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# IL-MUSBIEH

## MALTA NURSING AND MIDWIFERY JOURNAL

Malta Union of Midwives and Nurses

Numru 75 - Ġunju 2017



**20<sup>th</sup>**  
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MALTA NURSING AND MIDWIFERY JOURNAL



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## Ħarga nru. 75 Ġunju 2017

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## Happy Birthday “Il-Musbieh”

Congratulations ‘Il-Musbieh’ for its 20<sup>th</sup> Anniversary since its first publication of July 1997. This publication was an important milestone in the history of MUMN since it was the only means of communicating with the authorities and with its members. The first copy of ‘Il-Musbieh’ had an Editorial title called ‘Ser Naslu Żgur!’ ‘We will Succeed!’, and succeed we did. In the past 20 years success was quite significant considering that Nurses did not have sole recognition, were not considered as professionals, legislations regulating Nurses and Midwives were outdated since colonial days, political transfers were the rule of the day and conditions of work were non-existent.

This journal communicated effectively between all stakeholders and the message got through. All Nurses and Midwives were updated on any important trade union matter, relevant National and International Nursing and Midwifery matters, news, research, and current issues. Articles ranged from Community Health Nursing, Public Health Nursing, Critical Care Nursing,

Oncology Nursing, Midwifery, Psychiatric Nursing, Paediatric Nursing, Geriatric Nursing, Emergency Nursing, Hospice and Palliative Care Nursing, Orthopedic Nursing, Rehabilitation Nursing, Cardiovascular Nursing, Obstetric Nursing, Maternal-Child Nursing and Nephrology Nursing.

‘Il-Musbieh’ title was appropriately given to this journal as it is an international symbol of nursing, accompanying the most important ceremonies. It symbolises a lit lamp used by Florence Nightingale while caring for injured soldiers during the Crimean war. It is also the sign of the International Council of Nurses logo. The lamp will always shine brightly as a symbol of the care and devotion the nurse administers to the sick and injured in the practice of Nursing.

The first Editorial Board had Tonio Pace and Louise Cini as Editors and the subcommittee was made up of 6 members. The Beta Printers of Zejtun were the publishers of this journal and from a humble 15-pager, published twice yearly, ‘Il-Musbieh’ grew to a 35-pager with a quarterly publication. The journal is also

bilingual so that it may be read abroad, were it is posted too.

It was not the first time that the media reacted to editorials or articles written in this journal. Management, politicians and opinion leaders often referred to ‘Il-Musbieh’ especially when controversial issues cropped up.

We all know that following evidence-based practice (EBP) can lead to improved patient outcomes. But obstacles to our members doing their research, such as lack of support, time, and authority to make changes can be barriers to EBP implementation. Such a journal can help take the difficulty out of research and allow our members to read about important treatment and best practices. This journal keeps abreast with the latest and best clinical research, promoting awareness of current research findings, learning to critique and appraise research, and encourages research utilisation.

The current Editorial board congratulates past and present board members, editors, authors, readers and volunteers who prepare this journal to be sent in everyone’s home, free of charge.

# President's message

Dear colleagues, I bring greetings to you all; valued members of the Malta Union of Midwives and Nurses (MUMN) from the MUMN council. I trust that your year has been going well and will continue to do so. It is my pleasure to present the MUMN June 2016 journal 'Il-Musbieh'. Summer is here and for some of you that means a bit of a break or a holiday abroad - this could be a time where you recharge or have some quality time with your dear ones. From the union's side, I can say that even though summer will be upon us soon, we at MUMN will continue to work hard for our members. Quite frankly, I can say that the MUMN has a busy year ahead – the coming months' promises to be just as busy as the last ones. We are working hard, at times even behind the scenes to ensure that your voice is heard about important issues such as the working conditions, training and education, staffing levels, and supporting staff. On this regard, I'd like to take just a few minutes of your time to share some highlights of what's been occurring since our last edition in March.

Upon preparing for this edition, I reflected on what I wrote in the June 2015 edition. At that time, I addressed that issue with the theme of "MUMN Leading the Way". In that issue, I attested that the MUMN can offer strategies to advance the professional status of its members and health care systems. After 2 years, I can say that the theme is still very valid till this day and upon reflection I can attest that the MUMN Council worked closely with the group committee members, so that their industrial relation input is more visible at their respective workplaces. As a matter of fact, and as you were informed, new group committees were appointed. On this regard, I take the opportunity to welcome the

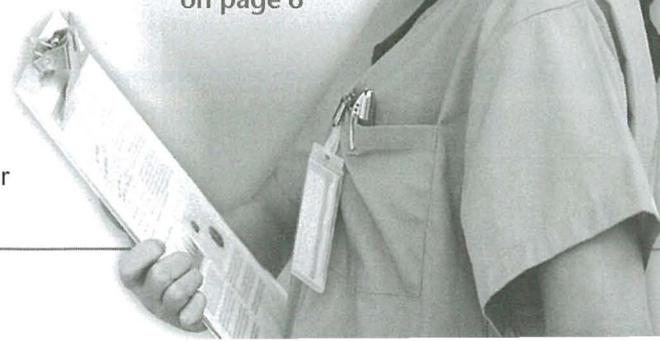
new group committee members who joined group committees, and thank others for their sterling work. Through the input of all, the MUMN is leading itself proactively rather than retrospectively, by eliminating some of the potential problems, and addressing and acting on others. On another note, as we informed you through our regular email shoots, together with the other trade unions representing employees working with the Public Service, we concluded and signed the Collective Agreement. We also reached an agreement on the payment of the Nursing Premium. As a union, we are still regularly meeting our members at ward, unit, departmental or hospital level – as the MUMN plays a great role in safeguarding its member's rights and good working conditions. The ethos of this council is to regularly meet with the members to foster clearer communication, while soliciting feedback from members to improve processes or take care of problems.

The past 3 months have been extremely busy for the MUMN Council and Group Committee members. As we informed you in our last issue, once again the MUMN successfully hosted the European Nurses Federation (EFN) General Assembly. During this assembly, all delegates present from EU countries had the opportunity to discuss the future of the EFN political agenda; mainly on: a) Directive 2013/55/EU; b) Nursing workforce and skills; and c) Patient Safety and Quality of Care. Progress is also being made towards the sectoral agreements for the ECG technicians; and Nurses and Midwives. As the saying goes 'united we stand divided we fall' – I couldn't thank you enough for the support and collaboration from your

end when we ask you to do so. In most cases we manage to reach agreements through effective negotiation skills, social dialogue and collective bargaining. But at times, dispute arises and industrial action will be backed up by your effort, support and collaboration. Once again on behalf of the MUMN Council and group committees, thanks for your continuous collaboration.

Last April, the Malta Association of Psychiatric Nurses (MAPN), launched the 'Psychiatric and Mental Health Nursing Standards'. I can say that I feel proud and honored to have been present during the launch. The establishment of these Nursing standards is a key milestone in providing sustainable leadership for patient safety and innovation. These standards are statements that identify the duties and obligations for which nurses providing mental health care are held accountable. On behalf of the MUMN council, once again I congratulate the MAPN for their endeavor to streamline nursing care; while at the same time provide the leadership and continuity to ensure good governance today and in the future. During the past months members of the MUMN also had the opportunity to present their research at local and international conferences; while others attended as delegates.

• continued  
on page 6



# mis-Segretarju Ġenerali

**G**ħall-erwieh! Ergajna lura ngħixu fil-ħajja normali wara li għaddejna minn kampanja elottorali intesiva. Kulħadd xi ftit jew wisq jintlaqat. L-ewwel ħaġa li l-MUMN għamlet kienet li talbet biex ikompli n-negozjati għal Ftehim Settorali ġdid għan-nurses u l-midwives. Se nkunu qed inzommukom aġġornati b'dak li jkun qed iseħħ u kif naraw li ma nistgħux inkompli niddiskutu madwar il-mejda, se jkollna niċċaqlqu lkoll sabiex nipperswadu l-Gvern bl-esiġenzi tagħna.

L-istess andament dwar il-Ftehim Settorali għall-ECG Technicians li konna viċin ħafna li nikkonkludu qabel l-elezzjoni ġenerali però wehilna fuq punt tekniku li issa hemm bżonn li nsibu soluzzjoni għalih biex nagħlqu.

L-abbozz tal-Ftehim Settorali tal-Physiotherapists huwa lest u għalhekk se nkunu qed nieħdu dawk il-passi kollha neċessarji sabiex inressquh quddiem il-Gvern biex nibdew ninnegozjawh.

Punt ieħor importanti huwa l-fatt li din il-Union se tkompli tiddiskuti mal-awtoritajiet konċernati sabiex ittejjeb il-kundizzjonijiet tax-xogħol tas-Social Workers. Huwa essenzjali li dawn il-professjonisti jaħdmu f'kundizzjonijiet xierqa sabiex ikunu f'pożizzjoni li jkomplu

jagħtu servizz mill-aqwa lill-klijenti tagħhom.

Il-ħarġa ta' dan il-ġurnal 'Il-Musbieħ' jimmarka l-20 sena mill-ewwel pubblikazzjoni tiegħu. Għadni niftakar il-preparamenti sabiex ħarġet l-ewwel ħarġa. Minn dakinhar ma ħarisniex lura u bqajna nippubblikawh kull tlett xhur sa llum. Meta tħares lejn l-ewwel ħarġa u tqabbilha ma' dik ta' llum tara kif it-teknoloġija inbidlet imma mhux biss. Matul dawn is-snin l-MUMN kompliet tikber, tevolvi u tissaħħaħ għall-union li għandna llum. Minn hawn nixtieq nieħu l-opportunità biex niringrazzja minn qalbi lil dawk kollha li kienu involuti f'dan l-iżvilupp tal-ġurnal. Mhux se noqgħod insemmi ismijiet għaliex żgur li nħalli lil xi ħadd barra.

Beda proċess biex jiġu fformati, fejn hemm il-htieġa, Group Committees godda. Ġie fformat wieħed ġdid u b'saħħtu ġewwa l-isptar Mater Dei u qegħdin fil-proċess li jkollna ieħor ġdid ġewwa l-isptar Monte Carmeli. Qed ninnota li hemm entuzjażmu kbir fost in-nurses biex ikunu involuti fl-istrutturi tal-MUMN u dan jawgura tajjeb ħafna.

Nixtieq nieħu din l-opportunità biex inwaslilkom it-tħassib tiegħi dwar l-użu tal-facebook u mezzi oħra tas-social media. Qed jaslulna rapport li hemm numru konsiderevoli mill-membri tagħna

li jpoġġu ritratti u materjal ieħor li jkollu konness mal-post tax-xogħol fejn naħdmu. M'aħniex awtorizzati li nagħmlu dawn l-affarijiet. Anki fil-kummenti tagħna rridu noqgħodu attenti u dan mhux bilfors li jkun relatat max-xogħol. Rajt kliem dispreġġattiv fuq il-football għaliex wieħed iżomm ma' team u mhux ma' ieħor. Dawn l-affarijiet ma jirriflettux sabiħ kemm fuq dak li jkun b'mod personali kif ukoll fuq il-professjoni ingenerali. Oqgħodu attenti ħbieb x'tiktbu u x'tgħidu. Toffendu lil ħadd u nkunu raġonevoli fil-kummenti tagħna għaliex nistgħu anki nkunu sugġett għal proċeduri dixxiplinari.

Kif stajtu taraw din is-sena wkoll l-MUMN reggħet imbarakat fuq kampanja ta' reklamar biex inħajru żaġħżagħ jagħzlu l-professjoni tan-nursing. Għalkemm din id-darba nzerajt f'nofs kampanja elettorali xorta kellha impatt pożittiv. Aktar tard din is-sena se nintensifikaw il-ħidma tagħna fl-iskejjel biex inwasslu il-professjoni fost it-tfal u t-teenagers. Dan huwa fattur relevanti li żgur iħalli l-frott.

Għal-lum se nieqaf hawn. Nawgura lilek u lil dawk qrib tiegħek li tgawdi s-sajf mill-aħjar li tista'.

Tislijiet,

**Colin Galea  
Segretarju Ġenerali**

## President's message • continued from page 5

We can all agree that in some way or another these events maximize our learning opportunities. On another note; I believe that members of the MUMN need to be more active in pursuing creative educational opportunities, facilitating change in health care delivery through various channels, achieving equal participation in all areas of clinical practice, exploring fundamental and current professional issues, mentoring new health care professionals to bridge the gap between education/theory and practice, and participating in a professional organization directed toward these goals.

To accomplish these ambitious goals, the MUMN in one way or another, continuously support all its members. On this regard, recently the role of

the MUMN educational executive committee was transformed and now the MUMN has its own Institute. The newly launched 'Learning Institute for Health Care Professionals'; has exciting opportunities.

