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Nurses sometimes view patient bathing as time-consuming, low priority task, when in reality it’s a golden opportunity to incorporate many key principles of care-providing a compassionate touch, taking time for education, meeting emotional needs, grooming, assessing skin and repositioning to name some. As a nurse, we do know that care is part of our responsibility, and we also thankful to the many great nursing assistants who understand the importance of a thorough bath. Our patients say they feel human again after a wonderful bath.

Back in the Nursing School days, bed baths were literally the second practical skill we learned, after making the bed itself. Nurses have to defend the bed bath as the most elemental nursing skill, simultaneously bringing comfort to the patient while establishing a therapeutic bond and allowing us to assess physical and mental condition. Proper bathing practices in adults can also reduce infection rates and complications and this, on its own is enough evidence for nurses to carry out proper patient bathing practices a priority.

On the other hand, Nurses will tell you of ever-increasing patient acuity taking time away from basic nursing, yet it's these acutely ill patients who need bed baths in the worst way. When one adds the time needed for the legion of non-nursing-related activities and documentation that crowd a nurse's attention, it quickly becomes clear how bed baths are deemed 'non-essential'. Bed baths, or the lack thereof, are symptomatic of a larger issue in nursing. Some nurses have declared that bed baths as a task which is far too simple and unimportant to them. Some have passed on this skill to nursing assistants and support workers to perform what was once thought to be 'sacred' activity that fostered intimacy between nurse and patient. If nurses consider the discarding of bed baths as acceptable, they are contributing to the extinction of the discipline of nursing.

When nurses start thinking of bed baths as just another task, like emptying the urine drainage bag, rather than as an essential part of the therapeutic process, we’re in trouble. So bed baths illustrate rather nicely the present conflict in the profession: are we mindless drones just doing the job, or are we thinking health care professionals engaged in a holistic therapeutic process with our patients?

And what is the fate of the conceptual models of nursing? Are we also claiming that these models are 'dinosaurs' and irrelevant? Without these models we are nothing more, or less, than skilled tradespeople. Our ambivalence would be resolved in favour of a clear directive to advance the discipline of nursing if nurse educators, practicing nurses and nurse researchers would individually and collectively become enamoured of the idea of being champions of nursing discipline-specific knowledge.

Is this non-acceptance to do bed baths for our patients the main cause of nursing malaise in our country? Do we really want nursing to be recognised as a distinct discipline, with all its rights and privileges? I can only hope that enough nurses will make commitment to becoming champions of patient care and continue to provide a valued and respected service to human beings, such as giving bed baths...
Dear colleagues,

Here we are reading the first issue of 2017, and very soon we'll be preparing for spring. A time of rebirth and renewal. It is a time of transition from the long dark nights of winter to the warm sunny days of summer. As we enter spring, I find that I have so much to be grateful for...the dedication of the council members, office administrators, group committee members, and all of you as members; who selflessly do the work professionally and in a dedicated way. Thank you all for your hard work, counsel and dedication.

So, as spring comes, students within our professions will soon sit for their final examinations; and we'll be looking forward to see these new graduates arriving on our floors. With that in mind, I offer all of you this challenge. Be the professional who inspires, the one who others want to emulate. Be the professional that makes the difference for that student on your unit; as these students are our future.

On another note, I wish all prospective graduates best of luck with their studies.

Away from trade unionism but at heart to the MUMN, we will soon be launching the nursing marketing campaign. We are also, in the lead-up to host associations from the European Nurses' Federation. During this two-day meeting, European nursing leaders will discuss nursing issues. In the meantime, we are also in the lead-up of a symposium, and I am in awe at the high level of abstracts we received. As before, the educational committee members, collaboratively, pragmatically, and enthusiastically came together with a common purpose—to create a forum for networking, celebrating and sharing the best of practice, education, research and leadership with our peers. From the planning committees, to those presenting and to those attending for the symposium, it takes a village of committed individuals to make the conferences or symposia a success. In every sense and every way, each of these individuals are leaders. And, it seems, we are very good at coming together for some things that are "inward facing" to our professions, such as focusing on our collective professional development and pride. I look forward to meeting you at the symposium, and I'm sure that it will be another successful event.

On another note, it is worth noting that we kept our industrial relations on all fronts; both at hospital level and ministry level. I can say that we have had a very busy winter indeed. All professions represented by MUMN received the attention needed at all levels; and this also include members working within the private sector. Irrespective where they work, employees need to work in good and conducive environments. May I also take the opportunity to thank the scrub nurses who are nominated for the elections for the main operating theatres group committee. Further details on the election proceedings will be issued soon. Special thanks also go to the members within each respective group committee who are always there to help and support the MUMN members. This is because trade unions play great roles in safeguarding employees from any form of discrimination or harassment in organisations, while at the same time negotiate better terms and conditions for workers. As a union, we respond to these challenges with professionalism, integrity, clarity of purpose and a willingness to collaborate where possible but also fight our corner when necessary. From last January, as a union we also introduced the service of the lawyer; where by members can have the assistance of the lawyer on work related issues.

During the last few months the MUMN together with other unions on several occasions met with the personnel from the standard and people unit to negotiate another collective agreement for the employees of the Public service and Public sector. This of course, is not possible without the collective strength, determination and commitment of trade unions working together to achieve significant improvements in wages and working conditions.

Moreover, when it's time to come together for more "outward facing" actions, such as having a voice in shaping health, policy and systems, we are no less leaders, and yet we are cohesive, visible and effective. We have so many voices, and we exercise our knowledge and power to promote sustained change. This is because individually and collectively, we can and should play a significant role in shaping the contexts and structures within the care we deliver. As your professional union, the MUMN strives to support you as its member, to continue to develop and lead this very important work. However, we must also come together in new and different ways to locate, position and augment our collective voice to influence policy and system change.

To conclude, I would like to thank each one of you for the excellent care you give to your patients on their road to recovery. Your workdays are busy and patient acuity is much higher than ever before; and let’s face it, our workplaces are much more intense than ever before. Your knowledge, skills and judgment are very much appreciated!

Best wishes for a Happy Easter to you and your family.

Best regards,

Maria Cutajar
MUMN, President
Kelmtejn
mis-Segretarju Generali

My life changing experience in European Voluntary Service

ABRAHAM AZZOPARDI

1st September 2015 at 11am I was alone at the Malta International airport flying off for a 10 months experience in a land I did not know named Croatia. I was asking myself if I was doing the right thing or not to leave my job in hospital and do a leap of faith in the unknown and go for EVS. 10 months later on 1st July 2016 at 7 am I was waiting at Zagreb international airport this time not alone but with a group of friends that I had made during my 10 month experience. At that point I knew that 10 months before I had made the right choice in taking this opportunity called EVS.

EVS is a short abbreviation for European voluntary service, which is an opportunity that the European Union offers to young people between the ages of 17-30 years. Young people have the opportunity to go for a volunteering experience in a country abroad for a defined period of time up to a maximum of 1 year. The European Union trough the Erasmus+ fund supports the volunteers by giving money for travelling, accommodation, food and also a specific amount of pocket money per month which varies, depending in which country the participant is carrying out the experience.

