

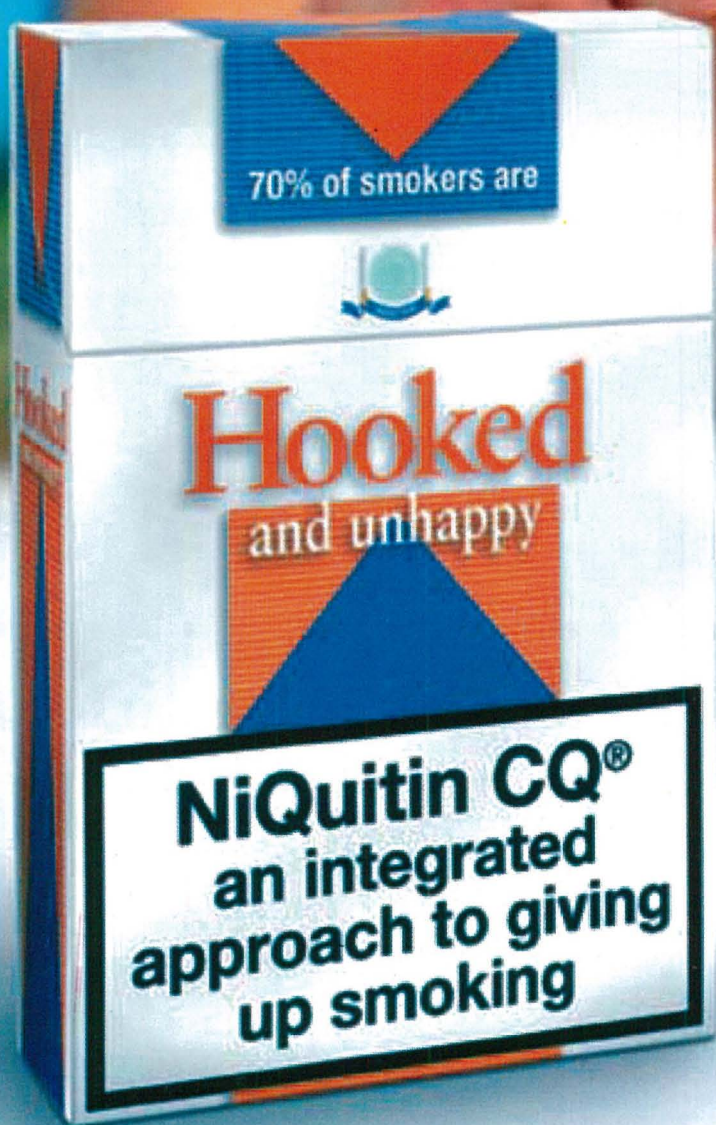
IL-MUSBIEH

MALTA NURSING AND MIDWIFERY JOURNAL

Nutrition and Wound Care

- Doctor dominance confine Nursing to an assistant role
- Psychiatry and Infection Control
- Epidural vs Non-Epidural
- European Networking
- The Waterlow Scale
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Fejn ser naslu?

Li kieku wiehed kellu jistaqsi lin-nurses u l-midwives, mistoqsija wahda dwar fejn iridu jaslu fil-karriera tagħhom, wisq nahseb li r-risposti jkunu ftit jew wisq l-istess. Hafna ma jafux fejn jistghu jaslu jew ahjar fejn iridu jaslu f'din il-karriera. Hawnhekk irridu nammettu li l-uniku mod ta, kif wiehed jista javvanza f'din il-karriera huwa billi tinvesti f'xi kors ta' management. Donnu dak biss huwa rikonoxxut bhala avvanz tal-karriera tagħna. Dan il-hsieb huwa f'mohh hafna nurses u midwives ukoll, bhallikieku biex inti titla, skaluna ohra trid tinza, l-uniformi tan nurse jew midwife, titlaq mis-sala fejn tkun qed tahdem u tmur go ufficiċju, u saħansitra tinsa' li int wara kollox għadek nurse jew midwife, għalkemm ir-rwol issa nbidel.

Ejja ma noqghodux ninhew wara t-titlu, jew l-ittri ta' wara isimna biex niġġustifikaw dak li qed naghmlu. L-ghan tal-karriera tagħna, huwa li nagħtu l-ahjar servizz lill-klijenti tagħna, tahdem f'liema posizzjoni tkun. Kulhadd huwa mportanti, mill-kbir saż-żghir u rridu nammettu li hadd m'ghandu jahseb li x-xogħol tiegħu mhux importanti. Hafna drabi dan li qed jiġri. Wiehed jipprova jgħattan lill-iehor. L-aqwa li nidher sewwa jien u haddiehor jiehu hsieb rasu hu. X'jimporta li bl-imġieba tiegħi incappas lil siehbi, x'jimporta jekk bin-nofs veritajiet li ngħid intellef opportunità, lil min kien haqqu, l-aqwa li jien sewwa. Din għandha tkun l-attitudni tagħna? Jekk ser naqdbu din it-triq huwa faċli hafna biex ngħidu fejn ser naslu. Qed inwasslu biex inkissru lilna nfusna bhala persuni u iżjed minn hekk inkunu qed nonqsu lil klijenti tagħna. Kif nista' jien ngħid lil xi klijent biex jafdani, jew kif jista' jemmini li ser naqbeż għalih meta jhoss li jien ma shabi naġixxi mod iehor. Din hija ipokresija kbira. Hadd ma jista' jagħti min dak li m'ghandux.

Nahseb li wasal iż-żmien li koll kemm ahna nharsu sew madwarna u napprezzaw kemm hawn nurses u midwives li għalkemm għadhom jahdmu fis-swali bl-uniformi normali ta' nurse u midwife dawn segwew b'suċċess korsijiet f'livelli universtarji u qed jużawhom kuljum fil-hidma tagħhom fi swali differenti. Forsi veru li xi korsijiet m'ghandhomx x'jaqsmu direttament mas-saħha, però, dak kollu li wiehed jitghallim jista' b'xi mod jew iehor jiġi utillizzat fix-xogħol tagħna. M'hemmx għalfejn inharsu lejn xulxin b'hars indifferenti. Jew ser nahdmu biex nutilizzaw dak kollu li nafu u naqsmuh ma l-ohrajn biex intejbu l-kura li qed nagħtu lill-klijenti tagħna jew nistghu nieqfu noholmu fuq *multidisciplinary teams* għax dawn ikunu biss aljenazzjoni. Kif nistghu ahna nippretendu li professjoni ohra tahdem id f'id magħna jekk ahna m'ahniex kapaċi naghmlu din il-biċċa xogħol bejnietna? Forsi qed nippruvaw ngħattu x-xemx bl-għarbiel? Nispera li le.

Li kieku wiehed jahseb ftit bis-serjetà jinduna li hemm lok fejn in-nurse u l-midwife jista' javvanza il-quddiem, u mhux ftit. X'qed iżommna milli nibdew? Hemm għalfejn inkissru 'l xulxin biex nitilghu xi skaluna ohra fil-karriera tagħna? X'qed iżommna milli nibdew?

Dawn huma xi mistoqsijiet li kull nurse u midwife għandha tahseb ftit fuqhom, u għandna naġixxu u nibdew naghmlu xi haġa biex minflok ingergru nibdew insaħhu dak kollu li suppost nemmnu fih; il-kura tal-klijenti tagħna. Mhux darba jew tnejn li fl-editorjali tagħna semmejna li l-pazjent ma jimpurtahx mill-ittri ta' wara isimna jekk dawn ma jkunux isarrfu f'kura ahjar. Għaliex inhallu lil min jgħid li ahna qed nitilfu l-*bedside nursing*, u dan minhabba li xi whud hasbu li għax akkwistaw iżjed għerf issa m'ghandhomx unur li jahdmu daqshekk viċin tal-klijenti tagħna.

Fejn qegħdin nafu... però nafu verament fejn irridu naslu...?



Il-Bord Editorjali ta' "IL-MUSBIEH"
flimkien mal-Kunsill ta' l-MUMN
jixtiequ lill-Membri kollha u l-familji
tagħhom

Milied Fieni u Sena Gdida

mimlija Risq u Saħħa

message from the president

Dear Members

Jovial time is once again with us and this is the one time of the year where all streets are lit with colourful bulbs and people are roaming around in shops to buy presents for their loved ones. This is the time when we are all living an illusion of feeling good. Mind you the very really reason to be jovial is the birth of Jesus Christ, but are we really aware that this is the real reason? It seems that during this time of the year we try to make ourselves believe that we are all happy, loving each other and above all healthy. The truth is that this is not so, we Nurses and Midwives know perfectly well the other side of the coin. We are constantly giving care to our patients all year round irrespective the season. No one shall argue that during this season there will be patients in wards suffering pain, undergoing therapy or giving birth, patients of all ages and coming from all strata of society. Nurses and Midwives will not be carried away by any illusion, they know the reality and they shall be there for the patients. Our hospitals and our health care services will not close on Christmas day or during this season. Nurses and Midwives are there all year round each and every second. Our care is not only constant but the methods are also evolving and changing dimension constantly. This ongoing change is needed to improve and update the role of our professions to be in line with changes that are happening in developed countries. Today Nurses and Midwives are following specialisation course and are becoming the experts' in particular fields. Nurses and Midwives are consulting one another in the way they deliver care. This means that our professions are gaining more autonomy. We are evolving but we need to need to make sure that this evolution will not take us away from our roots. We must make sure that we do not get distant from our patients. We must be near our patients giving them the best possible care, irrespective the age, race, religion, gender and the season of the year. Nurses and Midwives must strive to encourage this momentum to increase the academic levels but we must blend this development with our tradition, the bedside care. This is the way that can make our public image improve. Unfortunately we are still being considered as assistants to the Doctors. A perception that is completely wrong, but how are we Nurses and Midwives helping to make a change of this perception. We have the responsibility to make a change and only if we start to believe in oneself and our potential we make this change truly happen. No one is going to help us out, we must do it ourselves, and we need to act and present ourselves as professionals. We must see that we continue to update ourselves and continue to develop professionally, attend conferences and subscribe to journals that update us with new ways of delivering care.