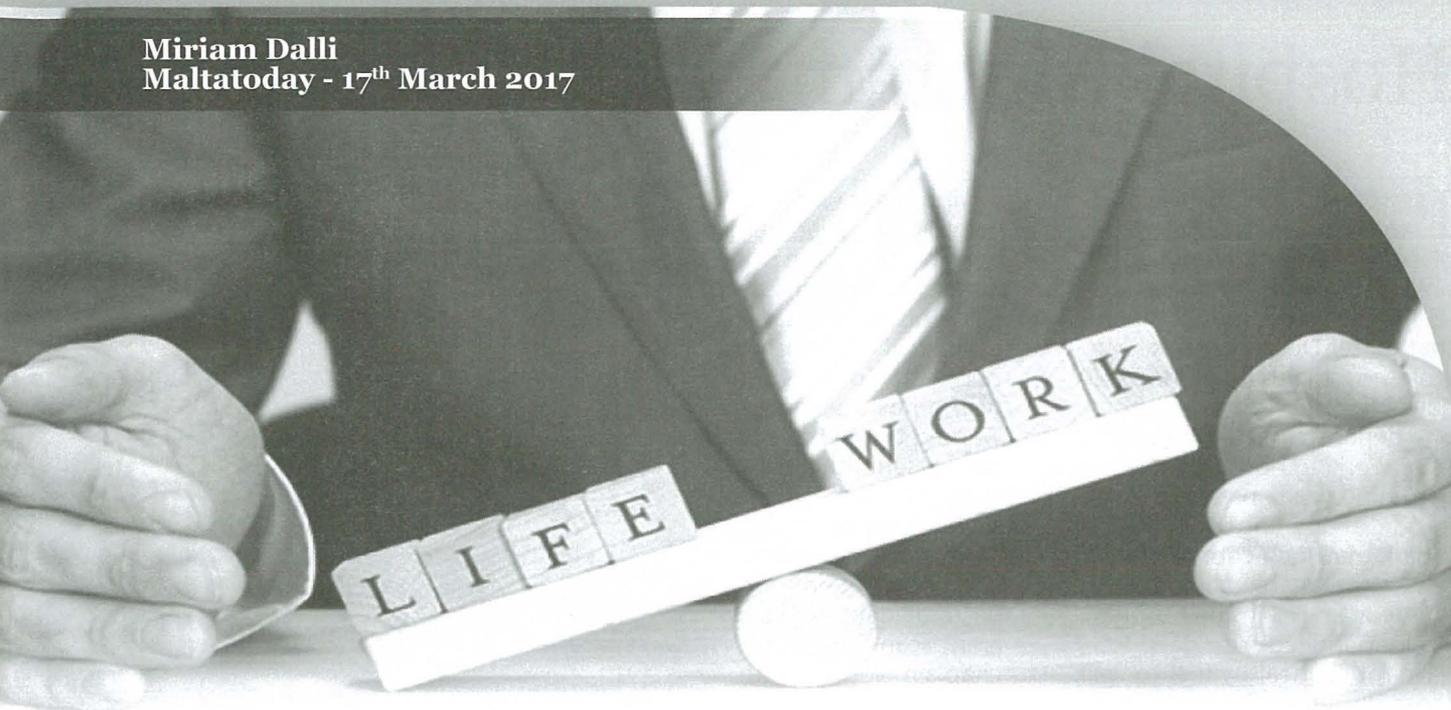
The Institute is offering monthly continuous professional development sessions, while at the same time offering continuous training in various areas. It is also working to formally accredit these continuous professional development courses. Further information on this regard will be given soon.

I look forward to continuing to work with you over the coming months. Till we met again, I wish you all a fun-filled summer! Stay safe and enjoy!

Best regards,

**Maria Cutajar  
MUMN President**

Miriam Dalli  
Maltatoday - 17<sup>th</sup> March 2017



## Unions want right to disconnect, as survey shows 97% take work beyond normal hours

*For.U.M. to seek stakeholders' support in pushing for legislation that protects the right of employees to disconnect: not work after hours*

The confederation of Maltese unions, For.U.M., will be pushing for government to legislate in favour of workers' right to disconnect.

In essence, the law would protect a worker's decision not to review emails, messages or take work-related calls outside work hours, while on vacation leave or during sick leave.

Such a law has already been enacted in France, with companies employing more than 50 workers are required by law to set up hours – usually during evenings and on weekends – when staff are not to send or respond to emails.

Some European companies have introduced restrictions on use of email outside of business hours.

Automaker Volkswagen prevents its email servers from delivering messages to employees in Germany when they are off-shift or on vacation. Others, including automakers

Daimler and BMW, insurance giant Allianz-France, telecoms firm Orange and IT giant Atos also have restrictions on employees' use of email.

A survey carried out by For.U.M. among 527 members found that 97% of respondents work after hours; 95% said they checked their emails during weekends whilst 82% admitted to checking their emails during family times such as during dinner or on vacation.

For.U.M. vice president Chris Attard and youth section chairperson Graham Sansone said the introduction of such a right will help workers and families reach a far better work-life balance, whilst employers could see the benefits in a less stressed workforce.

"People are expected to remain connected to their offices 24 hours, seven days a week. Holidays are not an exception. Constant email communication causes not only mental tension

and burnouts, but also creates issues within families," Attard said.

The survey was conducted by the For.U.M. youth section, with research being carried out over a period of six months.

"We are the instant generation, were replies are demanded instantly," Sansone added, noting that the competitive market forced people to work more.

Sansone said the For.U.M. was working to see that Malta becomes the second country in Europe to adopt a legislation defending the right to disconnect.

Meetings will be held with the government and opposition, and the For.U.M. will be holding individual meetings with social partners in order to better explain their proposal and how this could be implemented.

It hopes that the political parties include their proposal in the electoral manifesto.

# Hospital Itinerants

Personally speaking the hospital environment is for me a place of deep reflection, which, obviously, occurs on many levels.

People sometimes comment that Mater Dei Hospital is such a big hospital that you need to have a scooter to travel it from one department to the other. After working now for more than nine years, precisely from its official opening in 2007, I think that such comments have a reasonable basis. Yes. Some distances in the hospital are long indeed. You need to have robust healthy feet to walk those distances. Especially if you are involved, like brothers and myself, in the chaplaincy ministry. Nevertheless such walking presented me with an intriguing reflection on the value of being an itinerant hospital chaplain.

The latter value is one of the core values of my Franciscan vocation. As a matter of fact, from 1 till 27 March 2004 the Franciscan Capuchin Order specifically dedicated its Seventh Plenary Council which particularly dealt with Our Fraternal Life in Minority. Throughout the history of the Franciscan Order the first friars who espoused Francis' gospel way of living became like him itinerant preachers. They owed no property and refused any office of great position and privilege in the Church. Instead the first franciscans happily opted to go from one place to another place proclaiming the good and saving news of Jesus Christ as the Lord of all. Thus, the ministry of the friars began to shape itself from their direct contact with the people they came across in the various towns they visited. One of the dominant pastoral needs which the early friars found out was the much-needed preaching of peace and reconciliation. For his account Francis experienced this painful reality first-hand. Due to his total yes to Jesus Christ by opting to live with the poor as one of them his family practically disowned him. Moreover the surrounding

environment wherein Saint Francis lived helped him to choose the poor. In fact, according to some historians as many as 80% of the Assisi population of the time was in poverty. If Francis wanted to live the gospel seriously how could he have avoided such a clear cut reality?

In order to unravel and appreciate my pastoral identity as a Franciscan Capuchin chaplain working with our patients at Mater Dei I strongly believe that it would be all the more wise to present some of the proposals of the Seventh Plenary Council which throw sufficient light on my personal and pastoral identity as being an itinerant friar chaplain.

In the fifth proposal, which has as its heading, itinerancy inserts us into the history of salvation, there is an interesting commentary on how we, as Franciscan Capuchin friars, can insert ourselves into the ongoing history of salvation.

"The strength to be itinerants, pilgrims and strangers in this world is found in faith in Christ the Lord of history, who will reveal himself fully at the end of time to judge everyone according to the law of love (cf. Mt 25, 31-46). This tension toward ultimate fulfilment does not make us outsiders in history but gives concrete direction to our life, frees us from the idolatry of immediate possession, from the narcissistic temptation to put on a show and to succeed, and to be attached to positions we have acquired. On the contrary, it impels us to recognize Christ and humbly serve him in our brothers and sisters, especially in the needy. Like Francis, who wished to call nothing in this world 'his own', let our hearts be ever more open to the unforeseeable



providence of God, who is greater than all our plans. Let us give to all people witness of the joy that comes from placing all our hope in him, and show ourselves attentive to the needs of all" (no. 5).

As a Franciscan Capuchin chaplain am I outsider or a gentle brother to the sick I minister to? How do I view my ministry at the hospital? Do I regard it as a position of power to succeed, a post to be attached to? Or else as a way of serving the least of Christ's brothers and sisters? Do I really recognize Christ in the sick I encounter and humbly serve him in them? Do I see my ministry at the hospital as directed by God's providential care for his children or merely the result of cold systematic planning? Do I really believe that when I am attentive to the needs of every person who lives or works in Mater Dei my whole pastoral being shall powerfully radiate God's joy and hope to others?

Another key proposal within the ones that the Seventh Plenary Council on the Franciscan

Capuchin life in minority proposes is that which speaks about itinerancy as the giving up of power and position.

It says: "Francis was inspired by the itinerant life of Christ and his apostles and he followed their example. In fidelity to Francis let us express our itinerancy by choosing to give up positions of publicly acknowledged, assured power, and choose instead those that are more accessible to the ordinary and poorest people. We should discern and decide in fraternity about giving up those ministries that have become occasions of appropriation, advancement and self-promotion. Such a choice favours our life in fraternity and offers individual brothers the possibility of personal growth by enabling them to make new relationships and to assume new responsibilities. In this way we will share in the characteristic that Christ has given to His Church as a pilgrim people. We wish to follow the sound tradition of the first Capuchins, who were nourished by faith, open to hope and always close to those who were needy and abandoned by others. We therefore propose, as a commitment to a new evangelization, to live alongside them, even if this means giving up structures that do not conform to our ideal" (no.25).

Do I consider my calling as a hospital chaplain more of a privileged way of being accessible to the ordinary and poorest people? Or a way of being in a position which personally offers me assured power? How am I aware that it was my Franciscan Capuchin fraternity and not myself who sent me to serve Christ in our brothers and sisters, the sick people? In my role as a chaplain do I appropriate it? Am I indulged in promoting myself? Am I conscious that the very fact that I work with the needy and abandoned helps me to be

a pilgrim with the vocation to serve? How much am I flexible in my way of ministering to others? Am I tied up with structures or am animated by the commitment to evangelize to our patients and relatives by sharing their difficult journey of their or their loved ones illness?

The thirtieth proposal of the Plenary Council addresses ongoing formation in minority and itinerancy of every brother in the order.

*The strength to be itinerants, pilgrims and strangers in this world is found in faith in Christ the Lord of history, who will reveal himself fully at the end of time to judge everyone according to the law of love (cf. Mt 25, 31-46).*

"Minority and itinerancy are elements of the Franciscan vocation that always accompany our fraternal life. Therefore through ongoing formation we should be constantly deepening our grasp of these values, and, in addition to providing opportunities for educational updating, should promote concrete experiences of closeness to people and to the poor. It is therefore appropriate that each brother periodically renews his consecrated identity and his ministry, through experiences of service to the suffering, of life shared with the marginalized and of some pastoral ministry in a new field. These experiences can be had in other circumscriptions or in a mission" (no. 30).

As a consecrated person to God through my Franciscan Capuchin profession of evangelical vows within the Capuchin Fraternity do I value every single day of my work at

Mater Dei as a tangible renewal of my consecrated identity and ministry?

The very fact that I spend a considerable amount of time on call as well as periodically I change the block of wards of patients under my care is not already a sign that I am being open to all and everyone? How much am I thanking God that, through the very structure of my work as a chaplain, He is renewing my consecration to bring the good news to those who are marginalized via my hospital ministry?

As a conclusion of my personal reflection on being a hospital itinerant chaplain I want to highlight the last paragraph of proposition 30. "Ongoing formation also concerns itself with the Franciscan quality of our prayer. We pray as true lesser brothers when we are ready to share our prayer with the people, when we know how to adapt it to the circumstances, whether through cultural forms or presenting to God the joys and hopes, the sufferings and concerns of our contemporaries (cf. GS 1)".

When patients or their relatives call me to pray with them does my prayer reflect that I am truly a lesser brother? Do I include them in my prayer with them? Do I adapt my prayers to the circumstances I encounter with? Or the people I serve have to adapt themselves into my own style of prayer? Does my prayer portray a genuine thankfulness for the joys and hopes that my patients experience? Does it show a genuine plea to God for their suffering and concerns? Is my prayer taking up the hardships of the people I serve to the extent that it truly becomes intercessory?

This simple yet heartfelt personal reflection squarely shows me that as a Franciscan Capuchin hospital chaplain I am still a chaplain in becoming.

**Fr Mario Attard OFM Cap**

## Carers being employed at St Vincent de Paul to make up for shortage of nurses - MUMN

The Malta Union of Midwives and Nurses has this morning called a press conference complaining that in order to reduce the costs for running St Vincenz de Paul, the management is employing carers instead of professional nurses.

Addressing the press summoned in front of the building in Luqa, Colin Galea the Secretary General of MUMN, said that the home for the elderly needs to double the number of nurses. The residence currently employs some 260 nurses and they entrusted to take care of more than 1200 patients.

"The situation is horrible. There are currently two nurses assigned with 40 patients when in reality, the number of nurses needs to be four."

As he explained, the management and MUMN commissioned a study on the residence which found out that the number of nurses needs to be drastically increased. However, Mr Galea said that this study was left shut down in the drawer and never implemented.



"Having carers taking care of patients in not on. They are not qualified and it is the residents who suffer because they are not being given the best treatment."