The EVS offers various opportunities for people who want to grab it. There is something for everyone starting from volunteering in gardening and agriculture, to volunteering in theatres or with young people. Although my job is that of a nurse, I decided to go for a different experience and experience youth work. I was part of a youth NGO called Nezavisna Udruga Mladih situated in the small city of Lepoglava. The role of this NGO in this small town was to give voice to the young people there. I was in charge of organising activates for the young people with a team of volunteers that formed part of this NGO. Some of the activates that we managed to organise are a treasure hunt, 2 quiz nights, money exhibition with currencies from around 60 countries from all over the world, CV writing workshops, snow fight, indoor games nights, cultural nights, communication workshops and much more.

I was also in charge of applying for European Union funded youth exchanges and managed to get funds for one youth exchange named “Empower Yourself”, which saw 35 people from 6 different countries gather together for 1 week in Croatia. They had various workshop and the main aim was to educate young people in the field of entrepreneurship.

Before I went for my EVS experience I used to hear people that did the experience say that EVS is a life changing experience. I used to ask but what is the big deal about this experience. However today I can say that it really is a life changing experience. The EVS managed to change me slowly without realising. However after the 10 months I saw the difference from the Abraham I was in September 2015 to the Abraham I became in July 2016. Some of the changes I experienced are the following.

Independent: We Maltese tend to stay with our parents for as longer time compared with our European counterparts. This was my second time living abroad alone, however the first time I stayed for such a long time. It helped me to become more independent and more proactive, while becoming more assertive as I had to fight in what I believed what was right. This served me well in my job as now I am more assertive and I can be a stronger voice for my patients within the team of care givers.

Working as team member in a team: Due to the fact that I formed part of an NGO, made up of a large number of people, I had to learn how to work in a team. This experience made a better team member and showed me how to work efficiently in a team and that if work is equally divided in a team, the work is done faster and the quality is also better. This skill also helped in my nursing career, as in hospital working in a team is essential to give the best care to our patients.

Digital competences: Working in an NGO that involves youths, I had to make use of technologies and innovative ways to make sure that we reach a big number of young people with the most attractive ways possible. Thanks to my EVS, I managed to be more computer literate and more capable in public speaking. In our job, we are also sometimes asked to present something to the public. I will be using the skills that I learnt to make a more interesting session for the public I would be addressing.

* continued on page 10
Virtues in pastoral care

Have you ever encountered the term virtue? What does it have to say to the domain of pastoral care with patients? Do chaplains need to have virtues? And, if yes, what kind of virtues do they really need to cultivate within a pastoral setting?

Before defining what virtue really is we have to go back a long while. Precisely to the milieu of ancient Greece. Around the fifth century BCE a new genius emerged on the philosophical and mathematical horizon. This man of outstanding learning was none other than the great Plato.

The latter is considered a foundational figure in the evolution of philosophy, particularly within the Western tradition of thought. Together with his teacher Socrates and his excellent student Aristotle Plato laid down the foundations of both Western philosophy and science. The distinguished and defining representative of process philosophy, the British philosopher and mathematician Alfred North Whitehead, rightly observed: "The safest general characterization of the European philosophical tradition is that it consists of a series of footnotes to Plato." It was the latter who, enraptured by his incredible passion for knowledge, instituted the Academy in Athens. This highly reputable place is still famous for the higher learning it imparted and the way it influenced the entire western history of thought.

Both Plato as well as his brilliant student of the Academy, Aristotle, treated the important topic about virtue. To put it plainly and simply virtue is that power which permits people to keep their integrity and character when facing all sorts of troubles and oppression. The word virtue is derived from the Latin word virtus which signifies strength or the capacity to achieve.

In an interesting book entitled Spirituality, Ethics and Care Simon Robinson has this reflection to make regarding virtues: "Virtues are the qualities of the person that enable something to be brought into being, i.e. moral virtues enable moral meaning and purpose to be embodied. By extension they are the qualities that enable a spiritual ethos to be lived out in individual and corporate practice. Hence, we would normally refer to the virtues of the individual, but also it is possible to see the term in relation to a community or a group, i.e. describing a group as having integrity".

Virtue is a basic part of who we are as human moral beings. As it stands virtue is the kernel of our identity. It adorns our character. In other words virtue helps us form our perception of other persons, groups or communities the way they behave or relate to us and the other way round too.

Plato theorized that because we are human persons we are able to intuitively acknowledge or come to know what is good and virtuous. On the other hand his highly esteemed student Aristotle took a completely different path. In the book Finding Happiness: monastic steps for a fulfilling life, written by Abbot Christopher Jamison, we find that Aristotle held that virtue "is a disposition a person has towards making good choices, and the way we learn to make good choices is through imitation". Take, for instance, when we were children. How did we grow up into mature adults? Precisely by learning to take decisions in the way meaningful people used to take them. Thus, due to our trust we imitated these significant people in our lives up to the point that today we have advanced in our habit of making the right (or the wrong) decisions. Abbot Jamison further explains that "Platonic contemplation involves knowing the good, the sense of knowing being like that of knowing a friend rather than knowing a fact. Aristotelian virtue involves
Marzu

Virtues in pastoral care

doing good, as in living out the virtues”. Learning by doing, as the great American philosopher, psychologist, Georgist, and educational reformer, John Dewey, aptly pointed out, characterises the difference between the Platonic and the Aristotelian idea of virtue. The endless test of education is always experience. If education fails the test of experience it overtly shows that it was never education in the first place!

In this respect it is imperative for me as a chaplain to always be engaged in this ongoing pastoral reflection in order that my ministry at the hospital would give its intended beneficial effect. In order for me to grow in this self-giving disposition which chaplaincy necessarily requires I need to be bold enough to ask myself pivotal personal questions. Who were the key persons, groups and communities in my upbringing that informed and formed my actual comportment, choices and manners of relating to people in need? For what purpose did I imitate them? Do I think that my imitating them was simply conscious or unconscious? Or, perhaps an amalgamation of both? What made me admire them? And why did I take their example as affirming my life? Can I detail their habits, components or precepts? To what extent do I realize that I really personify or put into practice the characteristics they handed me on by their powerful example in my role as a hospital chaplain?

Simon Robinson advocates that virtues are passed on through the stories we hear, and are fashioned in meaningful relationships. Hence, in my therapeutic relationships as chaplain with others I may incorporate good and make good choices. At the same time possibly I can learn more of what is good as it is experienced in my relationship with the people who use the pastoral service I provide at the hospital. Therefore, my moral character matures and evolves through a course of habituation (or impersonating), incorporating, commitment with others (practice) as well as reflection. Like my spiritual care ministry, which I heartily offer at the clinical setting, that which informs my pastoral comportment as a chaplain together with my decision making is clarified and remodelled through the agency of reflective practice.

Both my theoretical and life education have consistently proved Robinson’s classification of virtues which enlighten and deepen my clinical pastoral profile thanks to spiritual care and reflective practice. The leading pastoral virtues of the list, as proposed by Simon Robinson, are integrity, courage, patience, empathy, humility, honesty, faith (not essentially a religious faith but, for instance, faith in self or others), temperance (self-control, sense of balance), hope and prudence (practical wisdom). The latter virtue is amply shown in the reflected experience and the capacity to employ this with discernment in various situations while, at the same time, being person-centred.