MUMN is doing its utmost to encourage this type of mentality. The continuing professional development agreed with the health division must be a motivation and I encourage you all to grab this opportunity when hopefully it comes available next year. These are the changes that we need to take advantage of so that we shall earn our due respect and society will realise that Nurses and Midwives are professional people and they are needed to be there at all times. No matter if its Christmas time, Nurses and Midwives are there for all society and we must be proud that our presence can make a difference.

I wish all of you and your family the best and wish you all a Merry Christmas, and augur that next year we will overcome all obstacles that may come our way.

kelmtejn mis-segretarju ġenerali

Gejjen fuqna żminijiet diffiċli. Irċivejna l-ewwel dokument dwar l-awtonomija u l-affarjiet xejn ma jidhru sbieħ! Veru li għad iridu jsiru diversi laqgħat u diskussjonijiet iżda x-xemx minn filgħodu turik. Kif dejjem sostnenjna l-MUMN ser tkun it-tarka tan-Nurses u l-Midwives kollha. Nisperaw li s-sens komun jipprevadi.

L-istess sitwazzjoni qed tirrenja fid-diskussjonijiet tal-Ftehim Settorali fl-Ufficcju tal-Prim Ministru. Veru li lhaqna Ftehim fuq l-iSpecialisations, Assistenti Diretturi u dwar il-Life Long Learning Allowance iżda għad baqgħa żewġ punti kruċjali, wieħed aktar mill-ieħor. Fuq l-iskali għaddejjen diskussjonijiet diffiċli iżda fuq l-Early Retirement, il-Gvern qed iżomm iebes u ma tantx aħna ottimisti li jista' jintlaħaq ftehim fuq il-mejda.

Punt pożittiv huwa dwar l-uniformijiet. Wara li konna deħlin f' battalja legali kien hemm żblokk li permezz tiegħu n-Nurses u l-Midwives ser igawdu minnu. Intlaħaq Ftehim li fl-1 ta' Mejju, 2005 ser ikollna uniformijiet ġodda b' mod radikali, kemm fil-kulur kif ukoll fl-istil. L-istil ser ikun dak bħal tal- Operating Theaters, filwaqt li l-kulur abjad ser jispicċa sabiex inkunu nistgħu naddottaw drapp aktar hafif mingħajr ma jkun trasparenti: tal-Midwives ser ikun turquoise; tal-iStaff Nurses celesti; filwaqt li l-Enrolled Nurses kulur mint. In-Nursing Officers u Deputies se jżommu l-istess kuluri pero', bħal kulhadd, il-qalziet ser ikollu l-istess kulur tat-tunic. Naf li dawn huma l-uniformijiet li dejjem xtaqna għal diversi raġunijiet u fl-aħħar irnexxielna. Sal-1 ta' Mejju ser inkomplu nilbsu l-uniformi l-bajda.

Aħbar oħra pożittiva hija li fl-aħħar il-Unions kollha f'pajjiżna qed jirrikonoxxu l-importanza li jiġi ffurmat it-Trade Union Council sabiex is-saħħa ta' l-istess Unions tiżdied fl-interess tal-membri kollha li nirrapreżentaw. Prosit tmur lil Workers' Participation Development Center, fl-Universita' ta' Malta li qatt ma qatgħu qalbhom minn din l-inizjattiva.

Il-Kunsill tal-Union iddeċieda li jniedi in-Nurse Annual Award u l-Midwives Annual Award sabiex jiġi rikonoxxut dak il-kontribut siewi li jsir. L-E.T. il-Professor Guido DeMarco aċċetta li jkun iċ-Chairperson tal-Kumitat li jagħzel minn fost in-nominazzjonijiet, dik il-Midwife u n-Nurse li tiddistingwixxi ruhha minn shabha. Aktar tagħrif jinstab fil-formola apposta f' dan l-istess ġurnal.

Nappella lil kulhadd sabiex inżommu kuntatt mad-diversi Rappreżentanti tal-Union f' kull Sptar jew Health Centre partikolari għaliex aktar minn qatt qabel irridu nkunu magħquda u attenti għall-avviżi li l-MUMN ser tagħti minn żmien għall-ieħor.

Ma nistax ma nispiċċax dawn il-kelmtejn mingħajr ma nawguralkom festi tal-Milied sbieħ u feliċi mimlija saħħa u paci. Nitolbu 'l Alla li s-sena li gejjja fuqna tkun aħjar minn din li qegħdin fiha!

Sehibkom,

COLIN GALEA
Segretarju

TRUE OR FALSE QUESTION!

(Part 2)

MARIANNE BUGEJA, BSc (Hons) Nursing, Dip. Gerontology
Financial Secretary, MUMN

What resources are required for the Primary Health Care Services to be delivered effectively and efficiently?

A policy-based framework for sustained improvement is presented, based on four principles namely: -

- ✓ Improve utilisation of nurses
- ✓ Adequate physical resources
- ✓ Adequate financial resources
- ✓ Adequate time

The doctor dominance confines Nursing to an assistant role

Improve utilisation of nurses

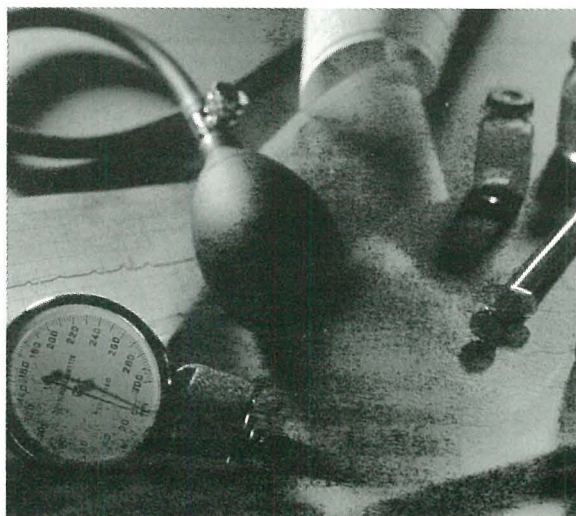
The developments and strengthening of the PHC services that is delivered at different level (Health Centers, *Beref* and Local Councils, Home Care, Schools and Workplaces) demands a widening of nursing responsibilities and the adoption of new methods of service delivery of working. Furthermore, PHC requires a knowledge and skill set which is qualitatively different than that required for the management of illness and injury.

A comprehensive PHC service with nursing as its centre will be able to make a real difference to the health of those who are living in poverty and are socially and economically disadvantaged. If nurses are to be in a position to take on these activities, they need to be adequately trained and educated in the fields of needs assessments, health promotion, community development and working in

partnership with other sectors and professional groups. Working in this way requires nurses to have greater autonomy and responsibility not only for individual patients but also for improving the health of the whole community, targeting their services at those in greatest need and carrying out interventions that are known to be effective in improving the health of the most disadvantaged. If PHC Nursing in Malta is developed in various areas of responsibility, accountability, decision-making and give a stronger role, our health services are more likely to reach the WHO targets for Health for All in the 21st century.

Only by raising the standard of education for nurses by organising professional training, ongoing education and specialisation opportunities for nurses would have an impact and improve the care that they provide.

This can only be achieved by the introduction and development of two new nursing services namely Family Health Nurse (FHN) and Nurse Practitioner (NP) through the competence of the PHC Nurse Practice Development.



Adequate physical resources

The availability of limited physical resources can be a barrier for the health professionals to provide an effective and efficient care. For instance FHN will need transport and good communication network such as telephones and computer in order to be more flexible and more accessible to the community and other health care professionals. Another inevitable need is to have an adequate physical workspace such as making a better use of the local *beref* and local councils.

Adequate financial resources

Unfortunately, PHC remains the Cinderella of the Health Services as huge financial resources are allocated for the development of secondary/tertiary care in Malta. In order to have a healthier society thus lessen the demands of hospitalisations depends highly on the shift of Health Care budget allocation from secondary/tertiary to primary approach. Thus health care reforms need to invest more in health preventive and promotive activities rather than curative measures.

Health Care is labour intensive. Staffing costs are a major focus of PHC reforms, especially as more human resources are requisite to strengthen and develop the PHC. There is a tendency for staffing to be regarded as part of the 'problem' of cost containment, and staffing costs are often a major focus of health sector reforms. It is more appropriate to regard staffing in general and nurses in particular as part of the solution to improving quality, access and cost of care. A well-motivated, well-educated and adequately resourced workforce will be key to the success of health care delivery changes. Thus funding the development of new programs to prepare nurses for the advancement of nurses' roles is a must. Also, the labour intensity of health care requires that available staffing resources are recruited, retained and deployed effectively.

There should be minimum bureaucratic and administrative

costs and the team should be accountable to their own consumers and local community. Thus the staff will be more aware of the cost of their direct behaviours and decision-making about the plan of care as they are kept accountable and responsible for their own actions.

Adequate time

For instance, this strategy will evolve over the next 4–11 years. In this strategy there will be flexibility about how new initiatives develop and tolerance of short-term teething problems. Key priorities for early action are for instance: an needs assessment project, the development of comprehensive workforce planning strategies to ensure adequate numbers of well-educated nurses/midwives and improving initial and continuing education and access to higher nursing education such as Family Health Nurse. Complementary with the short-term strategies there can also be long-term strategies, such as enabling nurses to work efficiently and effectively to their full potential, both as independent and interdependent professionals.