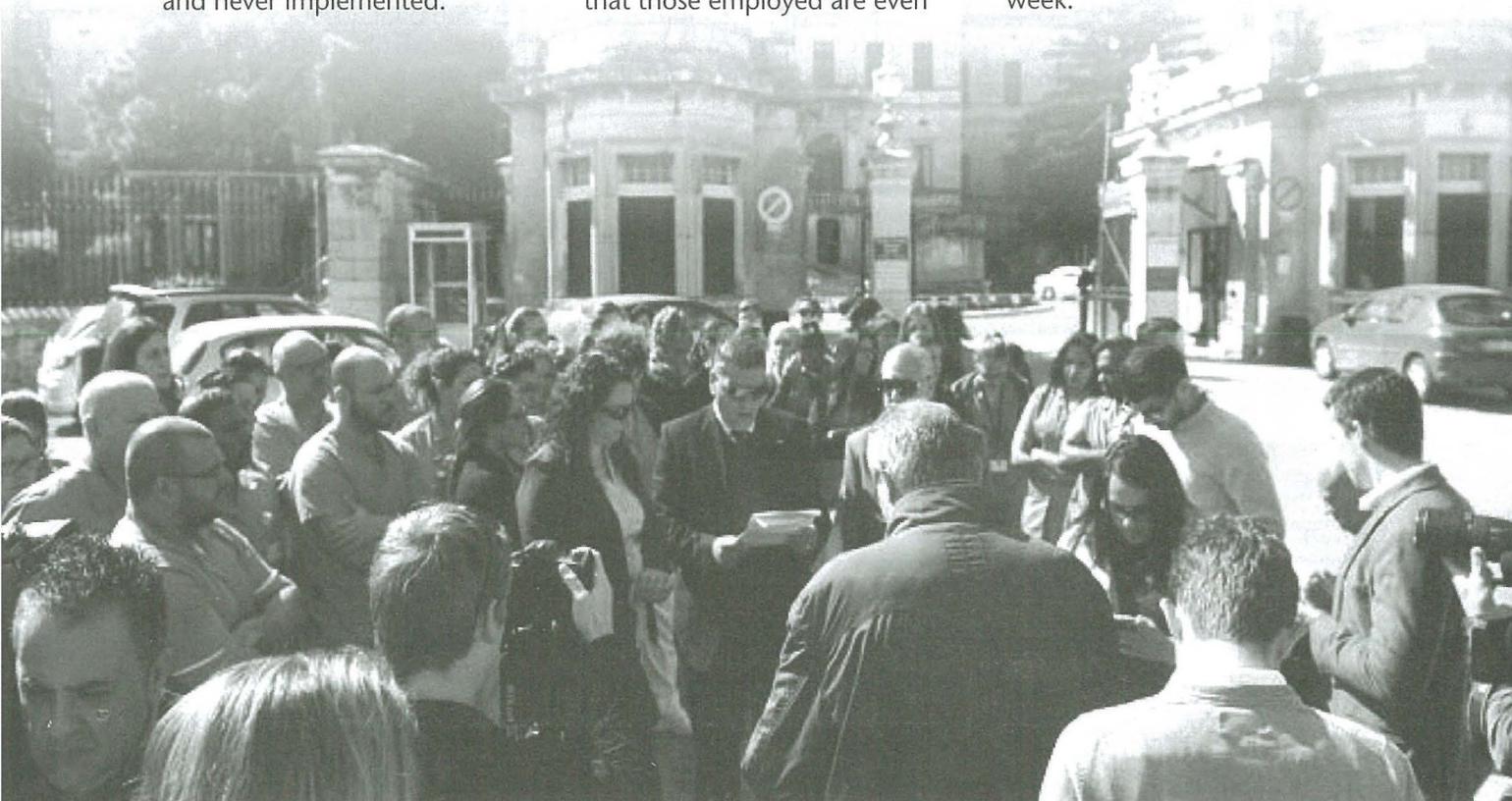
MUMN explained that these carers often have language barrier and cultural problems which hinder their work. It was also remarked that the carers qualifications are also questionable.

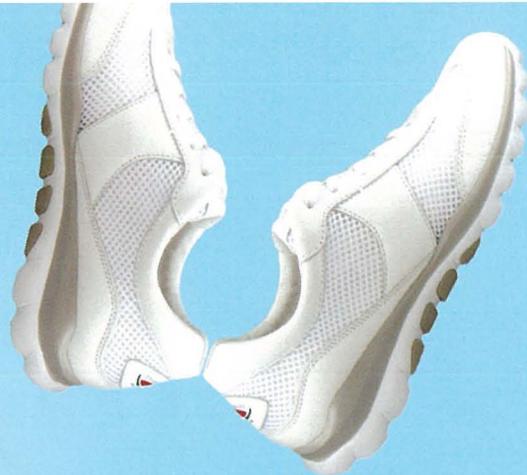
The Union also mentioned the fact that the residence is in such a dire need for new nurses, that those employed are even

being denied their basic vacation leave.

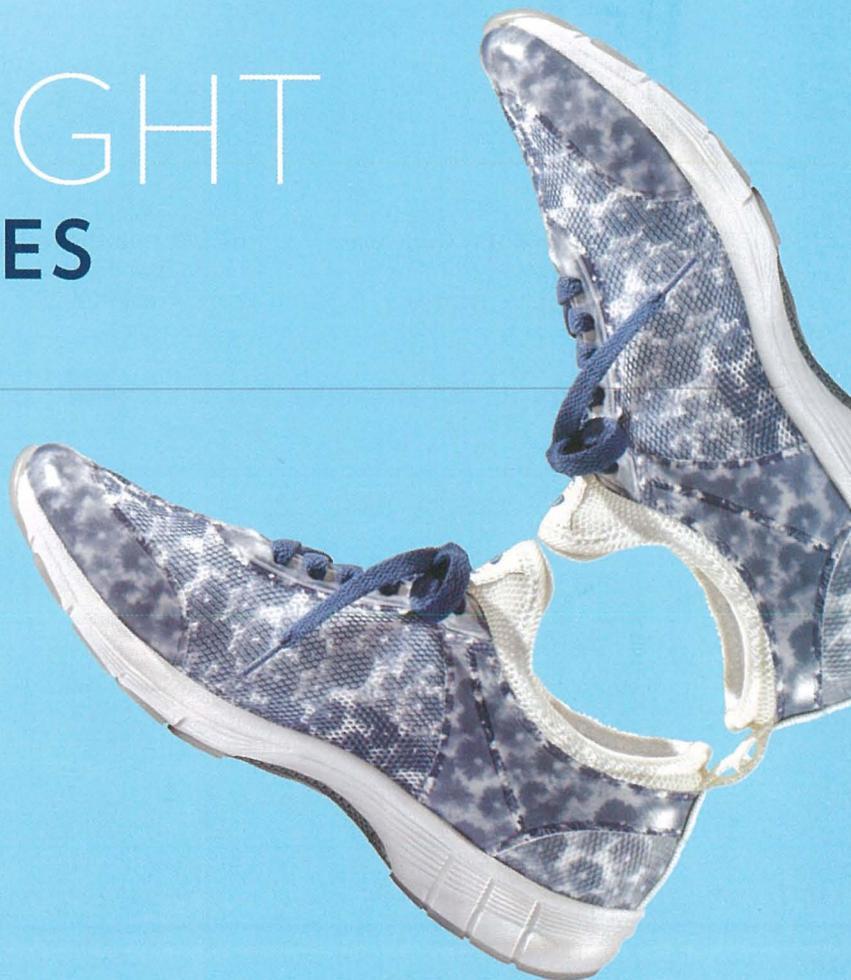
"Carers cannot replace nurses. A lot of times, the only thing these carers are assigned to do is change nappies."

Following these complaints, the MUMN is now asking for an urgent meeting with the Parliamentary Secretary for the Elderly Justyne Caruana. Asked if they would be willing to give the Parliamentary Secretary an ultimatum, MUMN said they expect a reply by end of this week.





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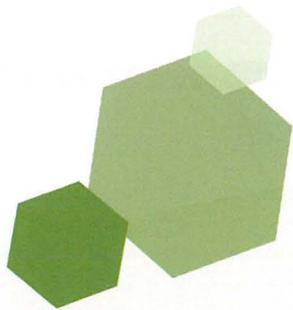


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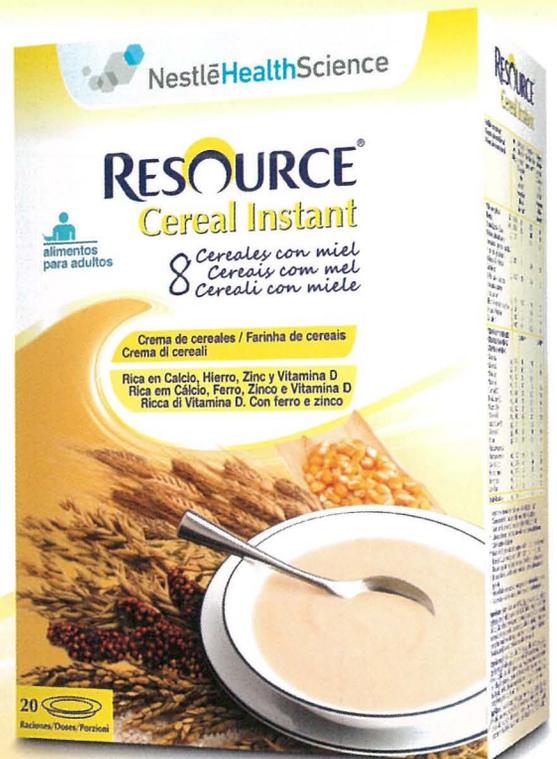
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promote intestinal health by stimulating a positive immune response and out-competing the growth of harmful bacteria.

OptiFibre® helps maintain normal bowel functions in patients suffering from constipation, diarrhoea and irritable bowel syndrome. Besides a regulatory effect on gastrointestinal function, Optifibre® has shown positive effects on lipid metabolism and mineral absorption. The main clinical benefits of Optifibre® are listed below:

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- Prevents and treats acute diarrhoea.
- Improves glucose and insulin response.
- Helps in preventing hyperlipidemia.

OptiFibre® has the advantage of improving patient compliance, given that it does not alter taste, texture or colour when added to food. Unlike other dietary fibres, OptiFibre® mixes easily into hot and cold meals and beverages without impacting texture or flavour, thus assuring maximum acceptance by patients. Consequently, OptiFibre® may be added to both hot and



cold meals such as soups, pasta and other hot dishes or to liquids such as tea, coffee or juices. OptiFibre® is non gelling, making the product also suitable for patients that use a PEG tube and require a fibre rich diet. This product may be recommended for both short and long term use.

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

## Reference:

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

## Il-qtar li nħobb

### Ktieb ta' poeziji ta' Jesmond Sharples

“Il-Qtar li Nħobb” huwa ktieb ta' poeziji ta' Jesmond Sharples, u li ġie ppublikat f'Novembru 2016. Jesmond Sharples twieled ir-Rabat fl-1964. Hu infermier u li għamel żmien jokkupa diversi karigi fin-nursing f'Malta fosthom dik ta' Director Nursing Services bejn 2002 u l-2016. Bħalissa Jesmond Sharples huwa wkoll il-President tal-Għaqda Poeti Maltin u fost id-diversi interessi li għandu, wieħed isib il-mużika b'mod partikolari l-kompożizzjoni.

Il-ktieb li fih 208 paġna, jagħtina numru ta' poeziji li nkitbu bejn l-1975 u l-2016 u dil-kitba tirrifletti l-mixja poetika tiegħu f'dawn l-aħħar 40 sena. Il-ktieb b'qoxra sabiħa b'warda ħamra bil-qtar tan-nida tisser il-qtar, li fi kliem il-poeta hu

jħobb, il-poeziji li permezz tagħhom jitwasslu l-ħsibijiet u l-ħsus tiegħu. It-tfassila tal-ktieb tadotta l-metafora tal-qtar mal-jum u l-ewwel poeziji bikrin tat-tfulija huma fl-ewwel taqsimha “Il-Qtar f'Sbieħ il-Jum”. Kull fażi fiċ-ċiklu tal-ħajja tal-awtur tidda b'poezija forma tal-ħajku u tuża l-metafora tal-qtar mal-mixja tal-jum.

Dal-ktieb jinkludi fih ammont rappreżentattiv ta' x'kiteb l-awtur f'dawn l-aħħar 40 sena. Sharples għandu diversi kitbiet oħra li għadhom ma rawx id-dawl u li nisperaw li ma ndumux ma narawhom pubblikati.

Min huwa interessat li jkun jaf aktar fuq din il-pubblikazzjoni jista' jagħmel kuntatt ma' Jesmond Sharples fuq jesmond.sharples@gov.mt



# Ethics & Health Care

## What is an Ethical Issue?

When the subject of ethics is put forward, it is often faced with mixed feelings in terms of its relevance, applicability and importance in our daily lives. It is common for people to approach the subject of ethics with a certain degree of scrutiny and passivity. There are many reasons for this including a limited understanding of ethics and related subjects, an inability to apply ethics to daily life and poor identification of what an ethical issue can be. An ethical issue can be defined as a situation, episode, experience or problem that requires an individual, group of people or an entity to choose between the available options or alternatives. This would require an evaluation of what is good or bad from an ethical perspective.

In health care, several ethical issues can be identified. Prominent ethical issues in the health care industry include:-

Disagreement about treatment decisions; Waiting lists; Access to care; Building and sustaining a healthcare work force; End of Life; Informed consent; Subject participation in research; Capacity and decision making; Innovation and latest technologies; Allocation of resources.

The effective evaluation of an ethical issue requires understanding of ethical principles. The four basic principles of ethics are respect for autonomy, justice, beneficence and non-maleficence. These principles were identified by Beauchamp and Childress as being the foundation of biomedical ethics. Developing a basic understanding of these principles also contributes positively to the professional development of health professionals. There are other essential principles that are important in both ethics and health care. These include confidentiality, fidelity, paternalism, self-determination, common good, and equity. Prior to considering each of these ethical issues in upcoming articles the principles of ethics will also be considered further. A brief

introduction of the four basic ethical principles is put forward here.