As beautiful as they look these virtues need a profound understanding of the context in which they take place. In other words, the hospital should be seen as the place of health and evangelization. It is this enlightening vision which totally transforms the clinical setting. Pope Benedict XVI’s address to the Participants of Health Care Workers Conference in November 2012 remains always a tenable point of reference in this respect.

“From this perspective hospitals are seen as a privileged place of evangelization, because there where the Church becomes ‘the vehicle of the presence of God’ she becomes at the same time ‘the instrument of a new humanization of man and of the world’ (Congregation for the Doctrine of the Faith, ‘Doctrinal Note on Some Aspects of Evangelization,’ 9). Only when it is quite clear that the center of medical and support activity is the well-being of man in his most fragile and vulnerable condition, of man in search of meaning before the unfathomable mystery of suffering, can the hospital be understood as a ‘place in which the relationship of care is not a career but a mission; where the charity of the Good Samaritan is the first seat of learning and the face of suffering man is the face of Christ himself’ (Address to the Catholic University of the Sacred Heart of Rome, May 3, 2012).

Dear friends, this concern for health and evangelization is always your task. Now more than ever our society needs ‘good samaritans’ with a generous heart and with arms open to all with the awareness that the ‘measure of humanity is essentially determined in relationship to suffering and to the sufferer’ (‘Spe salvi,’ 38). This ‘going beyond’ the clinical approach opens the dimension of the transcendent to you. Chaplains and members of religious orders who work in health care have a fundamental role in this respect. It is their first duty to allow the glory of the risen crucified Christ to appear in the diversified panorama of health”.

However the context points to the One who has the power to create it and transform it: Jesus Christ. That is why Saint Camillus de Lellis wisely noted: “The poor and the sick are the heart of God. By serving them we serve Jesus, the Christ.” It is my fervent and humble prayer to the Father that my whole being as a chaplain, particularly when I am serving the sick, will always be rooted, focused and changed in the unique person of Jesus Christ. That Jesus who is “the pioneer and perfector of [my] faith” (Heb 12:2). The pioneer and perfector of the virtues I must have to serve him wholeheartedly in the sick in whom He is most distinguishably present.

Fr Mario Attard OFM Cap
5 things I’ve learned in my first month as a real nurse!
by ANI BURR, RN

It’s officially been one month since I’ve been an official, practicing peds nurse! And while I’m still learning, here’s a list of 5 of the “gems” I’ve learned so far.

1. REAL NURSING IS NOT LIKE NURSING SCHOOL – for some reason I am reminded of this every time I put on sterile gloves. In nursing school, even the simplest tasks like donning sterile gloves felt so huge because you were always under scrutiny of an instructor watching your every move. When you’re on your own just you and your preceptor, you begin to realize that you can handle those little things so much better when you’re accountable for your actions because you love your job, not because you’re trying to get an A – and THAT makes all the difference.

2. BE PREPARED – I was a girl scout for 6 years and while none of our activities required much preparation, the rule still stands with me, and now more than ever – BE PREPARED!!! It doesn’t hurt to carry an extra flush in your pocket with some spare caps for your tubing. It’s better than having to go in and out of your patient’s room over and over, and saves some very valuable time on a busy day!

3. Always be thorough – If you’re charting and you’re ever not sure if you need to say something, think about it this way: If you were brought to court to defend what you did, and someone who doesn’t know anything about nursing were to read it, would they know what you did? And then go from there.

4. TIME MANAGEMENT ISN’T SOMETHING YOU LEARN IN A DAY – it’s something you have to keep working on for your whole career. I feel like I am getting better, but there’s always something that comes your way when you least expect it. It’s all about learning to get things done efficiently and thinking one step ahead. It takes time to learn, but you get there (hopefully).

5. YOU BECOME A PART OF AN EXTENDED FAMILY – A part of the family of nurses, a part of your patient’s family, especially for those who spend their lives in and out of the hospital. When you’re working with family, there’s a bond you all share, and you have to learn to cherish that bond, and work with it. Because after all…. And I guess this counts as a rule number 6: You’re never alone! When things get crazy or your confused about something, remember that you have your fellow nurses there to help you out – don’t try to figure it out on your own!

There’s still a lot to learn, but I am getting there. Being a real nurse is so much different than the last 3 years in nursing school – and it’s so worth it!

My life changing experience

Cultural awareness and expression: This was a very good opportunity, were I learned a lot about different cultures. It was not just a learning process on the Croatian culture but also on other cultures, because I was meeting other EVS volunteers from various countries. I attended a number of cultural festivals that gave me a better insight on the local way of living and traditions. Apart from this I also shared my culture with the locals and with other EVS volunteers. This was a good opportunity for me to learn to live in a multicultural community. This experience helped appreciate more the benefits of living happily together with different cultures. It helped me to become better in adapting to different cultures and societies.

Today it is a fact that we are living in a multi cultural country. One cannot deny the fact that a lot of foreigners are working in our hospitals. This experience helped me to be better equipped to integrate and work hand in hand with people from different cultures.

These are just a few of the benefits that I got out of my experience. There is much more to this including lot of fun travelling, lot of new friendships formed with people from all over Europe and being on the Croatian national television more than once.

When I came back, I decided to continue the voluntary work that I was doing abroad with a Maltese NGO called Prisms which is working in various areas amongst youth. To keep updated on such opportunities one can visit our website on http://www.prismsmalta.com, find us on facebook by searching for Prisms Malta or send us an email on prisms.malta@gmail.com and we would be very keen to answer any question that you might have. We will surely help you find the right opportunity for you and you will surely not be disappointed.

As I already stated, people say that EVS changes their lives but unless you try and experience it, you will never know, why people say so. So do take the advice and just do it. You will not be disappointed for sure.

continued from page 7
SOCKS for DIABETICS

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Reference:
Vitals Global Healthcare to finance nursing degree at MCAST

The degree will be offered by MCAST in collaboration with Northumbria University

In a statement, VGH said that the degree will meet all of the requirements of the EU Directive for General Nursing, the Malta Council for Nurses and Midwives’ Scope of Professional Practice and the Malta Council for Nurses and Midwives’ Code of Ethics.

"Northumbria’s nursing programmes are widely considered to be the best in the United Kingdom and are the first in the country to be accredited by the Royal College of Nursing, in addition to being approved by the UK Nursing and Midwifery Council," read the statement.

According to the hospital operator, the programme will initially take in 30 new students per year, with students receiving three years of full-time education and training that will lead to a Bachelor’s Degree in Nursing Studies at 180 credits. Moreover, VGH said that in the first year, the programme will be taught on MCAST facilities, until works on a nurse skilling facility at St Luke’s are completed.

VGH CEO, Armin Ernst, speaking at the signing, said that the shortage in the nursing sector presents one of the biggest challenges in healthcare across the world. "By setting up a world class degree, we will attract more nursing students to the profession, working to tackle this shortage directly," he said, adding that "it is as known fact that healthcare students often develop an emotional bond with the hospitals where they receive the clinical part of their education, which makes us confident that a significant number of these students will chose to stay on and work at hospitals across Malta and Gozo, once they complete their education.