Cost-Benefit analysis of the proposed Primary Health Care delivery System

Benefits

Various benefits can be attained if the PHC is strengthened, for instance by health promotion and disease prevention services at community level, together with the home based care delivery service to certain patients such as cancer patients, prevent or reduce the number of referrals to the acute hospitals by the collaboration of the FHN and GP thus reducing also the number of inpatients. Hence,

- Reducing the waiting lists at the outpatient department or at E&A

department. Dr. Deguara (1995) stressed that 80% of the people using A&E Dept. and Outpatients services at St Luke's can easily be served at the Health Centers (The Times, 1995).

- Reduce the overcrowding of patients in the acute wards
- Less hardship and anxiety for the patient, relatives and staff
- Reducing the risk of hospital induced infections
- It is a more cost effective service delivery so funds can be allocated for the introduction of other new services: Keeping a patient at St Luke's costs Lm 85 per day or Lm 31,025 per year (The Times, 2001).
- Reduce the morbidity and mortality rate due to healthier population.
- Ensure a higher quality of service
- Reducing the barriers, particularly financial barriers, for the groups with greatest health need both in terms of additional services to improve health, and to improve access to first-contact services.
- Lead to earlier productive normal life within the community

Cost

- Introduction of these innovations to health care on a short-term basis can be expensive, however when analysed on long term basis the outcomes are more positive
- Any changes creates resistance in any individuals however by adequate information and involvement of personnel in decision-making, resistance is minimised.
- Doctor dominance confine Nursing to an assistant role and frequently precludes collaboration and the appropriate utilisation of nurses. The potential of Nursing in the community is often considered a role that is little more than assistance with primary medical care. However by improving the

Nursing professional and enhancing the concept of multidisciplinary teamwork approach in order to have a successful PHC this mentality can be diminished.

Conclusion

A lot is being preached about solidarity however one must keep in mind that the ultimate responsibility is that of the Government being a nationalist or socialists or any other party, does not make a difference. The difference will be if the Government in power is seeing the development and strengthening of the Maltese Primary Health Care System as a priority or not in its Health Care Reforms. Now dear colleagues you are in position to tell me if a comment like this is true or false - *"In Our Primary Health Care System there is an over supply of Nurses"*. Personally I feel that by better skill mix or utilisation of Nurses within the Primary Health Care System, together with better Nursing professional career opportunities within the Primary Health Care System, a quality PHC will be achieved therefore leading to a healthier Maltese society.

NB. The term nurse reflects as well midwife but it also depends according to working practice.

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Dr. Deguara (1995) stressed that 80% of the people using A&E Dept. and Outpatients services at St Luke's can easily be served at the Health Centres (The Times, 1995).

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Donation mostly appreciated by SCBU children

er and Child Company", has donated a pram and pushchair (Unit) for their patients' needs. Both pram and pushchair children who need to undergo investigations that have to be St.Luke's Hospital.

and hand in hand to choose a specific pram/pushchair model, ideal and appropriate for the ward's needs. Milupa specialises in infant feeding to guarantee the well being of newborns right up to toddler age. This is the reason why it felt the need to make this contribution.

Milupa wishes to congratulate SCBU staff for their hard work, dedication towards their patients and the support they show towards the parents of these less fortunate children. Well done for the team work and keep up the good work!

Llara Abela Scolaro B.Pharm.(Hons.)
Milupa Medical Representative

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Bottlenose Dolphin (*Tursiops truncatus*) *Id-Denfil geddumu qasir.*
The Bottlenose Dolphin is one of the three most common marine mammals recorded in Maltese territorial waters. It is protected by local legislation and by regional and international nature protection conventions because it is endangered.

Nutrition and Wound Care

GEOFFREY AXIAQ

B. Sc (Nursing), S.R.N., Dip. R&C.
Hypnotherapy (T.O.R.C.H.),
P.G.Dip. (Nutrition & Dietetics)

Nutritional status plays an essential role in the prevention and treatment of wounds. The body requires energy, protein, and micronutrients for optimal wound healing. It is well documented that malnutrition is associated with slower postoperative healing and increased complications.

Good nutritional status prior to surgery can enhance wound healing and minimise complications. Malnutrition is associated with higher morbidity and mortality rates compared with well-nourished patients. As well, poor nutritional intake increases the risk of developing pressure ulcers. Energy, protein, vitamins A, C and E, and the mineral zinc all have an effect on wound healing. There are three stages of wound healing:

- **the inflammatory stage (resolution),**
- **the proliferation stage (sloughing)**
- **the remodelling stage (repair)**

Each of these stages requires adequate intake of energy, protein, and specific vitamins and minerals for tissue repair. Otherwise, healing may be prolonged or disrupted.

It is well documented that malnutrition is associated with slower postoperative healing and increased complications.

Energy and protein

An adequate intake of energy and protein is required for tissue repair. Adequate caloric intake is essential for cellular growth and leukocyte functioning. When insufficient calories are taken, the body resorts to skeletal and visceral protein as its source for energy. Protein is required for fibroblast proliferation, collagen and proteoglycan synthesis and wound remodelling. Inadequate protein intake can deplete lean tissue, reduce circulating proteins and increase risk

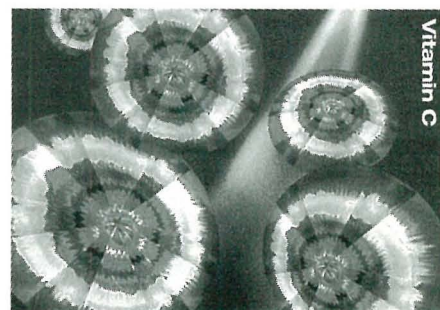
of infection. In addition, the inflammatory and wound remodelling stages of wound healing are lengthened as a result of protein malnutrition. When energy and protein intake are low, patients in hospital and in the community are at greater risk of developing pressure ulcers. Hypoalbuminemia reflects the body's protein losses and is a risk factor for developing pressure ulcers. Protein-calorie malnutrition may also cause anaemia. Anaemia may promote ulcer formation and delay wound healing by impairing oxygen delivery to tissues. It should be noted that one of the indicators of protein malnutrition is peripheral oedema. However, the associated swelling may lead to protein malnutrition being overlooked. Practitioners must be alert to the possibility of protein malnutrition notwithstanding the absence of a gaunt, wasted appearance of the patient. Preoperative protein supplementation has been shown to be more effective than postoperative supplementation to improve wound healing when patients are protein malnourished. In a healthy adult person, the normal needs are approximately 25-35 Calories/kg and 0.8-1.0 g protein/kg. Patients with pressure ulcers and other stress factors have increased calorie and protein requirements. Recommendations for protein in the treatment of pressure ulcers are 1.25-1.5 g/kg/d up to 2.0 g/kg for positive nitrogen balance, collagen synthesis and for visceral protein needs. Caloric needs may be as high as 40 Cal/kg/d.

Vitamin A

Vitamin A is involved in the normal epidermis and synthesis of glycoproteins during the inflammatory process of healing and fibroblast differentiation, as well as collagen deposition during the proliferation stage. Vitamin A deficiency delays collagen synthesis, which in turn delays wound healing and increases susceptibility of infection. Patients with chronic leg ulcers have shown to have decreased serum levels of vitamin A and carotenes (vitamin A precursor). Vitamin A deficiency is common in hospitalised patients, especially in those that are severely injured or burned. Good sources of vitamin A include liver, egg yolk, dairy, dark green and yellow vegetables and yellow and orange fruits. Vitamin A supplementation aids in reversing impaired wound healing. Supplementation for seven days post-surgery improves collagen synthesis and scar strength.

Vitamin C

Vitamin C is an essential component of the amino acids, lysine and proline in collagen synthesis and is therefore essential for wound healing. Vitamin C also helps leukocyte transport to wounds, increasing infection



Vitamin C

resistance. Adequate nutritional intake and vitamin C and zinc intake have been associated with improvement in the stage and size of pressure ulcers. Vitamin C depletion is associated with the formation of pressure ulcers, while vitamin C deficiency can lead to the breakdown of wounds that have already healed. Vitamin C requirements are higher for smokers and for burns, fractures and surgery. Vitamin C supplementation accelerates collagen synthesis, helping in the treatment of leg ulcers and other wounds. Vitamin C should be supplemented in severely ill patients by 1-2 mg/d. Large doses of vitamin C can cause complications including the formation of oxalate stones which may lead to kidney failure. Supplementation must be carefully monitored.

Zinc

Zinc is essential in the wound healing process, as it is a component of hundreds of enzymes, including those involved in collagen synthesis and cell proliferation. Zinc deficiency is linked with delayed healing of wounds and ulcers and lower breaking strength on incisions. It also weakens the immune system, causing lymphocytopenia. Zinc is one of the most common micronutrients taken in inadequate amounts. This is especially true in women, the elderly and in lower income households. Zinc is found mainly in beef, pork, dark poultry, shellfish, dairy and beans, which are high in protein but often expensive, this may be why both protein and zinc are often found low simultaneously. Zinc deficiency occurs in many populations, including people with increased metabolism, diabetes, high gastrointestinal losses, malabsorption and malnutrition.