### RESPECT FOR AUTONOMY

The word autonomy is derived from the Greek "autos-nomos" meaning self-rule or self-determination. Fundamental ethical theories support that autonomy is the individual's capacity to think, decide and act based on being able to think freely and independently, whilst being supported with rational guidance. Respect for autonomy holds that this capacity should be respected by others. Nowadays self-determination is gaining momentum, encouraging health care providers to move away from the paternalistic approach. Self-determination leads to individualistic care, allowing the patient to have a more active role in their health and well-being. This also requires that patients take responsibility for their decisions, including any consequences that may occur from those choices. Here lies a varying degree of debate in the health care setting as not all health professionals agree on the emphasis made in promoting autonomy. The debate lies mainly in determining how much autonomy a patient should have and finding a balance between the provision of unbiased advocacy and supporting individualised care.



### JUSTICE

The principle of justice is based on the element of fairness in all healthcare decisions. The allocation of resources, scarce resources, new and limited treatment is a particular issue in healthcare. The availability

of resources and being able to effectively achieve equal distribution is a challenge. The main challenge lies on the impact it has individuals in terms of burden and benefit. Healthcare equity and equality must be profoundly understood. Healthcare professionals as well as the management should be competent in upholding relevant laws while also respecting ethical grounds when making decisions.

### BENEFACTENCE

The health professional has the duty to do all they can to help the patient in every situation. All clinical procedures or otherwise, treatments, interventions and information must be delivered to provide the utmost benefit for the patient. In order to achieve beneficence, health professionals need to be highly skilled individuals, continuously keeping themselves updated with the latest recommendations and the best clinical practice. This also places a lot of importance on the delivery of individualised care using a person-centred care approach, with the understanding of what may be good for one patient is not necessarily good for another patient.

### NON-MALEFICENCE

Non-maleficence looks at achieving "to do no harm" as the end result of our interaction with our patients. In the therapeutic relationship, the health professional must keep the "to do no harm" intention at the forefront of care given. Maintaining safety and infection control are practical clinical examples of how this can be achieved. This principle can also be applied to a wider context, where decision makers, including politicians, health managers and health professionals must evaluate the impact of decisions made for the benefit of individual patients, groups of patients as well as society.

Marisa Vella

# Social Security Benefits in Malta in 2017

**S**ocial Security Benefits in Malta are divided in two, namely Contributory Benefits and Non Contributory Benefits. Contributory Benefits are paid according to the amount of National Insurance Contributions an insured person paid during his lifetime, while Non Contributory Benefits are paid according to a means test and according to other provisions in the Social Security Act(Chapter 318).

## CONTRIBUTORY BENEFITS:

There are two types of Benefits namely Short Term Benefits and Long Term Benefits.

### Short Term Benefits

Types of short term benefits:

**Sickness Benefit** – A client has to file Sick reports weekly - First 3 days are paid by employer – entitlement is worked out on two contribution averages- first the client has to have fifty contributions paid and secondly he has to have at least 20 contributions paid in the last two years. For the period covered by sickness he will be credited with National Insurance Contributions Credits.

Rates: single €13.14 p/day  
married €20.30 p/day

**Unemployment Benefit/  
Special Unemployment Benefit** – A person has to be registering as unemployed under Part 1 with Jobsplus – Maximum number of days paid is 156 days - the number of days awarded is the equivalent of the number of National Insurance Contributions paid in the last three years. National Insurance Credits are also awarded.

Rates: single UB €8.05/SUB  
€13.64 p/day married UB €12.31/  
SUB €20.68 p/day

**Injury Benefit** – Claimant has to file an Injury Form within ten days – he will be paid, even if he has only one NI Contribution, for a maximum period of one year or less if the Medical Panel decides otherwise. If after a year he is still unable to resume work he will be requested to start filing sick reports and he will be paid SB. National Insurance Credits are also awarded.

Rates: single €22.92 p/day  
married €30.46 p/day

**Marriage Grant** – this is granted to the couple if each of them has at least 26 NI contributions paid.

Rates: €277.70 each

**Maternity Benefit** – is paid for 14 weeks (8 weeks before birth and six weeks after) to persons who are unemployed (at the rate of €90.27 per week) and to self occupied persons. Due to the fact that self occupied persons cannot usufruct of Maternity Leave, as from 1/1/15 the rate payable is that of National Minimum Wage (€169.76) per week.

**Maternity Leave Benefit** – this is paid to persons who have opted for Maternity Leave through their employer and wishes to extend the maternity leave by four weeks. The rate is fixed at National Minimum Wage (€169.76) per week and is paid by the department

### Long Term Benefits

#### Retirement Pension

Pension Age Reform –  
retirement age Born 1952 – 1955  
- 62 years

1956 – 1958 - 63 years

1959 – 1961 - 64 years

1962 onwards 65 years

Yet a person can opt to retire at age 61 if he was born between 1952 and 1961 and has 1820 paid or credited contributions(equivalent to 35 years contributions), while if he is born after 1962 he needs to have 2080(which add up to 40 years contributions). If he is born in 1969 he need 41 years of contributions.

On the other hand if a person had the necessary contributions to retire early and continues in employment until he/she is of pension age, his/her pension will be increased by a percentage for every year past age 61.

- an increase of 5% if he decides to receive the pension a year later;
- an increase of 10.5% if he decides to receive the pension after two years;

- an increase of 16.5% if he decides to receive the pension after three years;
- an increase of 23% if one decides to receive the pension after four years.

With a maximum amount of contributions a person will receive a Two Thirds Pension.

While receiving a Retirement Pension an individual can work unless he had opted to retire early.

### Widow's Pension

A widow or widower will receive five sixth's of the late spouse's pension. If he/she was still in employment before his demise, the entitlement will be five ninth's of the pensionable income.

As from year 2016, if a Widow is of pension age and is entitled to a Retirement Pension by virtue of the contributions she paid, and she is receiving the 5/6 of her late husband's pension as it was more beneficial, she will now get her husband's full pension as her widow's pension.

### Invalidity Pension

If a person is found by the Medical Panel to be totally unfit for work he is awarded an Invalidity Pension as long as he has 250 contributions paid. Rate will be decided according to the contribution average test. A person can apply for an Invalidity Pension only after filing sick reports for six months(except in cases of terminal illness).

### Grant given to persons who did not qualify for a pension due to low contribution average

This measure was introduced in the 2015 Budget.

Persons who did not have enough contribution to qualify for a pension and are between the age of 62 years and 74 years will qualify for this grant.

If they have over 50 but less than 260 they will get a yearly grant of €150

If they have 261 and over will get a yearly grant of €250.

- continued in next issue



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# Regulations for the Chambray Mental Hospital - Gozo

Approved on 7th September 1933

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

In Part 1 published on March 2017 edition, I presented the first five of the Regulations for the Chambray Mental Hospital – Gozo. These were on admissions, discharges and transfer.

This article will be on the duties of the medical board, the visiting physician, the resident medical superintendent, the chaplain, the storekeeper, the chief nurse, the matron, the sister, the nurses, the porter, the cooks and the servants.

## MEDICAL BOARD

- Members of the Medical Board of the Hospital for Mental Diseases, Malta, may, on their own initiative, visit the Hospital and inspect same. The record of such inspections and any observations made shall be entered in a Visitors' Book which shall be kept in the Superintendent's Office for that purpose.

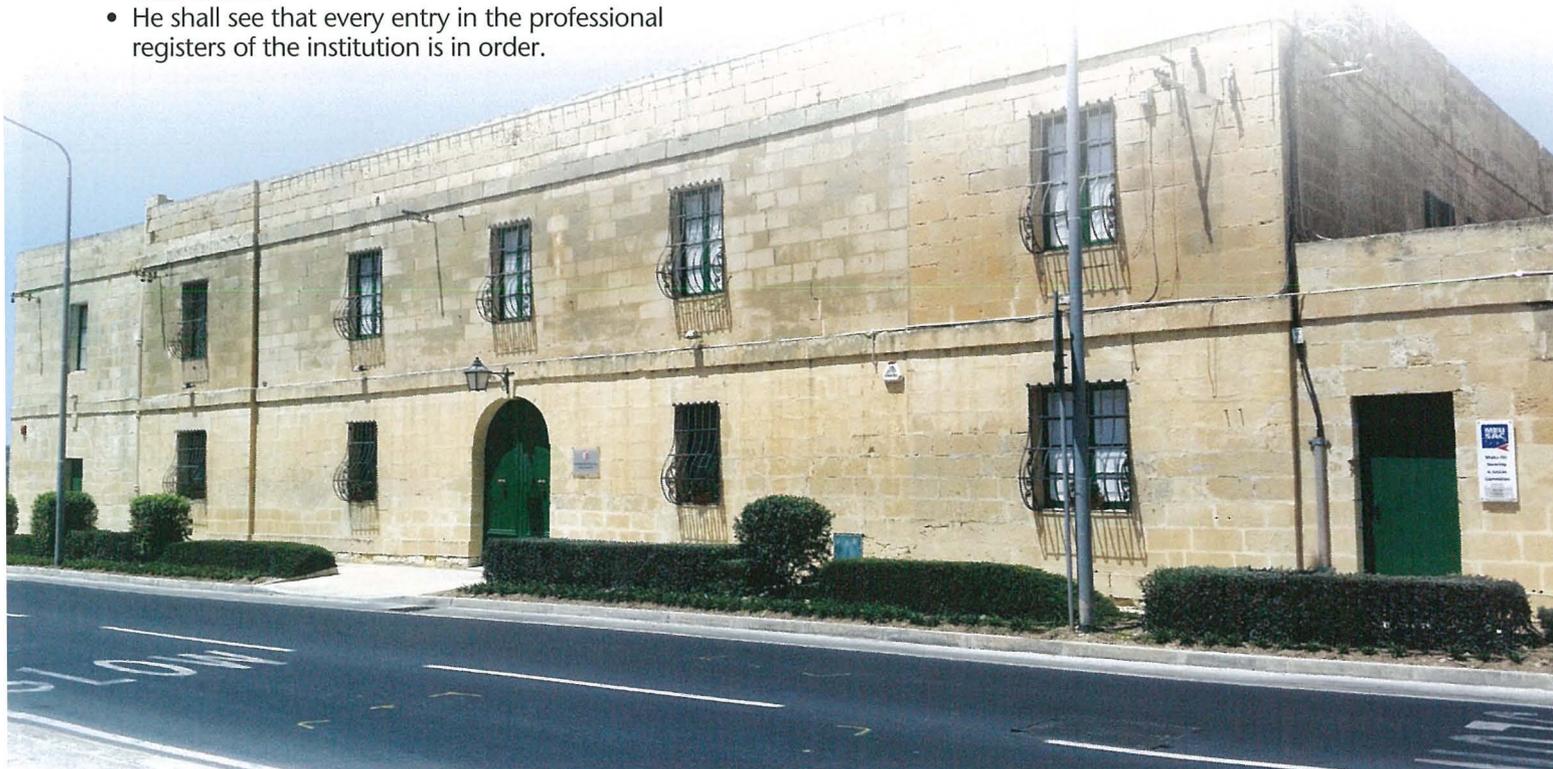
## VISITING PHYSICIAN

- The Resident Physician of the Hospital for Mental Diseases, Malta, shall attend at the Hospital at least once every 15 days. He shall also attend at other times whenever he receives notice from the Comptroller, or the officer in charge of the Hospital, that his attendance is required.
- The Visiting Physician shall examine all the patients and any observations he may make with regard to them shall be entered by the medical Officer in the Case Sheets.
- He shall see that every entry in the professional registers of the institution is in order.

- He shall ascertain that his instructions regarding the treatment of the patients are strictly carried out and, and shall bring cases of the neglect or disobedience of orders to the notice of the Comptroller. He shall also make surprise visits to the Hospital whenever he deems it proper.

## RESIDENT MEDICAL SUPERINTENDENT

- The Resident Medical Superintendent shall be entrusted with the general management of the institution.
- He shall carry out, as far as may be practicable, the treatment prescribed for each patient by the Visiting Physician. Should it be necessary to make any departure from the treatment prescribed, he shall inform the Visiting Physician accordingly.
- The patients of both Divisions shall be visited by the Superintendent every morning at 8 am and every afternoon at 3 pm. In winter and 4 pm. in summer.
- The Superintendent may leave the Hospital after the afternoon medical visit on the week-days and after the morning visit on Sundays. He shall, however, make arrangements to remain in touch with the hospital during his absence and shall on no account sleep out of the Institution without the special permission of the Comptroller of Charitable Institutions.



- The Superintendent shall see that all officers, nurses, and servants perform their duties strictly in accordance with the regulations, and shall bring all instances of neglect or disobedience of orders to the notice of the Comptroller.
- The provision to the Hospital shall be inspected daily by the Superintendent together with the Storekeeper. The Superintendent shall ascertain that the food is properly cooked and distributed and that the patients receive the diet that has been prescribed for them.
- The Superintendent shall pay surprise visits to the wards at night, at least twice during each month. The results of the inspections shall be entered in the Night Inspection Book, which shall be forwarded to the Comptroller of Charitable Institutions every quarter.
- The Superintendent shall submit to the Comptroller such weekly, monthly, quarterly and annual statistical returns and financial reports, and such other reports regarding the management of the Hospital as may from time to time be prescribed.
- He shall have charge of the dispensary of the hospital, and shall make out requisitions for medicines and prepare prescriptions.
- He shall be accountable for the medicines, etc. under his charge.
- He shall keep the following registers:-
  1. The General Registers of Admissions and Discharges,
  2. The Case Sheets,
  3. The Register of Drugs,
  4. The Diet Books.