Furthermore, Ernst said that foreigners applying for these courses will also be trained in the Maltese language in order to minimise any possible language barriers.

"Education and high level training of staff are important to our organisation, as we continue to strive towards improving patient care and upping standards across the board. We envisage that this €2m will further contribute towards making Malta a leader in Healthcare services," he concluded.
Regulations for the Chambray Mental Hospital - Gozo

“For this vision Minister Salvatore Borg Olivier should be kept remembered in the psychiatric section both in Malta and Gozo in particular”

The New Mental Health Act 2012 replaced the antiquated 1976 legislation which was based on the 1959 British Mental Health Act.

This new law significantly impact individuals with mental health problems in a variety of positive ways, above all else, by eliminating the extant stigma against mental health problems, an outlook that is entrenched in the mentality of many individuals.

With this legislation, involuntary treatment (forced upon patients with serious conditions for their own benefit and safety and for those around them) be able to take place in the community. Patients are therefore able to receive treatment at home if they meet the criteria stipulated within the Mental Health Act 2012.

The Mental Health Act 2012 includes a Commissioner to safeguard those rights, introduces specific sections on the mental capacity, minors, special treatment, restrictive care and clinical trials and other medical or scientific research. It also introduces the concept of Community Treatment and Social Inclusion.

It is interesting to note that prior the 1976 legislation, which was, in turn, was based on the 1959 British Mental Health Act there was a set of 92 Rules for the Chambray Mental Hospital approved by Salvatore Borg Olivier, Minister for Public Health, on 7th September 1933 – Office of the Charitable Institutions.

It is interesting to note that from 1933 to 1983 Fort Chambray was used as the Gozitan Mental Hospital. Then it was transferred to the place where there is today the University of Malta – Gozo Centre and later in 1994 as a unit within the Gozo General Hospital.

I ask those concerned to honour this Minister for approving these 92 Rules in 1933, that is, 84 years ago. Minister Borg Olivier had a vision of how the mental patients should be treated in those years.

For this vision Minister Salvatore Borg Olivier should be kept remembered in the psychiatric section both in Malta and Gozo in particular.

Regulations for the Chambray Mental Hospital, Gozo

1. The Hospital is intended to accommodate persons of either sex who are affected with mental disease and whose transfer from the Hospital for Mental Diseases, Malta, has been sanctioned in accordance with rule 2.

Admissions

2. Transfers from the Hospital for Mental Diseases, Malta, shall be recommended by the Medical Board of that Institution and authorized by the Comptroller of Charitable Institutions.

3. Urgent cases from the island of Gozo who for unavoidable circumstances cannot be transferred immediately to Malta, may be provisionally admitted to the hospital, provided they are duly certified according to existing practice and accompanied by a statement signed by the remitting officers stating reason why such transfers could not take place in the ordinary way. Such cases must, however, be transferred to the Hospital for Mental Diseases, Malta, without delay at the earliest opportunity.

Discharges

4. No patient may be discharged from the Hospital without the sanction of the Medical Board of the Hospital for Mental Diseases, Malta. If a discharge is contemplated the patient must first be transferred back to the Hospital for Mental Diseases, Malta.

 Transfers

5. Patients may be transferred back to the Hospital for Mental Diseases, Malta, on the recommendation of the Visiting Physician, duly authorised by the Comptroller of Charitable Institutions.
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If breastfeeding is not possible formula is recommended. At SMA we strive to continually improve the quality of our formula. Over the past 90 years, SMA Nutrition has invested in early life nutrition research. As a result, SMA PRO is born. Inspired by the specific nutritional needs of babies, SMA PRO represents some of our most advanced formulas yet.

SMA PRO Follow On Milk specifically meets the nutritional needs of babies aged between 6 to 12 months. It is used as part of a weaning diet and contains important nutrients such as iron, vitamin D, calcium, omega 3 & 6 which are very important in the development of infants.

ESPGAN 2014 recommends that all infants from the age of 6 months should receive iron rich foods or iron-fortified foods. The amount of protein has been reduced to 1.30g/100ml to reduce risk of excessive intake.

SMA PRO Follow On Milk is available in 400g and 800g tins. SMA PRO Progress Kids is used as part of a healthy balanced diet in toddlers aged 1 to 3 years. It has been designed to complement the toddlers diet, providing important nutrients shown to be at risk in toddler diets.

The amount of protein has been reduced to 1.5g / 100ml and the amount of Vitamin D increased. It is important to remember that any toddler milk should not replace a meal and be part of a balanced diet. No more than 3 servings daily should be given to toddlers.

IMPORTANT NOTICE: Breast milk is best for babies and breastfeeding should continue for as long as possible. 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. A caregiver 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 formulae and on all matters of infant feeding. Social and financial implications should be considered when selecting a method of infant feeding. Infant formulae should always be prepared and used as directed. Inappropriate foods or feeding methods, or improper use of infant formula, may present a health hazard.

Information for Medical Professionals Only.
Breast is Best for Babies.

References
8. SMA PRO Follow-on Milk datacard.
FOR HEALTHCARE PROFESSIONALS ONLY
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European Food Safety Authority 2014

"The breast milk content of amino acids as the best estimate of amino acid requirements for this age group" 
WHO/FAO/UNU 2017

"Of the essential amino acids, branched chain aminoacids have been shown, when supplied in excess, to be more associated with increased release of insulin. This may trigger a cascade of reactions in the body which may result in faster growth" 
European Childhood Obesity Trial Study Group 2015*

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President of European Midwives Association and MUMN President at Verdala Palace during the first meeting in Malta on Maternal health and refugee organised by the Women in Parliament Global Forum

MUMN Administration addressed the guests attending the Christmas annual gathering

President of European Midwives Association and MUMN President at Verdala Palace during the first meeting in Malta on Maternal health and refugee organised by the Women in Parliament Global Forum

MUMN new monument being set up at San Anton Garden and a copy of the main panel of the monument being set up at MUMN premises in Mosta

FORUM organised a press conference on the issue related to the ‘Right to Disconnect’

Maltese Nurses & Midwives participating at the Commonwealth Conference in Cyprus

The Physiotherapy Group Committee was awarded the Paul Bezzina Shield as being the most efficient Group Committee who went that extra mile in 2016
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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, suprapubic catheters, tracheostomy and nasal cannula sites.

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*Up to category 2
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Clayton Scicluna

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The Monthly Investment Plan ("MIP") provides you with an excellent way to start planning for your future. By allocating a small amount of your salary every month, you can easily start an MIP. Whether you are a post-graduate about to embark on your career and looking for a way to start investing, or you have been earning a regular salary for a while and wish to discipline yourself to develop a savings habit, a MIP fits your objective.