Medications that are chelating agents and diuretics may also cause zinc deficiency. Zinc deficiency may cause decreased taste sensation, further limiting nutritional intake. Preoperative zinc supplementation improves healing in deficient patients, and is more effective than postoperative supplementation. Adequate zinc intake has been also associated with improvement in the stage and size of pressure ulcers. Recommended dosage for zinc

supplementation is 25-50 mg elemental zinc/d (110-220 mg zinc sulphate). Zinc supplementation may have its adverse effects. Excess zinc (> 100 mg elemental zinc) may negatively affect immune response and lipid profiles. Zinc supplementation may also result in copper deficiency due to competitive absorption in the small intestine. Zinc should therefore only be supplemented in the recommended levels for a specified duration, e.g. two – three months, then stopped for four – six weeks. High levels of zinc have also been known to cause nausea and vomiting. Consequently, zinc should be taken with meals to

minimise side effects. Note that iron supplements may decrease zinc absorption and should therefore be taken between meals, not with meals.

Vitamin E

Patients with chronic leg ulcers have shown to decrease serum levels of vitamin E. Vitamin E's role in wound healing, however, is controversial and not completely understood. Vitamin E does seem to have an anti-inflammatory response and an immune enhancing effect, increasing antibody production. Vitamin E has been shown to improve wound healing in some studies. In animal studies, vitamin E supplementation may impair wound healing while in other studies it has been shown to increase healing rates in some patients with leg ulcers.

Summary

Patients with wounds have increased Calorie and protein requirements and may also benefit from supplementation of specific vitamin and minerals to help improve the healing process. People with the noted deficiencies may also have other risk factors for malnutrition such as decreased intake, limited mobility and access to food, taste changes, swallowing and chewing difficulty. Chronic leg ulcers have a significant impact on mobility and therefore food accessibility. Oral supplements can increase the Calorie and protein intake of patients. Nutritional supplements with protein, energy, and micronutrients may help prevent the development of pressure ulcers in high-risk individuals. A special supplement, such as Ensure HP, is a good source of nutrition for people with high protein needs. It contains 225 Calories per can with 21% of total energy coming from protein. Ensure Plus contains 355 Calories per can with 15% of total energy coming from protein, useful for people needing extra Calories and protein in a limited volume. Both contain 25% of the recommended daily vitamin and mineral intake per can. It is important to remember that wounds, nutrient deficiencies and other medical problems should be diagnosed by a physician and treated on their advice.

NUTRITION REQUIREMENTS

Nutrient Healthy individuals

Increased requirements

Energy 25-30 Calories/kg/d
30 Calories/kg/d stage I and II ulcers
35-40 Calories/kg/d stage III & IV ulcers, burns

Protein 0.8-1.0 g/kg/d 1.0-2 g/kg/d
varying with level of ulcer or injury

Vitamin A 800-1000 IU/d 5000 IU/d

Vitamin C 30-40 mg/d 100-1000 mg/d post-op

500-1500 mg/d burns

Vitamin E 6-9 mg/d

No recommendations

Zinc 9-12 mg/d 25-50 mg/d
for 3 months

THE ROLE OF NUTRIENTS IN WOUND HEALING

Protein	Tissue formation Collagen synthesis Wound remodelling Immune support
Vitamin A	Collagen synthesis Epithelialisation Immune support
Vitamin C	Collagen synthesis Antioxidant Immune support Capillary integrity
Vitamin E	Antioxidant
Zinc	Collagen synthesis Protein synthesis

Messaġġ miċ-Chairperson tal-Entertainment and Cultural Committee

Hbieb tiegħi,

Huwa ta' sofisfazzjon kbir għalija li nikteb f' dan il-ġurnal li minn żmien għal żmien jaġġorna lill-infermiera u qwiebel b' dak kollu li jkun għaddej.

Din is-sena organizzajna diversi attivitajiet - bdejna bin-Nurses Day li ċċelebrajna fit-12 ta' Mejju, fejn gattajna ġurnata divertiment flimkien.

Il-Gmix Summer Party kien attività' ohra mmirata għal generazzjoni żgħażuġha fejn intlaqgħet tajjeb ukoll.

Il-League tal-Football tas-Sajf għal darb' ohra kien ta' suċċess.

Il-BarBQ li organizzajna f' Awissu ġewwa l-Grand Hotel Mercure San Antonio kien wiehed sofisfaċeti, f' 'ambjent saffi, b'ikel u xorb mill-aħjar u b' ammonti ta' 'sponsors' fenomenali.

Issa l-attività' li jmiss hi l-Banquet tal-Milied li se jsir nhar il-Ġimgħa 17 ta' Diċembru ġewwa r-Razzett tal-Hbiberija fejn ahna herqana li nerġġhu nistennu l-appoġġ tagħkom ukoll.

Għas-snin il-ġejjin bi hsiebna ntellghu aktar minn dawn l-attivitajiet fejn barra li niltaqgħu l-bogħod mill-ambjent tax-xogħol tagħna, inkunu nistgħu naqsmu l-idejat tagħna b' mod amikevoli u f' ambjent pjaċevoli.

Nirringrazzja lil shabi kollha tal-Group Committee għax-xogħol siewi flimkien li qed naghmlu. L-appell tal-aħhar hu li nhegħu aktar voluntiera biex jghinuna f' attivitajiet li ahna ntellghu minn żmien għal żmien.

Nirringrazzja lill-Membri tal-Kunsill tal-Union u l-Membri tal-Eżekuttiv Social & Cultural Committee ta' l-appoġġ li dejjem urew magħna. Fl-aħhar iżda mhux l-anqas lill-isponsors u agenti tal-hwienet li dejjem lesti jghinuna. Niehu l-opportunità' nirringrazzja lil Ms.Lora Pullicino tal-paċenzja kbira li tiehu bina.

SIMON VELLA

Validation of A&D UA-767 device for the self-measurement of blood pressure

A&D Medical is proud to announce that their best selling automatic blood pressure monitor, UA-767 has been clinically validated with the highest grade possible. The validation paper was recently published in the October issue of Blood Pressure Monitoring.

In the article, doctors, Rogoza, Pavlova and Serveeva concluded:

"For an adult population, the A&D UA-767 device for the self-measurement of blood pressure satisfies the AAMI criteria, achieved a BHS grade of A/A and can therefore be recommended for monitoring blood pressure in home and clinical conditions"

(Blood Pressure Monitoring 5:227-231 © 2000 Lippincott Williams & Wilkins)

AAMI: Association for Advancement of Medical Instrumentation.

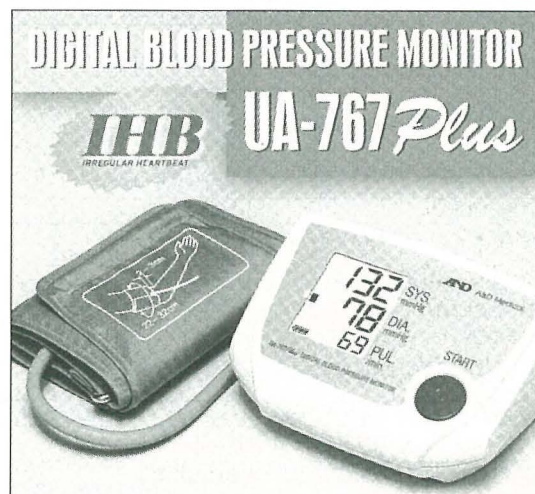
BHS: British Hypertension Society

Given the success with professional ambulatory blood pressure monitors, A&D has been a trusted name for over 20 years. The UA-767 has been widely used and appreciated by many medical professionals as well as general public around the world even before this excellent validation result was published.

This successful clinical test result and validation granted to UA-767 is confirmation of the decisions made by millions of satisfied users who own UA-767.

This validation also vindicates the reliability of the entire range of the UA-767 family products. The ingenuity and innovation of our R&D engineers created unique and thoughtful products.

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Pressure Sore Prevention

CORINNE SCICLUNA

SLH Tissue Viability & Wound Care Services

■ corinne.scicluna@gov.mt



Pressure sores are costly, painful, take a long time to heal and in addition, impede the individual from living a normal life. As we all know, prevention is better than cure, and on many an occasion, we can prevent and/or delay their formation.

One way of preventing pressure sores is by providing the patient with a propad overlay. This has to be done as soon as the person is admitted to hospital. When the patient is, for example, a patient with chronic illness in an old peoples' residence, and his/her general condition starts deteriorating (i.e. an acute on chronic condition, such as, pneumonia), then it is the nurse's responsibility to provide the patient immediately with a thorough assessment and with a propad.

When do we know when to provide a patient with a propad? To help assist the nurse in assessing patients for pressure sores there is the Waterlow Scoring System. This tool is being used by the Tissue Viability Clinic to assist patients who are "at risk", "at high risk" and "at very high risk". Ideally we would use a propad for "at risk" patients, a pressure-relieving air mattress overlay for "at high risk" patients and a pressure-relieving air mattress for "at very high risk" patients. Below find the Waterlow Scoring System to assess patients who are at risk of developing pressure sores. Also find the pressure sore classification, prevention and nursing care.

If you desire further information please contact us on telephone St. Luke's Hospital extension number (2595) 2053 or on 21223951 when phoning from outside St. Luke's Hospital.

WATERLOW PRESSURE SORE PREVENTION / TREATMENT POLICY
CIRCLE SCORES IN TABLE, ADD TOTAL. SEVERAL SCORES PER CATEGORY CAN BE USED.