#### **CHAPLAIN**

- The Chaplain shall reside in the Institution.
- He shall have charge of the patients' library and the periodicals presented to the Institution.
- He shall visit the wards in the male division as frequently as possible, and see that the customary prayers are said.
- He shall mix freely with the male patients and it shall be his principal duty to endeavour to influence them with good advice, and to promote their recreation and amusement.
- He shall see that the Chapel is kept scrupulously clean, and shall apply in writing to the Superintendent for any article that may be required for the divine service in the Chapel.
- The Chaplain shall say mass daily, between 5.30 and 8.30 am. As directed by the Superintendent.
- Subject to the directions of the Superintendent he shall comfort the patients with spiritual assistance and prepare them to death.
- After saying the mass on festival days, he shall deliver a sermon on the Gospel or any subject that may be appropriate to the occasion.
- The Chaplain shall report at once to the Superintendent any irregularity on the part of the Nurses or patients which he may observe in the Chapel or wards.

- The Chaplain shall deliver corpses from the mortuary to the parish priest who conducts the funeral; he shall see to the identity of the deceased patients and they are decently and properly shrouded. In the absence of the Chaplain these duties shall be performed by the Superintendent.

#### **STOREKEEPER**

- The duties of the storekeeper are those laid down by the Regulations for the Storekeepers and Ward Masters of the Charitable Institutions.

#### **CHIEF MALE NURSE**

- The Chief male nurse shall obey the orders of the Visiting Physician and the Superintendent.
- He shall have charge of the male division, and the male nurses shall be under his immediate orders. It shall be his duty to report to the Superintendent any neglect or disobedience of orders on their part.
- He shall be responsible for the maintenance of good order in the male division, for the execution of the orders of the medical officers, and for the safe custody, proper nutrition and personal cleanliness of the patients.
- He shall pay frequent visits to the male division by day and at least twice weekly by night, and shall inspect the baths, lavatories and privies. He shall be present when patients are placed in the seclusion room, and shall visit them at frequent intervals. He shall strictly enforce the established routine, and give such instructions to the nurses as may be necessary.
- A record of his visits to the place mentioned in the preceding paragraph shall be entered by him in the Daily Report book.

#### **MATRON**

- The duties of the Matron in the female division shall be the same as those of the chief nurse in the male division.

#### **SISTERS**

- It is the duty of the Sisters to supervise the treatment of the patients and the work of the nurses in the female division.

#### **NURSES**

- The Nurses shall be under the immediate orders of the chief male nurse and the Matron respectively.
- They shall attend to the cleanliness of the Divisions and the patients entrusted to them. Their conduct towards the patients shall be marked by humanity, and they shall not resort to any form of mechanical restraint which has not been formally prescribed by the medical officers. They shall not use violent language, or strike, or in any way ill-treat the patients. They shall report to the Superintendent any complaints which the patients may make.

• continued on page 38

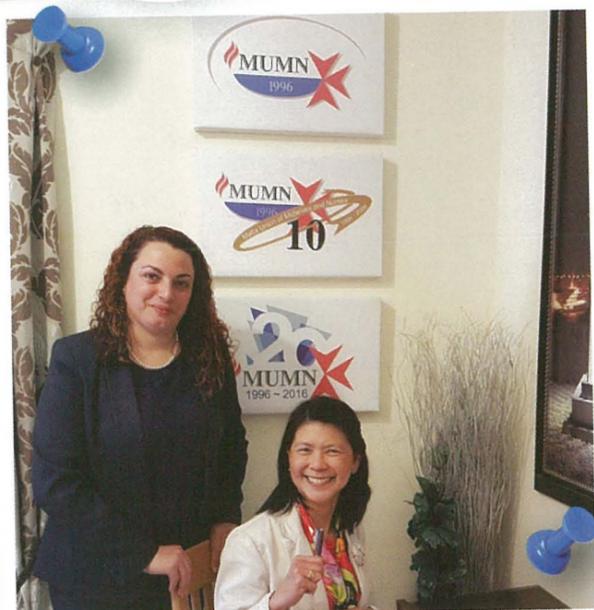
from our diary



On the International Midwives' Day, our Midwives Group Committee organised a very pleasant day for all the Midwives who attended on this occasion.



MUMN organised a one hour strike for the nurses at St. Vincent de Paule's Long Term Facility due to issues related on safe staffing and working conditions.



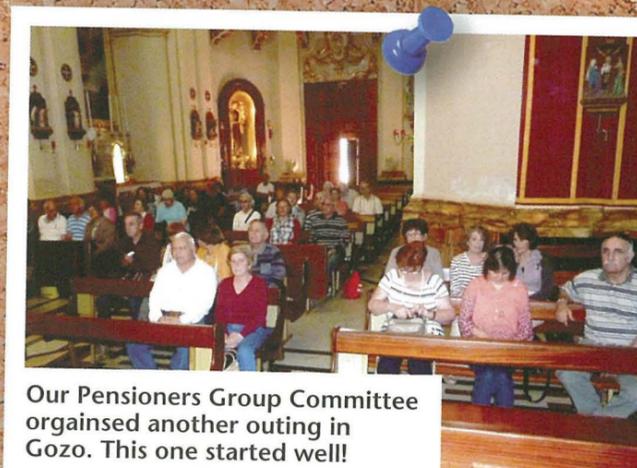
Vitals Global Healthcare appointed a new Nursing Director, Ms. Maria Theresa Panizales. The new VGH Nursing Director visited MUMN's offices.



Mr. Joseph Aquilina, MUMN Council Member and Office Administrator was recognised by the Siggiewi Local Council for his talent and contribution to the locality.



The European Nurses Federation and MUMN organised a meeting in Malta where the leaders of the Nurses' Unions/Associations from the respective EU Countries discussed and decided upon nurses' policies, development goals and other nurses issues. This meeting was organised in our country due to the EU Presidency.



Our Pensioners Group Committee organised another outing in Gozo. This one started well!



The Learning Institute for Health Care Professionals organised a very interesting seminar which was well attended. The next one is going to be organised in Gozo!



The Learning Institute for Health Care Professionals is organising several courses and workshops at MUMN Office in Mosta



# Eczema in babies

**E**czema (atopic dermatitis) is the most common form of eczema.<sup>1</sup> It mainly affects children, causing their skin to become dry, red, cracked and itchy and usually occurs in folds of the skin (e.g. behind the knees, inside the elbows, on the sides of the neck, around the eyes and ears).

About 20% of children in the UK have eczema.<sup>1</sup> It often manifests before the first birthday.<sup>1</sup> The exact cause of eczema is not known, but there is thought to be a genetic element and in some cases it is linked with other allergies.

## What are the common allergens?

Atopic eczema can sometimes be triggered by food allergens, especially before the age of 1 year. Common food allergens include:

- Cows' milk
- Eggs
- Fish
- Nuts
- Soya
- Wheat

Other allergens include; house dust-mites, pet fur and pollen.

## Reducing the risk of developing allergy?

Reducing the risk of developing allergy in formula-fed infants has been a major focus of research. The German Infant Nutritional Intervention (GINI) Study  $\text{D},\text{D}$ , a large independent study looking at the prevention of allergies (2,252 babies), noted that certain formulas, including SMA.H.A.<sup>®</sup> Infant Milk reduces the risk of a baby developing atopic eczema when compared with the use of standard infant formula. This finding was for high-

risk infants in the first year of life, who had a family history of the condition (at least one parent or sibling with an allergy). Not all hydrolysed formulas have been found to reduce the risk of developing eczema. Therefore, clinical guidelines such as those developed by the European Academy for Allergy and Clinical Immunology (EAACI) should be followed for high risk infants. Guidelines recommend breastfeeding but in the absence of breastfeeding infant formula that has some clinical evidence of allergy prevention.

## Identifying babies who may benefit from SMA HA

SMA H.A. Infant Milk is designed to specifically reduce the risk of developing allergy (e.g. eczema) to cows' milk proteins

## References

1. NHS Choices. Atopic eczema. 2014
2. Alexander DD, Cabana MD. *J Pediatr Gastroenterol Nutr* 2010; 50: 422–430.
3. von Berg A *et al.* *J Allergy Clin Immunol* 2003; 111: 533–540.
4. von Berg A *et al.* *J Allergy Clin Immunol* 2008; 121: 1442–1447.
5. Muraro A *et al.* *Allergy* 2014; 69: 590–601.

**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. Caregivers 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.

# The new SMA H.A.

## An easy to digest formula, designed to reduce the risk of developing cows' milk protein allergy.

Allergy arises due to the inappropriate reaction towards otherwise harmless antigens such as cow's milk protein. Several studies have shown a significant increase in allergies in the last 30 years.<sup>1-4</sup> Atopic dermatitis affects 20% of children under two years in many countries, and it is the first manifestation of allergic sensitization.<sup>5-9</sup> Additionally, 50% of the paediatric population suffering from atopic dermatitis in their first two years of life have shown later development of asthma.<sup>10</sup> This increase in allergies has led to the research of hypoallergenic formulae, which help to reduce the risk of development of atopic dermatitis till 10 years of life.<sup>11</sup>

Clinically proven to reduce the risk of developing eczema by up to 50% in first year of life for susceptible babies<sup>12</sup>

Reduced protein levels, similar to values found in breastmilk.

Contains Omega 3 and 6 LCPs

Contains lactose as the only carbohydrate

< The partially hydrolysed, 100% whey protein in SMA H.A. reduces the risk of eliciting an allergic response towards cows' milk protein.

< It is also easier to digest, improving gastric transit times, making them similar to breastfed babies<sup>13</sup>

< Early growth, adipogenic activity and adipocyte differentiation have been thought to be linked with excessive infant protein intake<sup>14</sup>

< Supporting eye and brain development<sup>15</sup>

< Studies have shown increased levels of Bifidobacteria in stools, due to its fermentation by colonic microflora<sup>16,17</sup>

### TO BE USED FROM THE FIRST FORMULA FEED.

**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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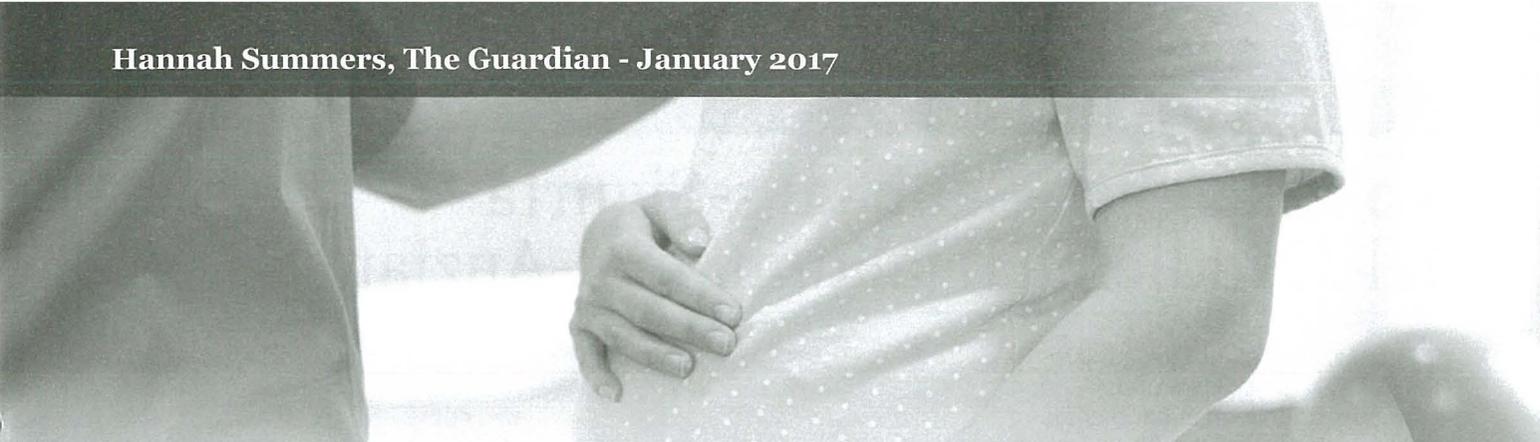


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## UK midwife shortage leaves women feeling like cattle, report finds

*Half of women surveyed experienced at least one 'red flag' event during labour such as lack of timely access to pain relief*

**A** chronic shortage of midwives across the UK means women in labour are left feeling unsafe and frightened or as if they are being treated "like cattle" or "on a conveyor belt", a new report has found.

In a study of 2,500 women who have given birth since 2014, half were found to have experienced at least one "red flag" event such as not getting timely access to pain relief due to insufficient staffing levels.

The research conducted by the National Childbirth Trust (NCT) and the National Federation of Women's Institutes (NFWI) found that since a similar report four years ago there has been "scant progress" in women's experiences of giving birth under the NHS.

A red flag problem is defined by the National Institute for Health and Care Excellence (Nice) as a "warning sign that something may be wrong with midwifery staffing".

Problems include delays of up to an hour or more in washing or suturing, medication doses being missed, delays of 30 minutes or more in getting pain relief, or when one midwife is not able to provide continuous one-to-one care and support to a woman during established labour.

The report found 17% of women did not get such one-to-one care from midwives, while more than a third who required or received pain relief experienced a delay of 30 minutes or more. Some even reported suffering post-traumatic stress as a result of

the way they were treated while giving birth.

Health experts said the findings should serve as a warning to the government that staffing levels are at crisis point. Elizabeth Duff, a senior policy adviser at the NCT, said: "Our research has exposed a crisis in maternity care. No woman should have to suffer a red flag event when bringing a baby into the world. Severe staffing shortages must be acted on so that every family receives an acceptable level of care."

The study found that 89% of women saw between one and six midwives during their pregnancy with most seeing between one and four. While 88% of women had never met any of the midwives who looked after them during their birth, just over half of those said it did not make a difference to them, mainly due to the professionalism of the midwives caring for them. But 12% said this made them feel alone and vulnerable and 6% said it made them feel unsafe.