By choosing to invest a sum of money every month in an investment fund of your choice, you will minimise the downside to the markets over the years by purchasing units at different prices. This strategy of price averaging does not try to time markets. Instead it reduces the risk of investing a large amount, at an unfavourable time, by spreading your investments over a period of months, years or even decades. BOV Asset Management with approximately €847 million in funds under management as at the end of December 2016, provides you with the flexibility to increase or decrease to a minimum of €50 (or US$50 or £30), suspend or cancel your monthly contribution as your financial circumstances may necessitate from time to time. Investing through a MIP also offers an element of flexibility since most investment funds are not closed-ended and have no maturity date, trade daily and are accessible within a short time frame. You can also keep your plan for as long as you wish. Whilst you should aim to save for the long-term, you can withdraw money within a short period of time.

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Horatio

Celebrating Psychiatric Mental Health Nursing... in Malta!

The 4th Horatio Festival of Psychiatric Nursing: ‘Working in Partnership’ will be taking place in Malta, at the Dolmen Hotel from Thursday 11th till Friday 14th May 2017. This is the third time that this event will be held in Malta and it represents praise for the Maltese Association of Psychiatric Nurses (MAPN) who have been the co-hosts and organisers on all of the occasions the festival was held in Malta in 2008 and 2014. The festival will have the same blend of scientific and practice development presentations, workshops and symposium from around the world, some very high profile keynote speakers from the field of mental health, plus a full array of cultural and fun activities including a music night with Gianni’s Band, a gala party and many local artists presenting their work for display and purchase.

This year the event is slightly different in terms of its theme. Horatio: European Psychiatric Nurses, under the leadership of its President, Martin Ward, has been working with the other major mental health staff groups in Europe, facilitated by the WHO, to develop common strategies and research objectives for the recruitment, training and support of mental health practitioners from all these disciplines. Psychology, psychiatry, social work, occupational therapy and physical therapists have linked with nursing for the very first time to produce a European consensus document that will be launched by the WHO at the festival. This, in conjunction with the initial research these groups have undertaken, will form the nucleus of the scientific programme, with the presidents of all the professional groups being the keynote speakers. Added to these will be representatives from the local mental health providers, including family therapy and carers of individuals with mental health problems.

This is the first time the event has been open to such a wide selection of different practitioners, though essentially it remains a nursing event. However, such a shift in emphasis represents the true nature of mental health care, where no one discipline can be said to offer everything a patient needs, but nursing tends to be the main coordinator of the different approaches. Many of the keynote speakers will be saying things that nurses have heard before, about multi-disciplinary working, collaboration with patients etc etc. However, they will also be challenging nurses to look at their own practices and establish a clearer focus for the way they contribute to multi-professional work practices, and in particular team work leadership. Nurses may not like everything that they hear, but that is not a bad thing as long as they don’t become overly defensive and reject suggestions that ultimately might help to improve their practice. To that aim, the Round Table discussion with the European heads of professional organisations due to take place in the form of a live audience on the Saturday 13th May, is likely to provide some lively debate and may provoke some interesting and probing questions from the audience itself. The panel probably needs to brace itself!

This year will also see the first Horatio Fellowship offered for outstanding services to psychiatric and mental health nursing. The first recipient, Mr. Des Kavanagh, was the first and long standing President of the European group, whilst also being one of its founding fathers. He was until recently the head of the Irish Psychiatric Nursing Association, an organisation he has successfully led for many years and in a country which rightly sees him as the leading champion of psychiatric nursing education and practice. The Fellowship Award will be considered each year by the Horatio Board, and may not be offered at times. However, it seems very fitting that in the year Des Kavanagh retires from over 40 years ‘active duty’ in different psychiatric nursing capacities, one of his protégés should honour him in this way.

Finally, both Horatio and MAPN will be working at the event to ensure that psychiatric and mental health nursing, no matter where it is being practiced, which country it is being delivered in, the professional background of its practitioners and the different skills they bring to the mental health care table, are fully recognised by everyone from colleagues, professional allies and politicians alike. This event is about celebrating the work of those nurses, whether they are in the community, a specialist centre, in hospitals, clinics or as individual practitioners. It is their work that fundamentally underpins the care offered to individuals with mental health challenges and as such they need the recognition and support necessary to do so. Because they are important, because they very often are there for people when no one else is and because what they do is special. Psychiatric and mental health nursing needs to acknowledge its achievements and seek new goals.

For further information about the Festival including programme and registration visit www.map-n.net or e-mail horatiomalta2017@gmail.com.

On behalf of the Boards of Horatio and MAPN we look forward to welcoming you at the Festival.

Pierre Galea
President - MAPN
The following fees are for Maltese delegate ONLY and cannot be used by another country delegate. Festival fees include registration (either full or part), all festival materials, lunch on 11th/12th/13th May, plus refreshments on all 4 days. It does not include travel, accommodation.

Please tick where appropriate:

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Daily rates - MAPN members

- Thurs 11th only: 60, 60, 65, 70
- Fri 12th only: 50, 60, 65, 70
- Sat 13th only: 60, 60, 65, 70
- Sun 14th only: 30, 30, 30, 35

Daily rates - non members

- Thurs 11th only: 65, 65, 70, 75
- Fri 12th only: 65, 65, 70, 75
- Sat 13th only: 35, 35, 35, 40
- Sun 14th only: 35, 35, 35, 40

Festival Party (13th)

- 55, 55, 55, 55

Music night (12th)

- Free, Free, Free, Free

All payments should be done in Euros. Cancellations received one full month before the Festival will be refunded minus a 25% administration fee. Regrettably, no refunds can be processed after this date. Programme may be subject to change.
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Royal College of Physicians, Regent’s Park, London, UK
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Call for Abstracts

Our world today is far from being safe, healthy or peaceful. Many countries are experiencing war or civil conflict; there are more refugees than ever before seeking a safe place to live for themselves and their families; bush fires, floods, earthquakes and tsunamis are a frequent occurrence; diseases such as Ebola and Zika threaten health and stability; climate change threatens entire populations.

Nurses and midwives are in a unique position to lead the way in promoting a safe, healthy and peaceful world through their work with individuals in health and education; with vulnerable groups; with young people; in disaster areas and in conflict zones; with refugees; by being an activist; and by influencing governments and their policies.

Your abstract should demonstrate, through your work, your projects, or your research, how you, as a nurse or midwife, are leading the way and contributing to a safe, healthy and peaceful world.

ABSTRACT SUBMISSION
Submit your abstract of no more than 300 words to the Commonwealth Nurses and Midwives Federation by 30 June 2017. No late abstract submissions will be accepted.

Abstract submissions must be made using the abstract template which can be downloaded from the CNMF website: http://www.commonwealthnurses.org/conference2018

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* studies available on request
How to spot a nurse at the bar

BY SCRUBS EDITOR, 2nd February, 2017

Nursing is our profession, but it leaks into other aspects of our life as well. Here's how you can spot a nurse at a bar, a restaurant, a backyard barbecue, or anywhere else where people are kicking back and enjoying a drink.