BUILD / WEIGHT FOR HEIGHT		SKIN TYPE VISUAL RISK AREAS		SEX AGE		SPECIAL RISKS	
AVERAGE	0	HEALTHY	0	MALE	1	TISSUE MALNUTRITION	
ABOVE AVERAGE	1	TISSUE PAPER	1	FEMALE	2	TERMINAL CACHEXIA	8
OBESE	2	DRY	1	14 - 49	1	CARDIAC FAILURE	5
BELOW AVERAGE	3	OEDEMATOUS	1	50 - 64	2	PERIPHERAL	
		CLAMMY (TEMP ↓)	1	65 - 74	3	VASCULAR DISEASE	5
		DISCOLOURED	2	75 - 80	4	ANAEMIA	2
		BROKEN / SPOT	3	81 +	5	SMOKING	1
CONTINENCE		MOBILITY		APPETITE		NEUROLOGICAL DEFICIT	
COMPLETE / CATHETERISED	0	FULLY	0	AVERAGE	0	DIABETES, M.S., C.V.A.	
OCCASION. INCONT	1	RESTLESS / FIDGETY	1	POOR	1	MOTOR SENSORY PARAPLEGIA	4-6
CATH / INCONT OF FAECES	2	APATHETIC	2	N.G. TUBE / FLUIDS ONLY	2	MAJOR SURGERY / TRAUMA	
DOUBLE INCONT.	3	INERT / TRACTION	4	NBM / ANOREXIC	3	ORTHOPAEDIC: BELOW WAIST, SPINAL, ON TABLE > 2 HOURS	5
		CHAIRBOUND	5				5
SCORE		10+ AT RISK		15+ HIGH RISK		20+ VERY HIGH RISK	
						MEDICATION	
						CYTOTOXICS	4
						HIGH DOSE STEROIDS	
						ANTHINFLAMMATORY	

For further information about the Waterlow Scale, please contact Judy Waterlow at: 'Newtons', Curland, Taunton, Somerset. TA3 5SG.

© J WATERLOW 1991 Revised May 1995

Psychiatry and Infection Control

Psychiatric facilities are no exception and should ensure that no transmission of infection occurs from patient to patient, patient to staff or staff to patient.

STEPHEN DEMICOLI (RMN)

MUMN Council Member
V/Chair Industrial Executive Committee
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Is there a need for infection control measures in psychiatric settings?

In line with Hippocrates' (460-355BC) famous statement that "hospitals should first do the sick no harm", it follows that health carers in any clinical setting are responsible for preventing and controlling the spread of infections, thus protecting both their patients as well as their colleagues. Though the incidence of, and number of patients suffering from infective diseases in psychiatric settings may be lower than that expected in a general hospital setting, the risk for spread of infection is still there and the institution still has the responsibility to prevent it (American Psychiatric Association, 1991).

The term **infection** was defined as "the invasion of the body by pathogenic microorganisms that produce and multiply, causing disease by local cellular injury, secretion of a toxin, or antigen-antibody reaction in the host." The term **infection control** was defined as "the policies and procedures of a hospital or other health facility to minimize the risk of spreading of nosocomial or community-acquired infections to patients or members of staff." The term **psychiatric** is taken to mean, "pertaining to the branch of medical science that deals with the causes, treatment, and prevention of mental, emotional, and behavioural disorders." (Mosby's dictionary, 1998) In view of these definitions, infection control issues in the psychiatric setting involve that behaviour which the nurse caring for a patient with a psychiatric problem is bound to carry out in order to minimise the spread of infection.

Literature regarding infection control in the psychiatric settings is very scarce, and mainly consisted of a very small number of policies and studies, often focussing only on specific infections such as HIV or Tuberculosis. This was also confirmed in the University of Texas Medical Branch (UTMB) infection control policy for psychiatric units (2003), who referred to absence

of any 'standard definitions', for infection control in behavioural health settings. Fleischman & Olmsted (1998) also agreed with UTMB that no published, validated definitions were available.

According to Stead (1989), places where people are housed together for extended periods present a risk to spread of nosocomial infections. He went on that authorities operating such facilities are responsible for taking the necessary precautions to prevent spread of infection and asserted that this means much more than merely keeping a clean environment. Psychiatric facilities are no exception and should ensure that no transmission of infection occurs from patient to patient, patient to staff or staff to patient. This was expressed in a statement by the American Psychiatric Association (1991) where it identified ideal strategies how this should be implemented, namely through:

1. designing and monitoring of appropriate infection control procedures,
2. appropriate management of affective, cognitive, and behavioural disturbances to ensure risk reduction for both patients and personnel, and
3. appropriate education and support services for patients, families, and staff.

However, when it comes to finding information regarding the policies themselves and their implementation there seems to be a 'grey area' and literature is very poor, particularly when compared to infection control policies in general hospitals. Loving, Porter, Stuifbergen, Houfek, and Collins (1992), in a descriptive study, explored practices for the surveillance of nosocomial infections in private psychiatric hospitals in the US. They concluded that the vast majority of work published about infection control programs, procedures, and practices addresses only general acute care

facilities. Consequently, infection-control nurses working at psychiatric hospitals have few established models to use in designing programs for the unique needs of their setting.

This lack of literature was also acknowledged by Fleischman & Olmsted (1998). They noticed the absence of standard definitions for nosocomial infection and its control in behavioural health settings, and argued that this contrasted sharply with the abundance of definitions for nosocomial infections in acute care hospitals. This position was strengthened by Davies, Finch, Hudson and Humeny (1993) in an article about the approach adopted by a large Canadian psychiatric hospital to develop a 'universal precautions' policy and educate both staff and clients about nosocomial infections. The authors commented about a large and rapidly growing body of knowledge concerning infection control issues in general hospital settings and the lack of adequate protection for psychiatric patients running the same risks in this unique environment.

Mitchell, O'Mahony, McKeith, Sprott, Codd and Wright (1989), whilst acknowledging the gap in literature related to infection control in psychiatric units, pointed out some characteristics that make this particular clinical area unique, to the extent that infection control protocols which work well in general care might not be adequate when applied directly in psychiatry. He pointed out, as an example, that whereas the absolute majority of those in general care are admitted voluntarily, a significant proportion of psychiatric patients are detained under the mental health act. A patient who is being detained against their will may use non-compliance as a means of protest. The American Psychiatric Association (1991) discussed this issue in their resource document and stated that if an infected patient engages in behaviour that places other individuals at risk, staff should assure that the behaviour is controlled, including the use of isolation and/or restraint if considered necessary.

Thus, Fleischman & Olmsted (1998) asserted that policy formulated especially for psychiatric settings needs to take these particularities into consideration. It recommended the use of standardized, written protocols preferably from federal agencies, regulatory bodies or professional organisations if at all available. However, in view of the lack of existing literature, it suggested modification of policies from other settings to suit the particular requirements of psychiatric settings. UTMB (2003) recommended the modification of nosocomial infection control protocols in acute care hospitals and long-term care facilities for use in psychiatric settings. Thus, policies from general and long-term settings were reviewed and an attempt to modify them was made in this article.

Adaptation of general policies

Infection control policies in psychiatric settings are likely to present special problems associated with both the design and the implementation of such policies, which one is not likely to encounter in a general setting. Mitchell *et al* (1989), Nicolle (2001) and MacLean (2002) all conducted studies to investigate these problems. They found that differences between acute-care and long-term care facilities do affect the development and management of infection control in psychiatric institutions.

While acknowledging the diversity of the psychiatric setting and the problems it is likely to generate, Fleischman & Olmsted (1998) suggested that this might be the reason for the shortage of literature on this topic. MacLean (2002) argued that standards and policies for psychiatric institutions differ from general hospital settings because the two settings have different patient characteristics, nurse staffing ratios, availability of diagnostics and treatment goals. However, he suggested the adaptation of pre-established universal precautions rather than development of completely new procedures, in order to allow comparison with published 'benchmarks'.

These suggestions were supported in an article by Davies *et al* (1993) commenting about a study they carried out to investigate the effectiveness of this approach when used in a large Canadian psychiatric hospital. Their findings suggested a two-tiered approach where standard, or universal precautions are applied on a routine basis and some additional precautions

apply when it is suspected that a particular resident carries a special risk.

However, the Nicolle (2001) also proposed some considerations and words of caution for policymakers when designing infection control policies for psychiatric institutions, bearing in mind that these are often considered the 'home' of some residents. Propositions aim to achieve an acceptable degree of infection control within the facility without affecting the quality of life for those residents who often need long-term care. These values transpire in the role of an infection control practitioner (usually nurse) within a psychiatric hospital, who tries to strike such a balance by acting as a resource and adviser to the ward staff.

In an online advert for a psychiatric infection control nurse (something that is unheard-of, locally) by the Alexian Brothers Behavioural Health Hospital, Illinois, USA it was specified that responsibilities included designing and ensuring the effectiveness of infection control policies with due consideration given to the impact on the residents' quality of life. It also specified that the infection control program must be designed in a way as to provide the least interference possible to the philosophy and objectives of the facility's Behavioural Health Department. These requirements were also recommended in a policy document issued by the UTMB (2003) regarding desirable standards of infection control in psychiatric facilities of its teaching hospitals.

Conclusion

Even though definitions of nosocomial infection in mental health are not readily available, the risks of infection spread are present just like any other setting. In this clinical setting associated with high-perceived risks to personal and job security, it is easy for infection control to get low priority on one's agenda. This is especially true with human resources stretched to their limits and in the absence of adequate systems such as an in-house infection control unit to design policies and issue guidelines for use in this particular setting. However, it is just as important to realise that infection control is everyone's business and if everyone (nurses as well as management) gives their personal positive contribution, it is likely that the present barriers to adequate infection control will be overcome for the benefit of everyone concerned.

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Epidural or non Epidural?

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Epidural has been introduced as pain relief during labour here in Malta for quite some time now; however is the way it has been introduced the right way?

It seems that our clients still have no say on the subject. I have been led to believe that most women do not even know what epidural is all about. Women choosing to have an epidural for pain relief in labour, ante-natally, are given only a vague explanation, during one of the later visits of pregnancy. Clients do not sign for their choice of pain relief they would like to have. Those women who agree on having an epidural analgesia during labour contractions are only given a verbal explanation; however, undoubtedly being in such an anxiety state, I am not sure whether the explanation is understood. Women do not sign for their choice of pain relief. They do not know the pro's and cons of epidural and if they do know the pros, I doubt it very much if they fully comprehend the cons. Are we giving detailed information about epidural to our clients?