Some women wrote about feeling like cattle or a machine, while others reported that a negative birth experience had had a lasting impact on them. One said: "I received a very 'robotic' care. It wasn't very personal and I felt like just another person on the conveyor belt."

Another said: "I wasn't treated as a human. I was just a product on a conveyor belt. I was not respected and my birth has left me suffering post-traumatic stress disorder."

One pointed to staffing issues, saying: "My chosen hospital ward and adjoining birth centre were extremely busy, or so I kept being told on the phone, which resulted in me having an unplanned home birth."

Another new mother expressed her disappointment at being unable to have the labour she wanted because of "staffing issues". She said: "There was no room for me on the delivery ward. I ended up giving birth in the antenatal ward, which meant I couldn't get either a water birth or an epidural."

Once women had given birth, almost one in five (18%) said they had not seen a midwife as often as they needed, with 36% saying this had caused them great concern. More than a third of women said the diagnosis of a health problem had been delayed due to lack of postnatal care.

Marylyn Haines Evans, the chair of public affairs at the NFWI, said: "The findings from this report show that chronic midwife shortages, an estimated 3,500 in England alone, continue to undermine the delivery of high-quality care for women and their families."

Louise Silverton, the director for midwifery at the Royal College of Midwives, said the report should be a "red flag event for this government". She said: "The fact that half of women have experienced a red flag event is hugely worrying. It is a sign of services under too much pressure, with too few resources and not enough staff."

# Politika għas-Saħħa u s-Sigurtà tal-Ħaddiema li jaħdmu mal-Anzjani

**F**l-okkażjoni ta' Jum il-Ħaddiem giet varata l-politika għas-saħħa u s-sigurtà għall-ħaddiema kollha li jaħdmu fi ħdan id-Direttorat għall-Anzjanità Attiva u Kura fil-Komunità.

Din il-politika, li se tolqot 730 persuna li huma impjegati tal-Gvern u 300 ħaddiem li jaħdmu mal-kuntrattur f'setturi varji, hija waħda minn tal-ewwel fis-settur pubbliku.

Waqf konferenza tal-aħbarijiet, is-Segretarju Parlamentari għad-Drittijiet tal-Persuni b'Diżabilità u Anzjanità Attiva Justyne Caruana fissret kif wara li sar eżerċizzju fi gradi differenti li jvarjaw minn amministrazzjoni u manigment sa ħaddiema manwali, nħass il-bżonn għal iżjed kuxjenza biex is-saħħa u s-sigurtà fuq il-post tax-xogħol tkun tassew imħarsa.

Hija qalet li b'din il-politika, se jkun hemm klawsola apposta li permezz tagħha l-kuntrattur ikun nformat minn qabel ma jibda jopera biex jissottometti *risk-assessment* u provi oħra li hu bħala kuntrattur se jieħu ħsieb is-saħħa u s-sigurtà tal-ħaddiema tiegħu u ta' dawn li jistgħu jiġu



affetwati mill-operat tiegħu.

Fost l-oħrajn, din il-politika titratta wkoll il-mod kif isir rappurtagġ mhux biss meta jsir incident iżda meta jkun hemm riskju potenzjali li jsir incident. Dan filwaqt li kull ħaddiem jista' jirrapporta kull tip ta' periklu li hu stess ikun osserva.

Miżuri konkreti oħrajn jinkludu sistemi ta' moniteragġ kontinwu

u mekkaniżmu ta' rappurtagġ li jista' jsir mill-ħaddiema stess permezz tar-rappreżentanti magħżula minnhom (li hemm diġà 29 rappreżentant), tagħmir u lbies protettiv, kif ukoll tagħmir adattat fid-djar, fiċ-ċentri u fl-uffiċini.

Fid-diskors tagħha, is-Segretarju Parlamentari Caruana faħhret il-koperazzjoni li ssib minghand it-trejdunjins biex il-Gvern jassigura li, filwaqt li s-servizzi jinghataw kif ippjanat, il-ħaddiema jinghataw għarfien sħiħ tal-kundizzjonijiet tal-impjieg. Hija temmet tgħid li l-għan aħħari ta' din il-politika hija li jkollna sistemi siguri fuq il-post tax-xogħol biex naħdmu għall-gid tar-residenti tagħna fl-istess waqt li l-ħaddiema jagħmlu dan f'ambjent sigur.

Preżenti għal din il-konferenza tal-aħbarijiet f'isem il-Malta Union of Midwives & Nurses (MUMN) kien hemm il-President Maria Cutajar u s-Segretarju Finanzjarju George Saliba, f'isem il-General Workers' Union (GWU) kien hemm is-Segretarju Ġenerali Josef Bugeja u s-Segretarju tat-Taqsima Gvern u Entitajiet Pubbliċi Jeremy J. Camilleri u l-Unjin Ħaddiema Magħqudin (UHM) kienet rappreżentata minn Charles Vella - Employment Relations Assistant Manager.

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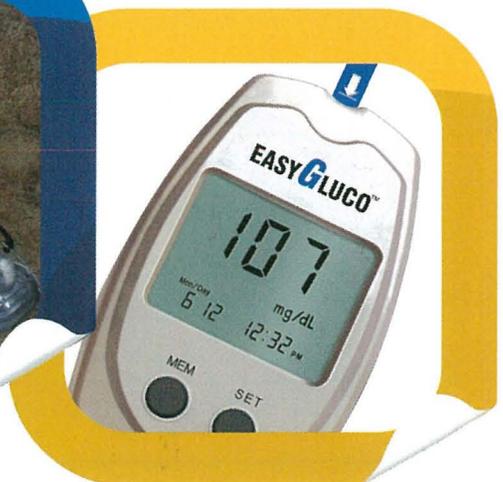
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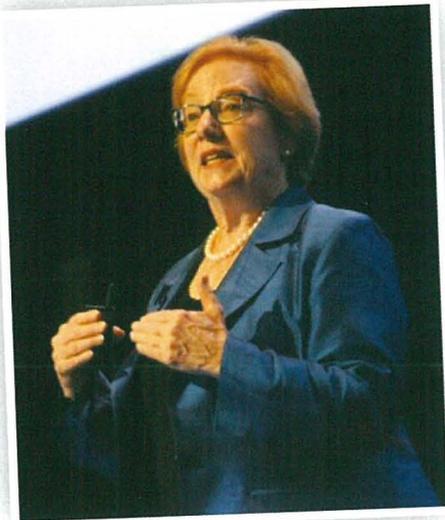
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# Safe staffing, social justice and gender advocacy raised as key issues for nursing

Barcelona, Spain; Geneva, Switzerland; 1 June 2017



**K**ey speakers from around the world addressed participants at the International Council of Nurses (ICN) Congress in Barcelona, Spain, highlighting the need for evidence to lobby governments to invest in nursing; as well as the key role of gender in this female-dominated profession.

Dr Linda Aiken, Director of the Centre for Health Outcomes and Policy Research at the University of Pennsylvania, received a standing ovation for her presentation on safe staffing. As one of the most recognised leaders in the field of research and evidence, Dr Aiken spoke about the importance of evidence and bringing it to governments. She presented findings of studies of 30 countries that show the important impact of nurse staffing on patient outcomes. "Hospitals that have evidence based staffing have the lowest mortality at the same or lower price," she explained. "Now is the time for us to act on the basis of the evidence we have!"

Michael Riordan, Senior advisor to the Queensland Minister of Health, received a huge applause by starting his speech saying, "Forget the doctors, health is all about nurses." He spoke about the Queensland governments campaign to reduce violence

in the health workplace and the current discussions at the Queensland parliament to impose a six-month mandatory prison sentence for anyone assaulting a health office during the performance of their duties. Riordan also spoke about two other initiatives in Queensland: mandated patient to nurse ratios and nurse navigators to help those suffering from chronic conditions, resulting in better patient outcomes.

Riordan quoted the ICN's document "Nurses: A Voice to Lead: Nurses' Role in Achieving the Sustainable Development Goals" saying it was an impressive piece of work. He quoted a key message of the document: "The underlying dynamic in all of this is one of social justice. We should learn about and contribute to the SDGs because it is the right thing to do."

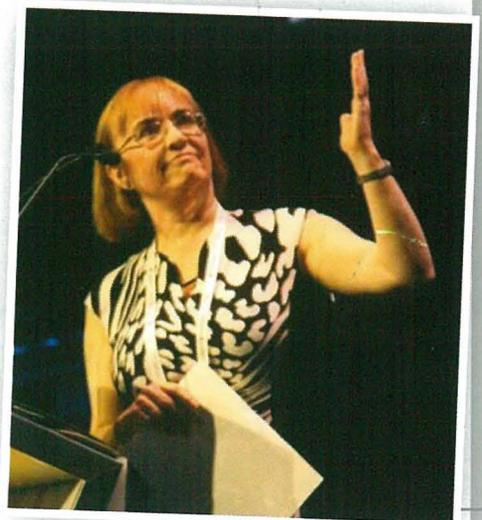
Examples of safe staffing also came from Wales, China, and Spain. Jean White, the Chief Nursing Officer of Wales, discussed her experience and progress in addressing some of the issues of quality and safety through safe staffing measure, citing the Nurse Staffing Levels (Wales) Act of 2016. She was followed by Liming You, Professor at Sun Yat-sen University School of Nursing, who spoke about raising the social status and prestige of the nursing profession and increasing the attractiveness of a nursing career. Finally, Amelia Amžzcua Sžnchez from the Spanish Nursing Union spoke about the necessity to reframe the discourse on nursing investment, and how we need to consider nursing as a gain to society and to the economy.

The afternoon session focused on advocacy and gender with Katja Iversen, President & CEO of Women Deliver, an advocacy organisation, who encouraged nurses to think beyond their

own lives, to influence the health agenda and to seize power. "Be catalyst, be a team player and know your audience she said "But don't wait to be handed the power – take it!"

Raquel Rodriguez Llanos, President of the Nursing College of Cžceres, asked a question of the delegates: Does being a man or a woman affect us as nurses? To answer this question, Dr Rodriguez Llanos discussed the effect of gender on professionalization, citing social expectations of women, the "double day" (a job at home and a job at work), and the risks presented by the working environment. She went on to talk about the impact of gender on health, including mental health, on workload and on absenteeism, due to the burden of responsibilities at home.

A final highlight of the day was the Florence Nightingale International Foundation Fundraising Luncheon where the recipient of the 2017 International Achievement Award, Dr Nancy Glass, an American nurse and researcher in women's health, spoke about her research on ending violence against women and girls globally. The Luncheon was the largest one ever held by the Foundation, with 750 guests, raising over \$15,000.





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Nicola Slawson - The Guardian, 15<sup>th</sup> March 2017

## Tips for new nurses

### NHS nurses offer advice on when to question doctors and how to deal with patients you don't like

#### **DON'T BE AFRAID TO QUESTION SENIOR DOCTORS**

Never be scared to question a doctor, however senior they may be. We are our patients' advocates and can protect them from potential mistakes. A good doctor will respect you for this. If you feel something isn't right but are not confident enough to challenge a situation yourself, go to someone you know, trust and respect – watch how they deal with it and learn.

*Emma McLellan, staff nurse in the ICU, Manchester*

#### **LEARN TO TRUST YOUR GUT INSTINCT**

I believe good nurses are really tuned into their gut instinct and new nurses should learn to trust it. A nurse's gut instinct is their deeply grounded knowledge base developed in practice, their critical awareness and what they have learned from previous situations plus an overall sense of knowing the patient well. You'll just know something doesn't add up, or you may be convinced there's something more going on, so make sure you go that extra mile to cover all bases. Maybe, for example, all of a patient's baseline observations are normal, but you just sense that there is still that underlying thing you can't put your finger on – monitor them really closely because you'll often be right.

*Zoë Hartwright, community mental health nurse, Shropshire*

#### **DEATH IS A PART OF NURSING – TALK ABOUT IT WITH PATIENTS**

Death is a regular part of nursing. Patients need someone to talk frankly about death. We plan births for nine months, but talking about death always seems awkward and hard. One

of the best things you can do for a patient who is nearing the end of their life is to give them opportunities to talk about their death and how they would like it to be. Being able to give advice and support to help them get their affairs in order can relieve a lot of their pain and worry. It is possible to have a good death but the conversations have to be had.

When death is unexpected this is very hard to deal with. I worked in an accident and emergency department for 10 years and learned that life and death is unpredictable. I have seen many patients and nurses struggle with the last words that they said to that person, so I try to adopt the approach of being kind. Really think about what you say during emergency situations – it is likely that patient can hear you right to the end – even if the rest of their body is not responding. Use their name, talk calmly to them, explain everything you do as you are doing it. Speak to them as if they are awake.

*Christine Bushnell, advanced nurse practitioner, nurse partner in a GP surgery and trainer, Harrow*

#### **DON'T TREAT PATIENTS YOU DON'T LIKE DIFFERENTLY**

It's OK not to like some patients. That's bound to happen, and some patients really won't be very likeable. Just be aware of yourself; notice that you don't like the patient and make sure you're not treating them any differently. Maybe confide in a trustworthy colleague and ask them to let you know if you are behaving differently towards that patient. And draw on other people, often you find that another colleague works well with a patient you just can't seem to get along with; make the most of that by getting them to tell you the good qualities of the

patient, or even letting them take the lead.