THEY ORDER RED WINE

It's no secret that too much alcohol is anything but good for you, but if you're going to drink moderately from time to time, red wine is a great choice. Nurses are pretty health-conscious people, so at the bar, you might notice them ordering a nice Cabernet Sauvignon or Merlot. Although the health benefits of red wine are probably overstated by pop science journalism looking for clicks and pageviews, it is true that red wine may actually have a few modest health benefits. Some of these include:

- **Neuroprotective effects from resveratrol.** Resveratrol is an antioxidant that may have neuroprotective effects that could help stave off Alzheimer's disease and memory loss.
- **Promotes longevity.** While the cause isn't completely clear, research has indicated that red wine drinkers seem to have a thirty four percent lower mortality rate when compared to people who drink beer or vodka in similar quantities.
- **It's heart healthy.** Red wine gets its dark color and bitter, aromatic astringe notes from tannins. The tannins in red wine contain procyanidins, which may help protect against heart disease.

THEY DRINK PRETTY MODERATELY

The relationship between alcohol consumption and health is a rather delicate dance. It's no secret that alcohol abuse is incredibly harmful — according to the World Health Organization, it caused 3.3 million deaths worldwide in 2014. Chronic alcohol abuse comes with a host of health issues that can dramatically shorten a person's lifespan, including Wernicke-Korsakoff Syndrome, malnutrition, alcoholic fatty liver disease, chronic pancreatitis, and a higher risk of cancer.

And yet, in low and responsible quantities, alcohol may have some positive long-term health effects, including better cardiovascular health. When you run into a nurse at the bar, there's a good chance they'll be drinking pretty moderately, in keeping with the CDC's alcohol consumption guidelines.

THEY'RE PROBABLY NOT ORDERING SUGARY DRINKS

Chances are, the nurse will take a gin and tonic or a rum and diet coke over a sugary cosmo or margarita. Those girly drinks like appletinis and daiquiris have a ton of sugar in them, which isn't great for your health. The World Health Organization recommends a surprisingly modest sugar intake for healthy adults, around six teaspoons or 25 grams.

YOU CATCH THEM USING HAND SANITIZER FROM THEIR PURSE OR POCKET

You might catch a nurse at the bar sneaking a squirt of hand sanitizer from a pocket-size bottle in their pocket or purse. If the bar bathroom has bar soap instead of dispensers, you can bet that they'll be reaching for the hand sanitizer instead. Believe it or not, bar soap can be a haven for bacterial pathogens. The CDC actually recommends dispensers over bar soap in public or shared bathrooms, and a 2006 study found that soap could potentially become a source of continued reinfection in dental clinics.

THEY'RE STILL WEARING THEIR SCRUBS

If a nurse just got off of a shift, they may still be wearing their scrubs. Let's get real: scrubs, and especially scrub pants, are ridiculously comfortable. It's a secret that only healthcare professionals know.

THEY MIGHT HAVE A TEXTBOOK WITH THEM

If they're working on a master's or PhD., a nurse at the bar might be quietly reading a textbook while they're sipping their wine or beer.

THEY ALWAYS COME PREPARED

If someone manages to get a minor injury like a cut or a bruise, it will probably be a nurse who happens to have a small first aid kit in their pocket or purse. You can also observe nurses, as well as doctors, EMTs, and other medical professionals, springing into action if something more serious happens in a public place. If someone's having a seizure or going into labour, you can bet that the nurse knows what's up.

THEY'RE A GREAT LISTENER

One thing about nurses is that we work with people constantly, and because of that, we learn pretty quickly how to become good listeners. Active listening and "reading between the lines" can be essential to gleaning more details about a patient's condition and status, and part of the therapeutic relationship is providing support for patients going through tough times. When you strike up a conversation with a nurse at the bar, you know they'll listen closely and provide a lot of sympathy and support.

SPOTTING A NURSE AT THE BAR

As nurses, we often recognize our own. These are just a few of the many ways that nurses can spot our fellow nurses out in the world, whether it's at the bar, at a party, or anywhere else.
In the general population, prevalence of incontinence is difficult to measure. However, it is estimated that 30 to 50% of elderly persons suffer from incontinence, and that one out of every 3 women aged over 18 years, experiences urinary incontinence. The emotional impact of incontinence may be devastating to both the person suffering and his/her relatives or carers.

Currently, although there is considerable awareness about incontinence, there still remains a great stigma and the psychological and emotional impact of incontinence, still causes a great negative effect on the lives of many persons. It is perceived as loss of control and can cause a feeling of shame, social isolation and depression in the person experiencing it.

Initially, some persons tend to refuse to admit the problem and go to extremes to conceal incontinence events, such as hiding soiled clothes. Embarrassment and frustration may also result, since there is the perception of losing personal privacy and becoming dependant on other persons for basic daily needs. Most incontinent persons have a constant fear of having foul odours or leakages showing on their clothes. This affects their self-confidence, since it triggers a sense of helplessness and insecurity. In an elderly person, incontinence may be the main reason for admission into a nursing home, since it is perceived to be a source of embarrassment and shame.

The main concern of such persons is attending activities in unfamiliar places where the availability and location of toilets is not yet known. In order to preserve their dignity, they tend to withdraw from social and physical events which they previously enjoyed, such as attending to church activities or cinema or sport events, with the aim of avoiding chances of such accidental situations in public. Others might stop going for walks, just for fear of being far from the toilet. The problem might also involve a person’s daily occupation for this same reason or for the fact that s/he may have to attend long periods of time in public attention. Sleep deprivation due to nocturia, might further aggravate the problem, and often leads to exhaustion and depression. Research shows that the amount of emotional distress experienced by a person is neither associated to the volume of incontinence, nor to the person’s age or length of time suffering from the condition, nor is it related to its cause. Often, healthcare professionals do not have the necessary knowledge and capability to carry-out a continence assessment and manage the situation effectively.
Healthcare policies promote the organisation of standard, integrated continence services which focus on the identification and assessment and appropriate care management of such patients. A continence assessment should be done and management of incontinence should be according to its outcome. Besides individual diagnosis of the cause of incontinence, practitioners are advised to involve their patients in the treatment and care, and should consider individual requirements and preferences. Incontinent persons should be enabled to make informed decisions about their own care. Periodical reassessment ensures that the needs of such persons are being met in the best way possible. This is very important because the continence needs of a person may change. In some cases the underlying cause may be diagnosed and treated and continence may be improved or even restored. Similar situations occur in cases of recovery from illness such as heart attack, or flare-ups of arthritis or trauma involving bone fractures, where there is reduced mobility and bed bound situations for a limited amount of time. It is also important when the medical condition worsens and the patient’s continence requirements increase.

Very often, incontinence is considered to be an aging problem which has to be accepted. Such attitudes lead to reactive care, as if the replacement of soiled clothes or diapers with clean ones is the only solution. Nurses are also encouraged to increase their knowledge in continence care, in order to be able to provide proactive care. Health-care organisations that focus on cost-cutting rather than exploring innovations in this area, create a barrier to the provision of optimum continence care. In England, due to the effect on the quality of life and the impact on the National Health Service resources, incontinence is a national healthcare issue, and nurses are expected to consider continence care as a fundamental aspect in nursing care.

Within the competing nursing demands, continence is often not considered as a high priority issue, and its emotional impact is frequently overlooked. Patient-centered care demands that practitioners should give more importance to the impact of incontinence on the well-being of a person in his/her daily activities. In the elderly, effective care and management may prevent early admission to long-term care facilities.