I believe that women should be well informed, if possible, before starting in labour, and sign a proper informed consent in order to make the choice of their own pain relief in labour.

The first time epidural analgesia was introduced in Malta, the verbal policy was that it was to be administered on demand. I could not say that in some cases it did not help, but one must look deeply into the subject by supporting evidence.

The abstract from the Cochrane Review entitled **Epidural versus non-epidural analgesia for pain relief in labour** states that 'Epidural analgesia was associated with greater pain relief than non epidural methods, but also with longer first and second stages of labour, an increased incidence of fetal malposition, and increased use of oxytocin and instrumental vaginal

deliveries. With new trial data included, no statistically significant effect on caesarean section rates could be identified'. (Eleven studies involving 3157 women were included) (The Cochrane Library, Issue 4, 2004. Chichester U.K.: John Wiley & Sons, Ltd.)¹

Epidural can interfere with the mechanisms of labour and such evidence is very well supported by research. "An epidural will often slow a woman's labour, and she is three times more likely to be given oxytocin drip to speed things up^{2,3}. The second stage of labour is particularly slowed, leading to a three times increase in chance of forceps⁴. Women having their first baby are particularly affected; choosing an epidural can reduce their chance of a normal delivery to less than 50%⁵.

This slowing of labour is at least partly related to the effect of the epidural on a woman's pelvic floor muscles. These muscles guide the baby's head so that it enters the birth canal in the best position. When these muscles are not working, uterine Dystocia (in coordinate uterine action) or poor progress may result, leading to the need for high forceps to turn the baby's head, or a caesarean section. Having an epidural doubles a woman's chance of having a caesarean section for Dystocia⁶."

Using epidural in normal labour as pain relief can lead to a whole cascade of medical interventions. Often the decision to accept epidural as pain relief in labour is taken without awareness of significant risks to both mother and baby. One commonly recognized risk is the sudden drop in blood pressure, which affects one of eight women having an epidural⁷. For this reason the mother is topped up with IV fluids. A drop in maternal blood pressure will affect how much blood is pumped through the placenta, which can lead to less oxygen being transferred to the baby.

Numbing the uterus will also affect the bladder, which in turn leads to the woman not being able to pass urine. In this case catheterisation is performed leading to an uncomfortable or an embarrassing situation for the client.

When an epidural has been in place for more than 5 hours, a woman's body temperature may begin to rise⁸ thus leading to an increase



Using epidural in normal labour as pain relief can lead to a whole cascade of medical interventions

in heart rate, both hers and the baby's, causing fetal tachycardia.

Studies suggest that babies born after an epidural have difficulty with breastfeeding^{9, 11} as epidural interferes with the release of oxytocin¹¹, which will in turn inhibit the let down reflex in breastfeeding, thus hindering bonding between mother and baby.¹²

We could go on and on about the side effects of epidural. For us, here in Malta it is still a relatively new system. However, I seriously doubt if we have looked at all the pros and cons before starting to offer the service to all our clients. Research based studies are suggesting other factors of which we are completely unaware.

I am not saying that the use of epidural in Labour is completely wrong, but what I am discussing is, "Are our clients well informed about the service? Do they know anything about the side effects of this service? Or are we hiding behind a curtain of insecurities?"

Women should be given a well-detailed booklet to be informed about epidural, before actually making the choice to have an epidural analgesia for Labour. It is only **their right** to know what to expect out of it. After all, the birthing experience is unique for every woman. Let's not spoil it by our attitude and sometimes by our instructed "ignorance" about the subject.

Education Executive Committee

This year will definitely be remembered for the great number of activities done by any education committee that includes the organisation of an international conference and two local specialised conferences. The standards that we have managed to achieve regarding the organisation of the Commonwealth Nursing Federation Conference awarded us with praise from the Executive Secretary CNF and praise from the Royal College of Nurses and the Cyprus Nurses Association. But the Education Committee did not stop there. As a committee this year, conferences were not the only events in our agenda. The education committee with the collaboration of the Director Nursing Services initiated a survey to analyse the different aspects of life long learning within nurses and midwives working in all government hospitals. All the data has been collected and various meetings on the evaluation of such data have

been organised. It is envisaged that by the end of this year a report will be handed to the MUMN Council, which will then be published on our Nursing journal at a later date. It is intended that such document will be easy to read and the assumptions will be present for all to see.

The MUMN Education Committee is at the moment embarking on new strategies on the dissemination of nursing education for next year. An unusual activity is being planned. Such activity will be addressed to the students who will be offered a "live in" for a weekend in one of our local hotels. The aim of this activity is to give the opportunity for the students to interact with some of their tutors. Students are intended to express queries on any particular subject and to clarify any subject that they find hard to understand. The education committee will be organising such an event with the Students Committee that forms part of MUMN. As a committee we will be sponsoring the extracurricular activities. It will be a new experience for all those involved but our approach has to be open even to new ideas especially when such activities are addressed to the students.

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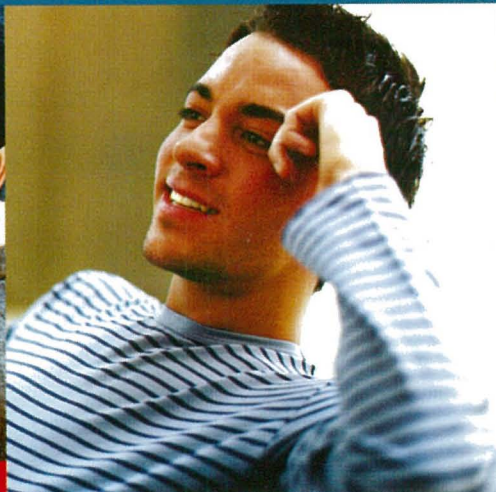
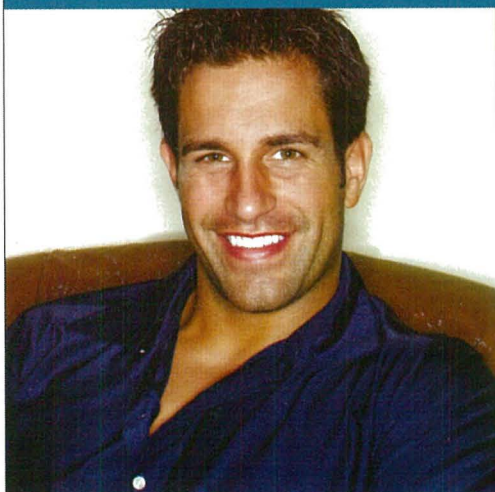
Another event that will be included in our agenda will be a conference, but this will be a "Conference with a difference". This conference will be organised in collaboration with a patient's organisation within the Renal Unit. As a committee at least two conferences have been held with the medical profession in the past and therefore it was decided to embark on a different road. As a nursing body our next conference will be with the Transplant Support Group where patients will have an opportunity to participate as speakers in the conference. Again it will be a good opportunity to hear the patient's perspective on our care and service that we provide.

I will not be surprised that we will also be active in other fields of educational matter. The education committee is always available too all our members to offer support for any new innovations. Whilst all members of the educational committee wish you all a Happy Christmas, we thank you all for the support you always showed in our activities.

PAUL PACE

Chairperson Education Executive Committee

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- 1.** MUMN organised the First Conference on Neonatal & Paediatric Care where different health care professionals participated.
- 2.** MUMN with the collaboration of the Institute of Maltese Journalist organised a reception. Together with MUMN Officials are Jason Micallef & Gordon Pisani from the MIP & PN respectively and Malcolm J. Naudi, President of the Institute.
- 3.** The second group of the new edition of the Conversion Course in front of the IHC. Good Luck for the Final Examination next month!
- 4.** Press Conference on the recruits of new Nurses was held by MUMN to inform the public that although the number of vacancies is larger than the number of Nurses qualified, the Health Division decided not to employ them because of financial restrictions!!
- 5.** Each year MUMN organises a seminar for its activists. This one was marked by the absence of the Health Minister which left the chair vacant due to some 'hot arguments' raised in last year's seminar.
- 6.** The Florence Nightingale MUMN Benevolent Fund launched its counselling and group therapy programme with the collaboration of the Richmond Foundation. Well Done.
- 7.** The Pensioners' Group Committee strikes again! This time they organised an activity in Gozo where the attendance is always encouraging. Keep it up boys!
- 8.** MUMN organised a meeting for the new Nurses in one of its offices to discuss the employment issue. The meeting was very tense and we hope that common sense prevails

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The Scaly Scalp

Introduction

A popular atlas of dermatology lists more than 35 diseases that commonly affect the scalp (1). Scaling is a prominent feature of several of them. Clearly, a comprehensive review is not possible within the compass of this article. Instead, attention will be focussed on some relatively common conditions that the community pharmacist may be called upon to recognize and treat. The discussion includes tips concerning diagnoses, pitfalls, over-the-counter (OTC) remedies, and when to refer.

Cradle Cap

Cradle Cap is the vulgar name for infantile seborrhoeic eczema. The cause is unknown. The baby's scalp becomes pink and scaly, and greasy yellow crusts may also form. The rash may spread to the face and flexures of the ears, armpits, and groin. Rarely, it could become generalized, but never dangerous. Curiously the lesions are not itchy, and they disappear with or without treatment after a few weeks. The condition is not infectious, and it does not lead to adult seborrhoeic eczema. The scales of cradle cap can be removed by rubbing with an emollient, e.g. the time-honoured almond oil, followed by a mild detergent shampoo. Alternatively, 0.5% salicylic acid in a cream base may be employed as a mild keratolytic. The regular use of salicylic acid over a wide area should be avoided in babies because it carries the risk of salicylism due to systemic absorption. It would be wise to refer infants with widespread eczema for medical examination. A prudent pharmacist would not dispense topical steroids on his/her own initiative in this type of situation.