*Elizabeth Cook, clinical charge nurse, south London*

#### **BE KIND TO PATIENTS' RELATIVES**

Don't say, "I know how you feel" when you have never been in that situation. Instead you can say something like: "I can't begin to imagine how worried you must be, but we are doing everything we can, if you have any questions please ask and if I can't answer them I will find someone who can, etc". It's very hard not to take it personally when relatives are difficult with you. As a nurse in paediatrics, I found it tough at first as a newly qualified nurse without any children of my own. Now that I am older and I have my own children, it is different. When dealing with emotional or difficult relatives, try to put yourself in their position and understand that they do not have anything against you – they are just desperately worried about their child, for example, and you may be the nearest person to them and so they might take it out on you. It is important to listen without judging and, if treated with hostility, try to respond with kindness. Speak to your manager if certain behaviour from a family member is bothering you, but ultimately try to be understanding.

*Sally al-Habshi, paediatric emergency nurse, Leicester*

#### **BE NICE TO HEALTHCARE ASSISTANTS**

Always be nice to healthcare assistants, they're amazing. Make lists of jobs you need to do – a good list helps everything. And always remember that when you're having a bad day, your shift will come to an end and you can go home and eat pizza.

*Laura Thompson, ward manager, London*

# Surgical Clothing - an Essential Barrier

**Surgery** is considered to be an invasive procedure, since on incision of the skin, the protective barrier of the skin is disrupted. This might lead to micro-organisms entering deeper tissues through the incised wound site by direct transfer<sup>1</sup>. In the controlled environment of a surgical theatre, the main source of contamination is the human body. Pathogens from the skin, hair and scalp of patients and the surgical team, were traced to be the cause of surgical site infections<sup>1, 5</sup>. Hence, the purpose of using surgical clothing, is to protect both the surgical team and patient from exposure to potential sources of infection, by creating an effective barrier to limit the spread of microbes into the environment<sup>1,5</sup>. Such devices also protect against exposure to blood and body fluids<sup>1</sup>.

**Surgical Site Infections (SSI's)** are infections that may occur after surgery, in the same part of the body involved in the surgical procedure. Such infections may be trivial, involving only the skin, or more serious and life-threatening, involving deeper tissues, organs and implants<sup>1,4</sup>. Surgical Site Infections are often associated with considerable morbidity and were reported as the main cause of more than 33% of post-operative deaths. They are also estimated to double the time of patient stay at hospital and so double healthcare costs of patients affected. It is also estimated that more than 33% of SSI's may be prevented<sup>1</sup>. The surgical team can prevent surgical site infections by adopting standards of practice, recommended in guidelines issued by the Center for Disease Control and the Occupational Health and Safety Authority regarding donning and wearing of appropriate personal protective equipment<sup>5</sup>.

**The use of Surgical Gowns and Drapes as Personal Protective Equipment (PPE)** was adopted in hospitals around 1970 when the manual "Isolation Techniques for Use in Hospitals" was published by the Centers for Disease Control and Prevention (CDC). This manual was revised in 1975, by which time 93% of hospitals had already adopted and conformed to these guidelines. In the beginning of the 1980's, healthcare professionals were asking for further support in infection control matters, due to the emergence of new bacterial strains which were multi-drug resistant. In 1983, the "Guideline for Isolation Precautions in Hospitals" was issued by the Centers for Disease Control and Prevention. This replaced the 1975 manual as it also brought some changes in practices. The use of personal protective equipment was further enforced in 1985, when the human immuno-deficiency virus (HIV) was identified and the Universal Precautions (UP) were launched to control disease transmission. In 1989, the Occupational Safety and Health Authority (OSHA) issued a rule regarding occupational exposure to bloodborne pathogens. All these events lead to increased awareness of possible risks involved for persons working in healthcare. This, in turn, imposed an urgent and enormous increase in demand for personal protective equipment which compromised the timely supply of sufficient goods, such as disposable surgical gowns and drapes, in the 1985-1990 period<sup>6</sup>.

**The major isolation guideline**, which is still currently in use, was issued by the Centers for Disease Control and Prevention in 2007. This guideline also gave details of the donning technique of personal protective equipment. The considerable rise in incidence of Clostridium Difficile infections and other similar multi-drug resistant strains at hospital; put more pressure on the importance that such facilities should provide proper education and monitoring of healthcare workers in the use of such protective wear.



Hence, the universal use of personal protective equipment was enforced wherever the contamination of clothing, hands and mucuous membranes was expected. In 2014, on emergence of the Ebola Virus Disease, the World Health Organisation and the Centers for Disease Control and Prevention, both recognised the importance of healthcare workers to have full coverage of their bodies. Since contact with infected bodily fluids is highly contagious, it was also considered essential that such workers should have coverage of mucuous membranes and so should wear a face cover, head cover and protective foot wear together with their gowns and gloves. In October 2014, the World Health Organisation published guidelines that included the use of personal protective equipment to cover the mouth, nose and eyes to protect from contact with contaminated droplets and fluids. The compilation of these guidelines recognised the fact, that the choice of such personal protective devices involved a delicate balance between the importance of properly protecting such workers, and the implications of providing excellent care whilst wearing full body coverage, which might subject workers to heat build-up, and interfere with movement<sup>6</sup>.

## "Safe" Surgical Barrier Materials According to EN 13795

The Medical Devices Directive 93/42 EEC was brought into national legislation in all EU countries, in June 1993. The European Committee for Standardisation (CEN), took 10 years to develop and finalise the European Norm 13795 in June 2006. This consists of a series of standards concerning surgical drapes, gowns, and clean air suits. Such standards ensure that the use of such clothing effectively protects both patient and healthcare professionals from the risk of exposure to infection. The EN13795 consists of 3 parts as follows:

- **Part I General Requirements** describes the fundamental properties of surgical drapes, operating theatre clothing and clean air suits. Single-use and reusable products are subject to the same safety standards.
- **Part II Test Methods** describes the tests with which the various properties of the material are tested. Test methods are normed and fixed in order to make products comparable.

➤ **Part III Limiting Values** defines the limiting values which a product has to achieve. Infection risk may vary depending on the duration and the amount of liquids involved during surgery, therefore 2 performance levels were fixed:

- High Performance: Longer procedures involving high volume of liquids
- Standard Performance: Short duration procedures involving low volume of liquids

**Characteristics to be evaluated in surgical gowns and drapes include:**

- Resistance to microbial penetration (dry and wet conditions)
- Cleanliness (microbial and particulate matter)
- Linting (prior and after twisting and compressing)
- Resistance to liquid penetration
- Bursting strength (resistance of a fabric to puncture under dry and wet conditions)
- Tensile strength (ability of a product to withstand fabric tearing under dry and wet conditions)
- Liquid control and adhesion for fixation (for the purpose of wound isolation), in the case of drapes

**Good Quality Barrier Materials** help prevent Surgical Site Infections and aid compliance of healthcare workers to Occupational Health and Safety regulations regarding the use of surgical attire. The material used for surgical gowns should be lint free and breathable to allow body heat to escape away from the wearer, whilst preventing the dispersal of skin squames into the surgical environment. In this manner the material provides protection as well as sufficient comfort to the wearer; without interfering with the course of his/her work<sup>5</sup>. Other issues to consider regarding compliance of gown wear would be secure and easy to apply closure systems, which do not scratch at the neck, nor catch any hair in the process. Such closure systems should have a safe and reliable hold whilst allowing for individual size adaptation closure of the gown.

**Healthcare facilities** should evaluate the efficacy of surgical clothing prior to purchasing stock, considering also proper wearing and compliance of surgical personnel, by establishing actual policies and procedures<sup>5</sup>. Hence, feedback from surgical teams, regarding barriers to wearing personal protective equipment, is critical; since certain materials might cause allergies in some team members, whilst others may be uncomfortable to wear whilst working. This input from surgical personnel might involve the choice between different gown materials in order to ensure ease of wear and safety of impermeability<sup>6</sup>.

In order to make the most benefit and effective utilisation of personal protective equipment; an infection prevention plan for a healthcare facility should:

- Conform with latest guidelines and standards for the prevention of transmission of disease
- Ensure that the guidelines chosen are evidence-based and issued from reliable sources
- Provide necessary education and supplies to enhance the proper use of personal protective wear
- Record concerns from surgical personnel regarding the choice and use of personal protective equipment
- Monitor compliance and develop an action plan for non-compliant personnel
- Document compliance and further actions undertaken<sup>6</sup>.

**Lessons learned from the past:** A study in 1996 concerning analysis of surgical drapes and gowns taken from hospitals in Germany showed considerable shortcomings in quality<sup>2</sup>. This was confirmed in an investigation carried-out in hospitals in England, Wales and France in 2000<sup>3</sup>. Results obtained for one brand of surgical gowns, revealed that varying performance was found at different areas of the same product. They gave a relatively low hydrostatic pressure resistance to microbial penetration in the front area of a specific brand of "High Performance" surgical gowns. This is a very serious issue, since this area is considered as a highly critical area<sup>3</sup>.

**Conclusion:**

Over the centuries, personal protective equipment has evolved to address increased and more challenging needs in healthcare. The use of such equipment, such as gowns and drapes, has played a very important part in infection prevention programmes of healthcare facilities with the aim of prevention of disease transmission<sup>6</sup>.

It is of utmost importance that Consultant Surgeons, and other surgical personnel, should be involved in the decision making process during the purchase of surgical wear, such as gowns and drapes. Such persons should also be involved in the establishment, review and evaluation of policies and procedures regarding the use of surgical wear in healthcare facilities<sup>5</sup>.

Innovative material properties of gowns and drapes can greatly reduce the risk of contamination and infection during surgery. Standard and homogeneous quality, in conformance with latest established norms, must always be demanded for surgical gowns and drapes. It is of utmost importance, in terms of dependability and risk minimisation, that the user should select his supplier with great care<sup>2</sup>.

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

*Paul Hartmann, 1885*

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

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# Tribute to Professor Donia Baldacchino

Marisa Vella

Professor Donia Baldacchino passed away earlier this year, leaving an unescapable void within the nursing profession. She was looked up to by a countless number of students, particularly nursing students as well as qualified nurses, and health professionals amongst others. Many of us have fond memories of Donia. She encouraged and supported all those who had the genuine desire to help and care for others. Her legacy is strong and all of us who knew her can honour the dedication, support and work she put into caring for others, by understanding a particular dimension she believed was essential in caring for others. We can do this by learning more about her work, and more importantly actively putting it into practice. I will be sharing here some highlights and reflections from encounters I had with Donia while discussing, teaching and sharing on a subject she held in such high regard.

Donia dedicated a notable amount of energy to understanding the impact of spirituality, particularly during the challenging times a person may encounter throughout their life. In extension to this, Donia also focused on the responsibility caregivers have on understanding spirituality and how to make this a central part in care giving. Spirituality can be viewed as the integration of the bio-psycho-social dimensions of a human life. Donia described spirituality as the strong will to live in all stages of life. Although this description may appear simplistic Donia identified with at least eight characteristics of spirituality. These are: -

## 1. BECOMING

This focuses on the experience of self-growth through positive

and negative life events. Illness can trigger a spiritual journey as it can be a humbling experience where one identifies priorities, creating a desire to reach something higher. The central aspect of becoming is developing an intra-personal relationship.

## 2. BELIEFS & VALUES

Through the spiritual journey one will seek to find answers. This may challenge the beliefs and values held for so long or strengthen them.

## 3. CONNECTEDNESS

The spiritual journey leads to understand what connects us within ourselves, with others, higher power as well as our surroundings.

## 4. DYNAMIC UNIFYING LIFE FORCE

This characteristic has two important aspects. First as a dynamic individual facing the challenges presented by life, to find meaning in our limitations while maintaining a strong will to live. Second, as an individual faced with adversity, seek to become a source of encouragement to others in a comparable situation.

## 5. POSITIVENESS IN LIFE

This is of particular significance during stressful events that can be harmful or challenging. The ability to count our blessings and consider what we take for granted is crucial here.

## 6. FINDING MEANING & PURPOSE IN LIFE

Discovering what meaning is given to the different circumstances and events in our life. For instance, what meaning is given to the process of dying?



## 7. SELF-TRANSCENDENCE

The experience of nothingness. The ability for one to go beyond the self to reach a higher place or power to gain strength and inner energy.

## 8. WHOLENESS

Identifying and living vital life principles that unite the body, mind and soul. Through becoming, we identify our priorities and give them importance accordingly. This could be family and friends, what makes you feel at peace and/or forgiving others who have hurt you.

Donia emphasised that caregivers have a duty to ensure that patients are encouraged and supported to take on the journey of spirituality. This journey helps patients to cope with the challenges they face in life, particularly illness, pain and death. Referring to Florence Nightingale, specifically "let the environment do no harm" Donia highlighted that as caregivers we have a duty to ensure that this does not happen when patients are under our care. As professionals, we can appreciate that the environment does not just refer to the physical aspects and aesthetics, but also to the compassion, care, and competence a patient can encounter in various settings. As professionals, how can we ensure that we are providing

spiritual care? Donia provided several examples on how professionals can integrate the bio-psycho-social dimension into care, ensuring that the environment does not cause harm. Perhaps the most important is the ability to be self-aware. Developing an intricate self-awareness will provide professionals with the right tools to develop an intra-personal relationship and helps to understand how you perceive the world. This is critical in view of the adversity witnessed by healthcare professionals, and enables them to deliver care with compassion.

Patients have a need to know who they can trust. The ability to understand the meaning behind a patient's actions and words is the skill of a compassionate and competent health professional. The reaction one has to pain and suffering should not be seen as something theoretical for instance. It should be viewed as an individual's reaction that indicates how the individual will cope with the experience. How prepared are you to deal with various reactions, particularly those that challenge you? The aspect of trust, security, the environment, life experiences and beliefs are essential in understanding the people we care for and the meaning of the experience they are living. When there is a trigger, such as illness or pain, an individual can change. This is something, that as professionals we must not only acknowledge and appreciate but also consider in all aspects of the care we give.