Policies and guidelines for Continence management strongly recommend the preservation of dignity and independence of such persons. Procurement of products used for continence should be according to the greatest value for meeting individual needs. Care teams working directly with such persons should be fully aware and understand the physical and emotional impact of incontinence in order to be able to give the right support and provide the best coping strategies.

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

References


The hospitals that won’t trap you in a bed when you’re fit to leave

Lilian Hemsley, 86, was admitted to Queen’s Medical Centre on the outskirts of Nottingham on 30 December following a fall. Seven days later she was able to return home to Chilwell, south Nottinghamshire with a package of help in place. “The social workers were fantastic,” she says. “I had to have my bed moved downstairs and a commode – I wasn’t allowed home until they were sorted out. But they did it really quickly.” Following some interim homecare, Hemsley is getting help washing and dressing in the morning for four weeks through Nottinghamshire county council’s reablement service. She will soon be assessed for ongoing care needs.

But as last week’s figures from NHS England show, Hemsley was one of the lucky ones. All too often patients are stuck in hospital waiting for a social care package, even though they are fit to go home, including 89-year-old Iris Sibley, whose six months in Bristol Royal infirmary was widely reported. In December alone, across England, the number of patients who were officially recorded as stuck in hospital when they could have been discharged topped 6,000, while the number of delayed transfers of care days reached 195,286.

The issue of patients being fit to leave hospital but not able to be discharged – sometimes called “bedblocking” – costs the NHS some £800m a year. It leads to hold-ups in A&E as people are prevented from having operations and moving into wards. It also has an impact on elective surgery. About 70,000 delayed discharges were caused by social care provision not being in place either in the patient’s home or in nursing homes or residential care. As delayed transfers of care are very tightly defined, the true extent of patients remaining in hospital when they are fit to leave is widely believed to be much higher.

According to research by the Nuffield Trust, the number of patients delayed because they were waiting for a care package to be available at home or in a nursing home had risen 172% and 110% respectively since November 2010. But Nottinghamshire is bucking the trend. Whereas in December, English councils were on average each responsible for 456 days’ delayed transfer of care, Nottinghamshire county council was responsible for just 65 days’ delay – none of them at Nottingham University hospitals trust, which runs QMC and the city hospital.

NUH is one of the biggest hospital trusts in the country, with 90 wards and 1,700 acute beds.

On Friday, when I visit, it has 1,380 adult inpatients; 890 are aged over 65 and 111 are over 90. Each month, there are around 350 patients who need some form of social care on discharge.

Last year, Nottinghamshire county council introduced a “cluster” model that allocates 18 social workers to specific clusters of wards. They are the named care coordinators for those wards. From the moment a patient is admitted, the social workers are responsible for establishing potential care needs after discharge and sorting them out as quickly as possible.

“We have a nobody waits approach,” says Nicola Peace, a group manager at Nottinghamshire county council who is in charge of the social workers at both hospitals. That approach starts the moment a patient arrives in A&E. Like many hospitals, QMC is not meeting the target that 95% of patients should be seen within four hours in hospital A&E departments in England.

On Friday, 72.3% were seen within the four-hour window.

On a quiet day like Friday there were just three patients on a trolley waiting to go into one of the 20 dedicated bays where the most unwell patients are treated. Often this emergency assessment area is crammed to the rafters, says Dr Mark Simmonds, a critical care and acute medicine consultant at the hospital. “At one point over the new year, we had 180 patients in the emergency department,” he adds.

It is the community care officer Nicola Todd’s job to help ease the pressure on the emergency department. “Sometimes patients’ conditions could be dealt with in the community if they had a bit of social care,” she says. Todd spends
most of her days on the phone organising urgent care packages for people who come through the emergency department's doors but who don't need to be admitted. Todd's job is so demanding, the county council is paying for more temporary workers to help her do this triage.

QMC's 45 wards are also under a lot of strain. On Friday, it had 93% occupancy, well above the 85% target. Over the winter it has opened 61 extra "escalation" beds and spent £139,000 running and staffing them in January alone.

The social workers liaise closely with doctors, nurses, occupational therapists, physiotherapists and dieticians to ensure discharge is not delayed. They attend daily "board round" meetings where patients' medical progress and potential delays to discharge are discussed. And crucially, they assess patients' social care requirements well before they are medically fit to go home.

Peace says one of the best ways to prevent delayed discharge is to have a dedicated interim homecare service, which can provide services at very short notice, while a longer-term care package is organised.

On the dementia ward, Barry Jones, 83, is having the first assessment of his care needs. He has had a fall and may have heart problems and dementia. Denise Monaghan, a care coordinator based on the dementia ward, is here to do the assessment and to ensure social care doesn't hold up his discharge when he is ready to return home. Monaghan explains to him that he will need more care and may not be able to go out as much as before. "My job is to make sure you will be safe and looked after at home," she says. Monaghan checks that Jones wants to be at home and not in residential care. "I want to go home," he says. Afterwards, Monaghan tells me he will need help getting dressed and ready for bed, and someone to help him with meals. An interim care package can be in place within 24 hours.

The case for reducing delays is overwhelming: on Friday there are 220 patients at QMC and the city hospital who are medically safe to go home, of whom 83 have already been logged as delayed transfers of care — most of them taking up beds because of bottlenecks within the hospital. These are not atypical numbers. A homecare package costs £50 a day compared with the cost of a hospital bed of about £300. In Nottinghamshire, £818,000 of the health budget in 2016-17 has been redirected into the interim homecare service. This is in addition to £7.68m locally from the government's Better Care Fund, which is designed to better integrate health and social care.

NUH could save £24.5m a year by cutting all its delays, as well as easing the pressure on the hospital. It has also invested heavily in a state-of-the-art IT system at both hospitals that records and monitors patients in real time. "Before, we used to walk around with pieces of paper and clipboards," says Simmonds. "Now we no longer need observation charts at the end of patients' beds. It connects everyone with the same information that's totally up to date. And crucially it shows us where any delays are occurring."

The system shows who is in A&E, how long they have been waiting, whether they are going to be admitted — and if so, to which ward. It shows where beds are available and possible pinch points. It is accurate to the minute and also flags up which patients could need social care before they can be discharged and what prescriptions they will need. Launched 18 months ago, this system, from the software company Nervecentre, has seen 6,500 mobile devices issued to all healthcare assistants, nurses, doctors, physiotherapists, occupational therapists and dieticians. They input patients' medical details, any diagnostic tests or procedures that are necessary and provisional estimated discharge dates. Some social workers also have access to the system.

It is early days and Nottinghamshire has some way to go before it could be classed as the area with the fewest delayed transfers of care for social care. Latest NHS England figures from December show that Darlington reported none, Newcastle six and Rutland 10.

A spokeswoman for NHS England says: "Any increase in delays in being able to discharge patients as a result of pressures in social care affects the ability of hospitals to quickly admit emergency A&E patients, so the NHS is working closely with local councils and community health services to enable older patients to get the support they need after a hospital stay, back at home."