Ringworm of the scalp

Ringworm of the scalp is technically known as tinea capitis. This is an infection of the scalp hairs by one of a number of dermatophyte fungi some of which habitually live on animals or in the soil, while others spread from one human being to another in epidemic fashion. In Malta, the commonest culprit is *Microsporum canis* (2), which is a species of animal ringworm commonly found on stray kittens. Children are the usual victims. There are patches of redness, scaling and, most important, hair loss in the scalp. Contact with furry animals (kittens, rabbits, goats), multiple cases in a family, and concomitant ringworm on the body are useful hints to diagnosis. A boggy swelling (kerion) may develop in neglected or mistreated cases, and this could lead to permanent hair

loss due to scarring in the area. Tinea capitis requires careful systemic treatment to prevent such complications. Suspected cases should consequently be referred immediately for specialist care. Dallying with topical anti-fungal creams and shampoos may pre-empt an accurate mycological diagnosis.

Dandruff and adult seborrhoeic eczema

Seborrhoeic eczema affects approximately 5% of adults. It is even commoner in Parkinson's disease, and in HIV/AIDS where it may be the presenting complaint. Our understanding of seborrhoeic eczema turned full circle over the years. In the 19th century Sabouraud implicated *Pityrosporum ovale* after he observed it in the scales. However, this yeast is also present as a commensal in normal skin, and interest dwindled when it was determined that seborrhoeic eczema responds to topical steroids which, if anything, should make the putative 'infection' worse. Interest revived with the introduction of ketoconazole. This antifungal agent clears seborrhoeic eczema, albeit temporarily, when given by mouth. Furthermore, the association with HIV/AIDS could be related to overgrowth of *P. ovale* due to immune suppression. Nowadays pityrosporicidal additives are included in many shampoos and other formulations intended for the anti-dandruff market, common dandruff being generally regarded as a mild variety of seborrhoeic eczema. Often, the diagnosis of seborrhoeic eczema can be made as the client walks in through the pharmacy door because the erythema and flaking on the scalp, eyebrows and nasolabial folds plus dandruff deposited on the shoulders are so embarrassingly obvious. Leading questions concerning covert patches in the praesternum, interscapular area, and possibly flexures may convince the client that he or she (seborrhoeic eczema is commoner in men) has come to the right establishment. Dandruff and seborrhoeic eczema are likely to persist, with improvement in the summer. In the winter, the face should be protected from dessicating winds. Common dandruff should respond to shampoos containing selenium, zinc pyrithione, tar, or 2% ketoconazole in difficult cases. The pharmacist can improve the chances of success by explaining the correct mode of application, for poor technique may account for treatment failure. Some modern facial moisturizers incorporate piroctone olamine or similar anti-fungal agents which may safely be used in the long-term control of facial seborrhoeic eczema. Another non-steroidal anti-seborrhoeic facial preparation contains 5% lithium succinate, but this is not yet available on the local market. On the face, seborrhoeic eczema must be distinguished from rosacea that requires appropriate treatment. In the scalp, seborrhoeic eczema

may overlap with psoriasis which is more obstinate to treat. In other areas of the body, dermatological referral may be indicated to exclude ringworm, candidiasis, erythrasma, psoriasis, or other disorders of keratinization which mimic seborrhoeic eczema.

Psoriasis

Psoriasis affects approximately 3% of the general population. It is the paradigm for chronicity in dermatology, so much so that in Malta severe psoriasis is listed among the diseases which entitle patients to free treatment on Schedule V Part 2 arrangements (the "yellow card"). The frequency and chronicity of psoriasis are just two of the many aspects which make it so important in terms of personal hardship and economic costs to the community. The Psoriasis Association of Malta is a useful source of information on the local scene (3). Immunological derangements are implicated in the aetiology of psoriasis but the fundamental cause remains mysterious, and so symptomatic remedies abound. The scientific rationale is to reduce the rate of epidermal cell turnover which is accelerated in the plaques and which, in the scalp, is responsible for the well-defined raised areas of salmon redness and heaped-up silvery scales which feel like a ploughed field when running the fingers through the hair. There is no hair loss except in an unusual variant called Pityriasis amiantacea which affects children and in which asbestos-like scales (hence the name) cling to the hair shafts. There is a genetic predisposition to psoriasis, and the presence of confirmed disease in forebears is a useful pointer to diagnosis. Other possible important factors in the outbreak of psoriasis are streptococcal infections, stress, intercurrent illnesses, operations, physical accidents, and drugs - particularly anti-malarials and lithium. Many patients have tell-tale changes in the finger nails consisting of pits or areas where the nail plate no longer sticks to the underlying bed (onycholysis). These nail changes are further clues to diagnosis. Spontaneous remission of psoriasis is common in the summer, and

ultraviolet therapy on an outpatient basis is a very useful alternative for treatment of patches on the body and which is available all the year round. Experienced patients may shop around in pharmacies for domestic ultraviolet sources for private use, but this should not be encouraged because of the risk of sunburn in the short term and skin cancer in the long run. Emollients are useful otc adjuncts in the control of dryness, scaling and irritation. Regular use of emollients may reduce the need for prescription medications like topical steroids. There are several proprietary formulations on the market. Some are oily and designed to be dispersed in the bath water. Others produce a lather and are meant to be used as



substitutes for soap. Several are oil in water emulsions intended to be applied directly to the skin. The pharmacist should help the client to understand the product clearly, thus preventing it from being put to the wrong use. A number of OTC emollients incorporate urea and lactic acid which help the epidermis to retain moisture. Others contain 2% salicylic acid or 5-15% alpha-hydroxy acids (AHAs) which help desquamation. Yet others contain tar. Crude tars are chemical mixtures obtained from the destructive distillation of organic material. They have soothing and keratolytic properties that have been exploited for the treatment of psoriasis long before their ability to reduce epidermal cell turnover was proven. Crude tars stain and smell. Refinement improves acceptability but reduces efficacy. Extemporaneous coal tar formulations are still an important standby in the hospital treatment of psoriasis. For a very long time coal tar has also been used in a wide variety of proprietary OTC products including soaps, shampoos, lotions, creams and ointments, but its use in cosmetic products is currently viewed with some anxiety due to its carcinogenic potential. Tar obtained from bituminous schists (fossilized fish) is not carcinogenic (4), and upmarket "parapharmacy" products containing them (in combination with some of the other ingredients mentioned previously) have recently hit the local market. Another interesting therapeutic adjunct that has become available locally is the mineral salts from the Dead Sea. Many European holidaymakers have experienced the anti-psoriatic benefits of the Dead Sea climate, but actually going there is expensive. The export of these minerals from the area is an attempt to reproduce just one of the components of the therapeutic regimen at home. Very severe psoriasis may need addressing with systemic anti-metabolites, retinoids, or immune-modulating drugs, and dermatological consultation is clearly imperative here. In addition up to 10% of patients may suffer from associated arthritic symptoms which may require attention by a rheumatologist. The natural history of psoriasis is notoriously unpredictable and isolated interludes of spontaneous remission may be interspersed with frustrating episodes of relapse.

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Keywords: Scalp dermatoses, Psoriasis, Eczema, Tinea capitis.

GRUPP PENSJONANTI

Il-Grupp Pensjonanti tal-MUMN ġie aċċettat bhala membru mill-Kunsill Nazzjonali tal-Anzjani. Fil-fatt diġa attendejna fil-kongress li sar aktar kmieni din is-sena 2004.

Fis-16 ta' April 2004 ghamilna harġa ohra ghal Ghawdex. L-attendenza kienet ta' 27. Minkejja li t-temp ma kienx favorevoli, kullhadd ha gost.

F'April 2004 ġie Malta r-rappreżentant tal-ghaqda "Age", Mr. Thorpe, Desk Officer ġewwa l-Belġju. Dan kien mistieden minn ghaqda ohra li hija l-Ghaqda Nazzjonali tal-Pensjonanti. Din stednitna sabiex nattendu. Fl-ewwel laqgħa attendejna bhala uffiċjali tal-Grupp Pensjonanti MUMN. Fit-tieni laqgħa din kienet miġtuha għall-Pensjonanti kollha, fejn hadna sehem ukoll. Fl-ewwel laqgħa ippreżentajna profil tal-Grupp Pensjonanti lil Mr. Thorpe.

Fil-5 ta' Ġunju 2004 hadna sehem bhala osservaturi fil-laqgħa ġenerali tal-Ghaqda Nazzjonali Pensjonanti ġewwa l-British Legion, il-Belt fejn ġejna mistiedna minn din l-istess ghaqda.

It-Tnejn 9 ta' Awwissu 2004 l-Alleanza ta' organizzazzjonijiet ta' pensjonati ltqajna mal-Prim Ministru f'Kastilja.

L-ghaqda insistiet sabiex tiġi ikkonsultata dwar iċ-ċaqliq tal-pensjonijiet.

Per eżempju:

1. Li jingħata żmien biżżejjed sabiex il-White Paper tiġi studjata meta tohogħ.
2. Sabiex il-pensjonanti jkunu nvoluti qabel ma jkun finalizzat in-"National strategy report of Pensions" li l-gvern marbut li jibgħat lill-Kummissjoni Ewropeja sal-harifa tal-2005.
3. Tintalab konsultazzjoni wkoll dwar is-servizzi tas-saħħa u dwar bidliet ohra.