Donia identified the following areas as essential for implementing and learning more about spiritual care: -

1. The importance of learning in real life situations.
2. The use of appropriate reflective practice and journals, writing care plans that include spiritual interventions, group discussions, analysis of case studies, reading literature and analysing research.

3. Develop an awareness and overcome conditions that inhibit spiritual learning

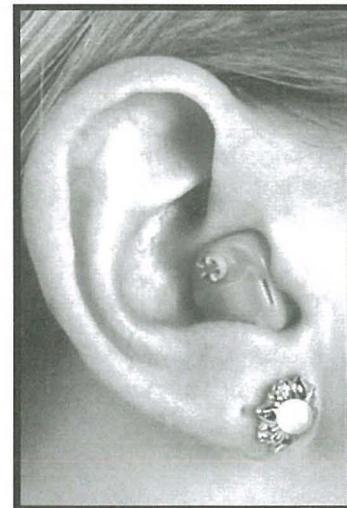
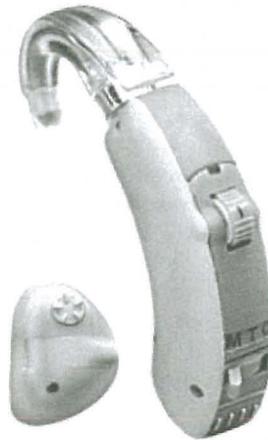
When delivering holistic care, the spiritual aspect is often overlooked. Donia identified distinct reasons for this, including feelings of incompetence on spiritual care; lack of training on the area of care; heavy workloads; time limitations; diverse cultures; lack of attention to personal spirituality; ethical issues as well as an unwillingness to deliver spiritual care.

The importance of spiritual care is supported by The International Council of Nurses (ICN) Code of Ethics, which specifies the nurse's role of promoting "an environment in which the human rights, values, customs and spiritual beliefs of the individual, family

and community are respected". The Maltese Code of Ethics for Nurses and Midwives supports this for nurses and midwives, stating that the nurse is to "recognize and respect the uniqueness of every patient's biological, psychological, social and spiritual status and needs". Florence Nightingale, perhaps the first leader of the nursing profession, ensured that spirituality was at the heart of nursing care, for both patients' and nurses themselves. Let us honour our own nursing leader, Professor Donia Baldacchino, by promoting the spiritual aspect of care with our patients. I augur that we continue to strive and ensure that spiritual care remains on the local agenda, now and in the future.

Thank you Donia.

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# Nurse shifts left unfilled at nearly every hospital in England, figures show

*Analysis of official data finds 96% of NHS hospital trusts had fewer nurses covering day shifts than they had planned*

Almost every hospital in England has fewer nurses on duty than each believes are needed to guarantee safe patient care, research shows.

Analysis of official data by the Health Service Journal (HSJ) found that 96% of NHS hospital trusts in England had fewer nurses covering day shifts in October than they had planned and 85% did not have the desired number working at night.

The disclosure of such widespread failure to ensure hospitals are properly staffed has prompted fresh concern that a chronic lack of nurses and the NHS's dire finances are putting patient safety at risk.

Nurse shortages have led to patients having to wait for medication, going unwashed or not having observations done on time, the HSJ said.

Janet Davies, the chief executive of the Royal College of Nursing, said: "This is yet more evidence that there are too few nurses caring for patients, putting people at serious risk. Safe staffing levels aren't an optional extra. Having the right number of nurses is essential to ensure that patients can recover properly."

The college estimates there are as many as 24,000 vacancies for nurses across the UK.

Nurses told the HSJ that understaffing meant hospitals were already providing substandard care, leading to patient safety "near misses".

The figures are the worst hospitals have recorded since they were obliged to start publishing details of staffing levels in 2013, in the wake of a report on the Mid Staffordshire care scandal.

The number of trusts that do not have planned numbers of staff at work has gone up despite the recruitment of record numbers of nurses by acute hospitals. Limits introduced in 2015 on the amount hospitals can pay to hire agency

nurses may help explain why staffing levels are dropping in many places.

One nurse said: "Sometimes observations get missed and I can recall many times where the patient is found to be deteriorating when they are eventually done. This gives you immense stress as you are left with the realisation you did not pick up on your patient's condition early enough to prevent an acute episode."

Another said: "I have seen patients not have proper care, dressings not changed, [and] not given the choice of shower or a wash as it takes more time that we do not have."

HSJ reached its conclusions by examining data on nurse staffing levels that trusts release through the NHS Choices website. These include the numbers present in general medical wards, maternity units, surgical wards and intensive care units at 214 acute hospitals.

In hospitals in England, a nurse is meant to look after no more than eight medical patients, and the ratio can be as low as one to one in neonatal and intensive care units.

The figures show that Dewsbury and district hospital in West Yorkshire had 75% of the number of nurses it had planned to have on duty last October, down from the 87% it managed in the first three months of 2015.

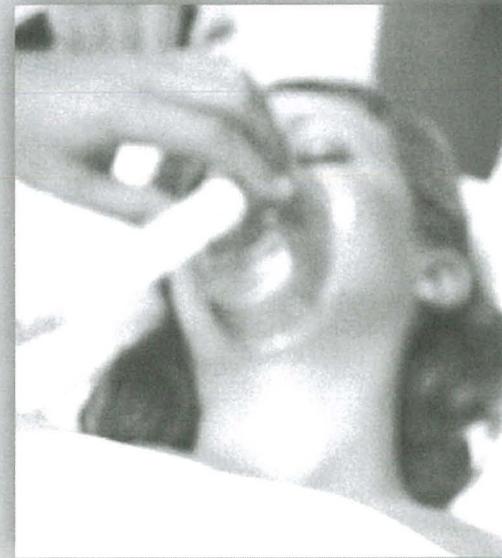
Princess Alexandra hospital in Harlow, Essex, which went into special measures that month, covered 77% of shifts, as did Pontefract general infirmary in West Yorkshire.

The HSJ found that some trusts were employing unusually high numbers of healthcare assistants. That may suggest they are replacing nurses with cheaper personnel who have little clinical training.

Prof Peter Griffiths, of Southampton University, a member of NHS Improvement's safe staffing committee for acute wards, said:

"This is clearly not a good place for the NHS to be and it isn't getting any better." He said healthcare assistants could help plug gaps but relying on them to deputise for nurses in the long term risked compromising patient safety and involved "the risk of a false reassurance".

The shadow health secretary, Jonathan Ashworth, said: "Tired, overworked nurses cannot be expected to continue providing the quality of care which patients need. The government needs to do much more to make sure nursing remains an attractive profession and to ensure hospitals can get in place the number of nurses they need to keep patients safe."



A Department of Health spokesman said: "We expect all parts of the NHS to make sure they have the right staff in the right place at the right time to provide safe care. That's why there are already almost 26,000 extra clinical staff, including almost 11,400 additional doctors and over 11,200 additional nurses on our wards since May 2010."



**Maltatoday - Miriam Dalli**  
**- 18th March 2017**

## Nurses still waiting for negotiations on new sectoral agreement

*A new sectoral agreement would address shortage of nurses, professional development, salary adjustment and health and safety issues*

**N**urses and midwives are still waiting for negotiations on a new sectoral agreement with the Health Department to start, the Malta Union of Midwives and Nurses said.

In a statement, the union's council said that a notice to the Health Department was sent over 15 days ago, but no reply has been forthcoming. The last agreement was signed four years ago.

According to the council, nurses and midwives in Malta and Gozo were "anxiously waiting" for the new agreement that would address shortage of nurses, professional development, salary adjustment and health and safety issues.

"MUMN Council is ready not to prolong these negotiations through weeks and weeks. On its first negotiating day it is going to be made crystal clear that MUMN expects that a schedule of weekly meetings needs to be agreed on a framework of maximum three months," it said.

It argued that such a schedule would lead to both parties knowing where they stand and take the necessary steps accordingly.

"MUMN Council has full support from the nurses and midwives who are constantly working in stressful and less favourably environment because of the shortage and the ever-increasing demands."

# “Depression... let’s talk”

*International Council of Nurses supports WHO’s World Health Day, campaign*



The International Council of Nurses (ICN) has joined the World Health Organization’s efforts to raise awareness on depression on the occasion of World Health Day.

One of ICN’s five priority areas, which will be extensively featured during ICN’s Congress in Barcelona, 27 May-1 June, mental health is a fundamental component of wellbeing and

governs and impacts all other aspects health. Any threat to its integrity can have wide reaching consequences, with mild to severe or even fatal outcomes.

According to Dr Frances Hughes, ICN’s Chief Executive Officer, “Mental health services must be integrated systematically into all health services, starting with primary care, and interventions should focus on support, not coercion, and be tailored to values and priorities of the individuals and their families”.

Depression is one of the most common forms of mental illnesses, recorded in every region of the globe and among all social classes; it is nevertheless still widely misunderstood. Often disregarded and stigmatized, mental health services are frequently under-funded. The last few years have witnessed

an alarming lack of specialist Mental Health Nurses --as well as a rise in institutional and political barriers preventing research and development, and contributing to an overall invisibilisation of the issues at stake.

These negative outcomes are often cumulative and in the worst cases, can contribute to the complete marginalization of those who already suffer, plunging them in a vicious cycle of poverty, homelessness, substance abuse and exposing them to violence and other correlative illnesses.

Nurses working with mental health consumers on a recovery-focused approach, tackling stigma and discrimination and addressing the social determinants of mental illness are crucial in carrying out effective prevention.

ICN/PR2017 #07

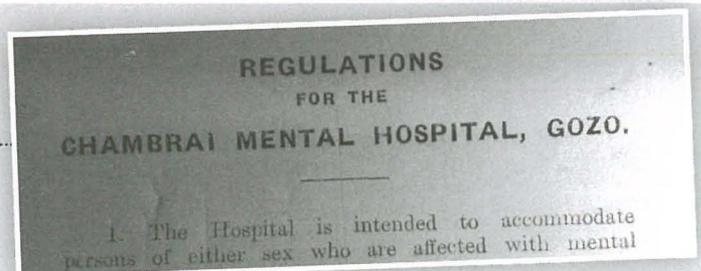
## Regulations for the Chambray Mental Hospital - Gozo

• continued from page 19

- The Nurses shall not absent themselves from their respective Division without leave.
- They shall escort the patients when they are taken out of the Hospital for exercise, etc.
- They shall not receive perquisites of any sort either from the patients or from their friends or relatives.
- They shall be subject to the same general regulations as the servants in Government Hospitals.
- No Nurse shall leave his post when his night duty is over until he has been relieved by another nurse. As a general rule, a muster of the patients shall be called when a nurse has been relieved.
- These regulations shall apply to nurses in the female division.

### PORTER

- The Porter, who is also the carpenter of the Hospital, shall have charge of the gate during the day.
- He shall not allow any patient or servant to leave the Hospital without an order from the Superintendent, and he shall allow no visitors to enter, except on the



- established visiting days without a written order from the Comptroller of the Charitable Institutions. He shall deliver the said order to the Superintendent.
- He shall count the patients when they leave the Hospital, and shall see that the same number return to the Institution.
- He shall note in the Attendance Book the time when the employees leave and return to the Hospital.
- He shall search the servants when they leave and return to the hospital.
- When not occupied in any of the above duties, he shall perform carpenter’s work.

### COOKS, SERVANTS, ETC

- The duties of the cook, servants, laundresses and other minor employees shall be the same as those laid down for the corresponding ranks in the Charitable Institutions.

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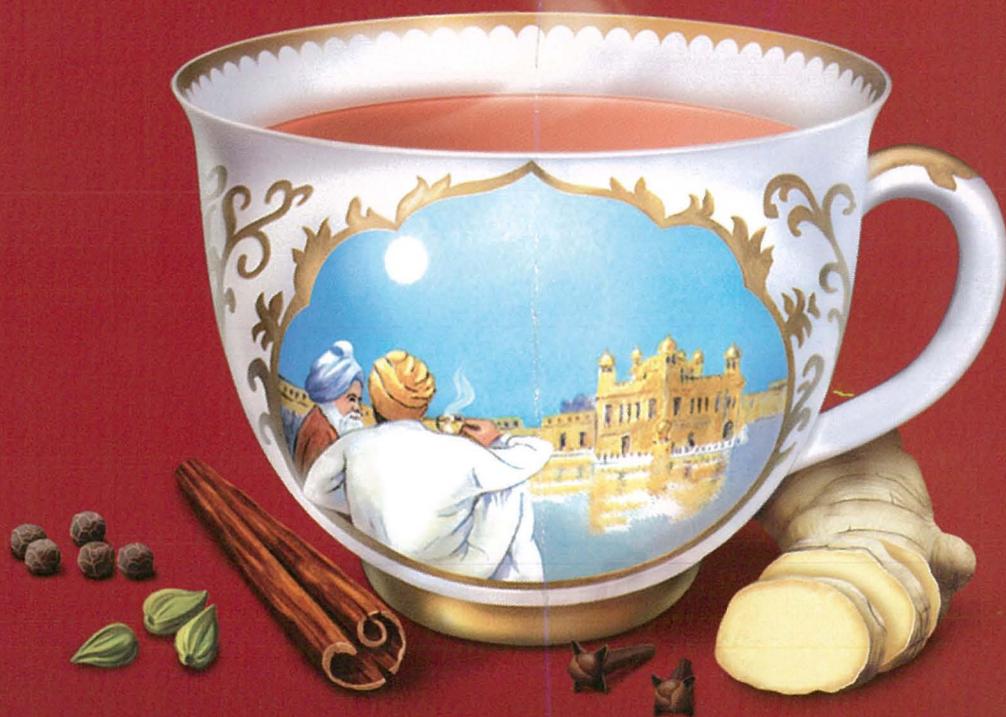
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