Paul McKay, service director at Nottinghamshire county council, says: "The hospital discharge homecare service is a good investment as people can leave hospital sooner, and is also meeting the wishes of most older people who tell us they would prefer to live at home independently rather than in a care home setting."

Liz Sergeant, part of the Emergency Care Improvement Programme (ECIP) at NHS Improve, says: "Our Emergency Care Improvement Programme teams are helping trusts to create teams within A&E and assessment units to allow patients to be treated at home when there is no clinical need for admission, or where the clinical needs can be met by services provided in the community." Back in Chilwell, Hemsley is starting to feel much better. "I had my hair cut yesterday and tomorrow I'm going to church for the first time since before Christmas," she says. "I'm really looking forward to that."
Il-Bedbaths

L-Ewwel Parti - JOE CAMILLERI, Charge Nurse MW1 - MDH

Ma rridux ninsewxd dawk il-korsija (sodod fin-nofs tal-kurituri) bil-laqmijiet taghhom; bhal-korsija sluice, korsija 6-bedded u sahansitra korsija Madonnal. Kien zmien iehor, fejn anke niftakar xi swali tal-irgien bin-nurses jahsla bla ingwanti, bis-sigaretta go halqhom, minghajar fardal u addio hasl tal-idejn.


Il-bedbaths kienu wkoll opportunità li nissoċjalizzaw, nidħaku xi daqqa, insira nafu sew il-pazjent, nqgħallmu ill-Istitudent u anke ndewww xi ferita tas-sodda (li ġak iz-zmien konna nseħjula decubitus ulcer). Kien minn kolloż: pazjenti misjuba mejta wara lejli tilvil; pazjenti ma jridux jinħaslu

Nurses jittgħallimu bedbath imdawrin ma’ sodda antika tal-halhid


L-Ispitar San Luqa, gabel Inbena L-Ispitar Karen Grech
O Żmien Helu!


Wara li ġhalaqt il-61 sena ġejt mitlub nahdem part time u għadni nahdem sal-lum. Illum il-jurnata qibżi il-50 sena servizz bhala nurses. Tidher karriera twila, però meta tkun thobb ix-xoghol ma taraxh twil u nappella liż-żagħzagħ biex jaqbdu din il-karriera qaddisa li tghin lill-bagħtut meta tkun taf li ma jistax jghidilek grazzi. Inħoss li ma jiddispjapċiien xejn li kont qbat din il-professjoni li b'għaqal kbir mal-mara, rabbejtt il-familja ta' tlett iftal u grażzi għall-hanin Alla, it-tifla gqegħda f'post maniżerjali, it-tifel konsulent tal-kirurgija w t-tifel l-lehor Perit.

Fl-ahjar nixtieq nIRRiggazzja l-awtoritijiet tal-isptar Mater Dei tal-hidma siewja li jagħmli u lil ħafna nies li mhux possibli nissmellhom kollha. Inselli għallkhom kollha. Thomas Agius

References
1. https://juta.co.za/support-material/resource/291/
The Maltese Code of Ethics for Nurses & Midwives

In 1997 the Nursing and Midwifery Board, now known as the Council for Nurses and Midwives, issued the Maltese Code of Ethics for Nurses and Midwives. The aim for this publication was to provide a guide on how to regulate the nursing and midwifery professions, more specifically through self-regulation. Professional codes of ethics are essential because they establish professional standards of behaviour. This is particularly relevant for those professions who have a distinct role in society. A primary reason is that a professional code of ethics is based on the principles and values of the respective profession and strives to bring the respective professionals in line.

Nurses and midwives have multifaceted and diversified roles within their respective professions. This becomes more complex when the multiple and dynamic interpersonal relationships; moral issues; legal obligations; accountability towards organisational frameworks and allocation of resources are factored.

The significance and responsibility the code of ethics posses in underpinning the values of the profession should be respected, while also being a practical guide for professionals. Challenges may emerge in view of the breadth of the subject of ethics and its application, coupled with the individuality of each professional and the variety of scenario’s they encounter. The appropriate inclusion of ethics in practice is a skill that can be learned through increasing one’s awareness of ethical issues, followed by a deeper understanding of how to apply ethics in practice.

The first step towards this is by becoming acquainted with the professional code of ethics. The code focuses on the responsibility a nurse or midwife has towards:

i. The respective profession
ii. The patient/client
iii. Colleagues/co-workers
iv. The public and society

Professional responsibilities focus on the nurse and midwife to be persons of integrity, maintain their own professional development while also striving to promote their respective professions through various activities including research; and ensure that the appropriate working conditions are maintained to provide high quality care. Responsibilities towards the patient group includes ensuring individualised care; the provision of holistic care; to be non-discriminatory towards all patients; promote and support informed choice; maintain confidentiality; decline duties in which the nurse or midwife is not competent; and refuse any form of gift, favour or similar from patients which may lead the patient to influencing and/or obtaining preferential treatment.

With regards to their colleagues, nurses and midwives are expected to cooperate with each other as well as the multi-disciplinary team. Nurses and midwives should also take every opportunity to mentor and guide junior staff as well as students, while also being responsible for those who are under their charge. Nurses and midwives are also bound by the professional code of ethics to report any wilful malpractice and/or professional incompetence that comprises the health and safety of colleagues or the standards of good practice and care.

In terms of the public and society, nurses and midwives are expected to maintain public trust and confidence; nurses and midwives must be committed to the welfare of patients in all professional settings, including those in administration, education and during research. Nurses and midwives are expected to put the welfare of patients first when industrial action is planned and implemented. The professional code of ethics also informs nurses and midwives of their responsibility to support actions implemented to improve the health and social needs of the public. Finally, nurses and midwives are not to have their professional judgement influenced by any commercial products.

The aim of this summary is to highlight the responsibilities nurses and midwives have according to the Maltese Code of Ethics for Nurses and Midwives. The principles and values underpinned in this document are the foundation of what a professional code of ethics represents. Twenty years on it is recommended that the Council for Nurses and Midwives revise this code of ethics, taking the opportunity to consider providing a separate code of ethics for nurses and midwives. This would allow each code of ethics to address specific issues pertaining to the respective professions, and it may also focus on how the professions and related services have evolved over the last two decades. Updated versions could also seek to inform the public and the community on what they are to expect from these highly-respected professions.

The Maltese Code of Ethics for Nurses and Midwives can be accessed and downloaded on https://health.gov.mt/en/reqcoun/cmn/Pages/Publications.aspx

Fr Brian Gialanze

Fr Brian Gialanze

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In 1969 Yogi Bhajan came to the West and brought an immeasurable knowledge of Ayurveda with him. As a teacher of holistic living, he shared his wisdom and knowledge of Ayurveda and yoga with his students while serving them an aromatic spice tea blend, which they affectionately named “Yogi tea.” This unique Ayurvedic tea blend is based on an original recipe by Yogi Bhajan and contains cinnamon, cardamom, ginger, cloves, and black pepper. It was first sold in Europe in the 1970s, and from 1987 under the official brand name YOGI TEA. Today, people all around the world enjoy the special blends of more than 80 selected organically-grown herbs and spices that give the YOGI TEA varieties their unmistakable flavour and healthgiving properties.

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