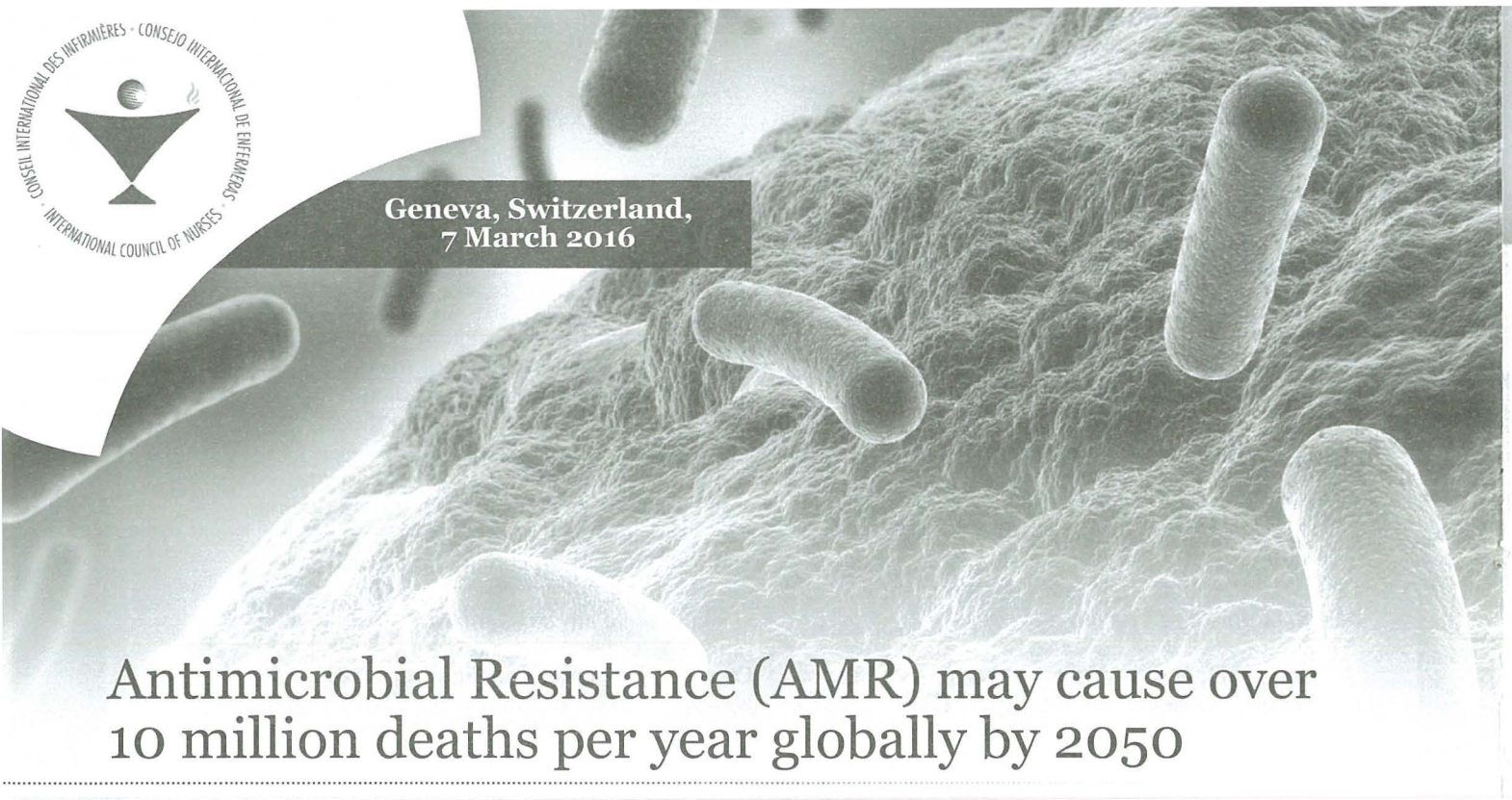
Mario Borg
12 ta' Settembru 2015

(Poeżija miktuba għall-Okkażżjoni tas-Serata Premju Ħaddiem/Tim tas-Sena 2015 - Sptar Ġenerali t'Għawdex)

Cancer support group activist passes away

Doris Fenech, the founder of the metastatic branch of Europa Donna Malta has passed away.

Herself a sufferer, Ms Fenech was an active member of the support group for over 18 years, first as a committee member and then as vice-president, and was also the national representative for Malta of Europa Donna, the European Breast Cancer Coalition.



Geneva, Switzerland, 7 March 2016

Antimicrobial Resistance (AMR) may cause over 10 million deaths per year globally by 2050

Nurses identified as vital to reducing impact of AMR

Following a meeting of professional organisations on the healthcare workforce implications on Antimicrobial Resistance (AMR) held at World Health Organization (WHO) headquarters on 2 March 2016, the International Council of Nurses calls on governments to support the Global Action Plan on AMR and stresses the key role of nurses in reducing the impact and limiting the spread of this major threat to public health.

The AMR meeting brought together healthcare professional organisations to identify the best methods to address knowledge and information delivery to prescribers and healthcare workers and the ways to achieve effective behaviour change.

Antibiotic resistance is one of the biggest threats to global health today. It leads to longer hospital stays, higher medical costs and increased mortality. At the meeting, Dr Caline Mattar of the WHO indicated that AMR is responsible for 25 thousand deaths in Europe every year, 38 thousand per year in Thailand; and over 23 thousand in the USA. AMR has huge economic costs as well: estimated direct costs of AMR in the US are up to US$20 billion per year and up to US$35 billion per year for indirect cost. A February 2015 review on AMR projected that by 2050 it would cause over 10 million deaths per year globally and result in a cumulative cost of US$100 trillion, roughly the same as removing the UK economy from global output each year.

A key role of nurses is to educate the public. Dr Matter reported the results of a WHO multi country survey which showed that 64% of those surveyed believed that antibiotics are good for illnesses such as cold and flu; and about one third believed they should stop taking antibiotics when they feel better.

At the meeting, Dr Frances Hughes, ICN's Chief Executive Officer, highlighted that nurses have the most impact on public and patient education; infection prevention and control; ensuring responsible use of AMRs and monitoring and evaluating treatment and reporting of AMR events.

"If the spread of AMR continues as projected, said Dr Hughes, "it will be nurses and families who will be caring for individuals in a manner not seen today."

"Nurses can play a key role in lobbying governments to develop and strengthen national antimicrobial resistance surveillance systems to monitor the extent and cause of resistance in order to strengthen knowledge and evidence bases," Dr Hughes added. "In addition, we can lobby governments for regulation to ensure that only quality assured, safe, and efficacious antimicrobial agents are licensed, distributed, and sold."

Further roles for nurses include supporting and strengthening infection prevention and control (IPC) policies and practices; supporting patients' adherence to antimicrobial treatment and correct use of antibiotics; and promoting vaccination.

In May 2015, the World Health Assembly adopted the Global Action Plan on Antimicrobial Resistance (AMR) which highlighted the vital role of the healthcare workforce "in preserving the power of antimicrobial medicines". The Global Action Plan set out five main objectives:

1. Improve awareness and understanding of AMR
2. Strengthen knowledge through surveillance and research
3. Reduce incidence of infection through sanitation, hygiene and infection prevention
4. Optimize use of antimicrobial agents and
5. Develop the economic case for sustainable investment that takes account of the needs of all countries, and increase investment in new medicines, diagnostic tools, vaccines and other interventions.

Later this year, a high level meeting on AMR will occur at the United Nations General Assembly.

Nutrition is of utmost importance during the first 1000 days, from conception to the first couple of years.[1]

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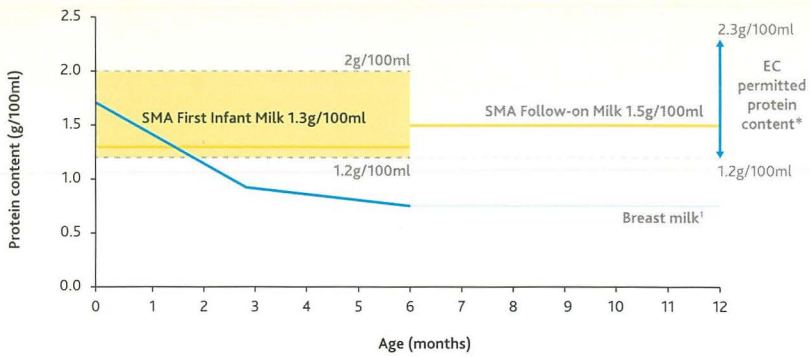
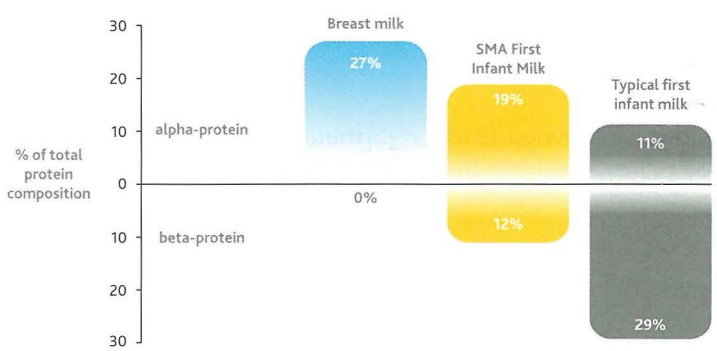
Breast Milk Substitute
1 from birth

The protein hypothesis postulates that early excessive protein intake might lead to increase in insulin and insulin like growth factor-1, leading to increased weight gain, and adipogenic activity.[2]



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

Furthermore SMA First Infant Milk, has a higher alpha-lactalbumin content compared to other traditional first infant milks.[4]



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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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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MF#IRC26P030

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