Bhala Chairperson tal- MUMN, jien irrappreżentajt lill-Grupp.

Il-Hamis 19 t' Awwissu saret harġa ohra lill-membri. Din kienet tikkonsisti f'quddiesa fil-Kappella tal-Providenza ġewwa s-Sigġiewi. Din ġiet iċċelebrata mil-Arċipriet ta's-Sigġiewi ghar-ruħ l-ex kollegi mejtin. Wara morna għal żjara sar-Razzett tal-Hbiberija u mbagħad għall-ikel fir-restaurant San Antonio ġewwa Marsascala. Wara morna lejn id-dar bil-coach. Kullhadd apprezza din il-harġa.

Harġa ohra għal Ghawdex saret nhar il-Ġimgħa 24 ta' Settembru 2004. L-attendenza kienet ta' 32 u l-programm kien jikkonsisti f':

Vista u Quddiesa fil-kunvent tal-Kapuċċini ġewwa r-Rabat. Wara ġejna servuti bil-kafe' u biskuttini ġewwa l-kunvent stess. Kollox kien provdut minn seħibna George u martu Grace Debono. Ta' dan niringrazzjom. Wara morna nżuru d-dar fejn kien jgħix Frenċ tal-Għarb. Gol-Għarb żorna wkoll il-Muzew Folkloristiku u wara morna nieklu fis-St. Patrick Hotel ġewwa x-Xlendi. Wara l-ikel morna x-Xagħra nżuru l-Ġgantija. Minn hemm tlaqna bil-vapur lejn Malta.

PAUL BEZZINA
Chairperson

Hidma Sotto-Kumitat SVPR

Nhar il-15 ta' Ottubru 2004 ktibna ittra lis-Sur Michael Bezzina, Direttur tad-Dipartiment ghall-Kura ta' l-Anzjani u Servizzi fil-Komunità, fejn irrimarkajna diversi diffikultajiet li qed jiltaqghu magħhom in-Nurses li jahdmu fir-Residenza San Vincenz jirriżulta li qed jinharġu sistemi ġodda mingħajr konsultazzjoni mar-rappreżentanti tal-haddiema. Dan ikompli jiggrava s-sitwazzjoni preżenti fejn l-MUMN diġa ssottomettiet sensiela ta' *issues* li għadhom pendenti. Dawn iċ-ċirkostanzi ma jistgħux jibqgħu jiġu ttollerati u jekk mhux ser jittiehdu miżuri biex din is-sezzjoni tkun aktar effiċjenti u ma tibqax tohloq tensjoni fost l-impjegati, il-Union tkun kostretta li tiehu kull miżura permessa bil-liġi.

Dawn il-punti kienu mressqa quddiem l-Onor. Ms. H. D'Amato, Segretarja Parlamentari. Ġie deciż li ssir laqgħa ma' l-MUMN flimkien ma' l-awtoritajiet tar-residenza SVPR u d-dipartiment.

Sar qbil fuq dawn il-punti:

Vacation Leave: Meta l-'A' u 'B' *vacation leave entitlement* jispiċċaw, kull impjegat

jista' jiehu l-opportunità li jgħaqqad żewġ 'C' *duties* biex jieħdu 'A' jew 'B' VL hekk kif appena jispiċċaw.

Nurses ġodda: Nurses li ġew impjegati f' Settembru 2004 ser ikunu ntitolati għall-hames granet VL (5 'D' *duties*) u tlett nofs ta' nhari (3 'C' *duties*) sa Diċembru 2004, sabiex innaqsu l-*accumulation* għas-sena 2005.

EDP's: L-EDP's għandhom jinqatghu skond r-rati tas-sena 2002, 2003, u 2004 rispettivament. Sar qbil sabiex kull nurse ikollu/ikollha l-fakulta' li j/tiddiskuti mal-*personnel section* dwar kif u meta għandhom jinqatghu l-flus ta' l-EDP's.

Ċertifikati tas-Sick Leave: Dan l-aħhar ġiet introdotta sistema fejn n-nurse irid iħalli ċ-ċertifikati tas-Sick Leave go *folder* fis-sala, liema sistema mhux biss tesponi l-marda li jkollu l-impjegat ma shabu iżda wkoll li hemm riskju li dan iċ-ċertifikat jista' jintilef. Intlaħaq ftehim sabiex nerggħu lura għas-sistema li kellna fejn l-impjegat imur biċ-ċertifikat personalment, u jingħata riċevuta li dan wasal fil-*personnel section* għar-records tagħhom.

Festi Pubbliċi li jinżertaw fil-Hdud:

Għandhom jingħataw fuq is-sistema ta' A, B, C skond kemm il-wahda jkun hemm. Għalhekk fit-2003 għandu jkollna A u B.

Ration Money tan-Nurses li jahdmu bil-lejl għandhom jithallsu mas-salarju li jmiss.

Increment tal-Part-time Nurses għandu jingħadem minnufih.

Jinharġu l-accumulation tal-VL 2003 ta' dawk li għadhom pendenti.

Fis-16 ta' Settembru 2004 harget applikazzjoni għall-post ta' *'Supervisor in charge of Cleaning staff at SVPR'*, wara li l-MUMN kienet ilmentat diversi drabi li x-xogħol ta' tindif ma jaqax fir-responsabilita' tan-Nurse.

Maintenance matul il-lejl: Fil-25 ta' Awwissu 2004 hriġna direttiva lill-NO's ta' bil-lejl sabiex ma jassumux responsabilita' fir-rigward ta' problemi li jistgħu jinqalghu minn naha ta' *maintenance* biex b' hekk jikkoncentraw aktar fuq ix-xogħol li huma responsabbli għalih.

RAYMOND CHETCUTI

Chairperson

Sotto-Kumitat SVPR

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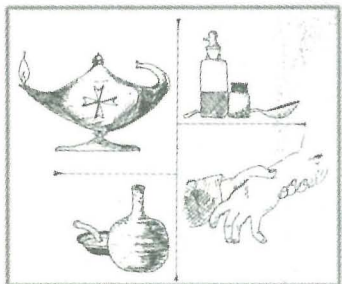
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*Best Wishes for Christmas & New
Year to all MUMN Members.*



Kitba ta' **JOE CAMILLERI**

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L-ISTORJA TAN-NURSING F'MALTA

MIS-SITTAX IL-SEKLU SAS-SITTINIJIET

.....*Gabra ta' storja riċerkata dwar l-evoluzzjoni tan-Nursing f'Malta mill-egdem żminijiet sa era aktar moderna.*

Harsa analitika dwar kif in-Nursing stabilixxa ruhu fil-hajja medika Maltija ta' Gżiritna.....

L-ISTATE DISTRICT NURSES U HEALTH VISITORS

Speċi ta' 'district nursing' rudimentali kien jeżisti f' Malta fi żmien l-Ordni ta' San Ġwann ta' Ġerusalem: tabilhaqq li l-prekursi tad-'district nurse' moderna kienu l-'pitanziera' jew 'almoner' li barra li kien jipprovdi l-ikel u l-flus lill-morda u lill-fqar anzjani kien jattendi lin-nies li ma kienux jifilhu taht superviżjoni medika. L-ewwel suggeriment, fi żminijiet moderni, biex jitwaqqaf 'district nursing' f'Malta ġie mil-'Public Health Department' fl-1920. L-ghanijiet ta' dan is-servizz kienu: (a) biex iżuru u jdur bil-fqar morda fi djarhom u ghalhekk itaffu l-pressjoni tal-akkomodazzjoni tal-isptar; (b) biex jinkoraggixxu lin-nies jiehdu parir mediku fil-bidu ta' xi marda; (c) biex jgħallmu u jgħinuhom jiehdu kif suppost it-trattament preskritt mit-tabib; (d) biex jagħtu tagħrif lil-ommijiet fuq il-kura tagħhom infushom u fuq kif jitimghu u jrabbu lill-uliedhom; u (e) jippromovu l-istandards ta' iġene personali u domestiku lill-massa. Fl-istess sena harġu applikazzjonijiet biex jiġu appuntati tlett 'District Nurses'. Il-kandidati kellhom jattendu course ta' taġlim u jagħmlu perjodu ta' tahrif fi spjar fl-aħhar tal-course u jintagħzlu b'eżami kompetittiv. Tlett nurses bdew jaħdmu f' Marzu tal-1921 fiż-Żejtun u Hal Għaxaq, Hal Qormi u l-Hamrun. Taht id-direzzjoni u s-superviżjoni tad-'District Medical Officer', kienu jattendu għall-pazjenti bi problemi mediċi, ta' kirurġija u mard tal-ghajnejn fil-Bereġ tal-Gvern. Kienu jżuru fid-djar tagħhom lill-morda fqar u ommijiet ta' trabi żagħar u kienu wkoll jitrattaw tfal bit-trakoma fl-iskola. Fl-ewwel sena 'l fuq minn tlett elef każ żaru l-Bereġ tal-Gvern, saru 'l fuq minn elf viżta fid-djar u żaru 'l fuq minn disa mija u sittin omm f'dawk id-distretti li msemmija, meta dawn kellhom popolazzjoni ta' tminja u tletin elf u 'l fuq minn elf u hames mitt twelid f'dik is-sena.



Florence Nightingale

IL-PRIVATE DISTRICT NURSING U THE MALTA MEMORIAL DISTRICT NURSING ASSOCIATION

Il-'Private District Nursing' fil-Gzejjer Maltin jaf il-bidu tiegħu, indirettament, fit-Tieni Gwerra Dinjija; tabilhaqq din l-ideja li jitwaqqaf dan is-servizz beda bħala mafkar għall-isforz li għamlet Malta fil-Gwerra. Appelli għall-fondi saru fir-Renju Unit u f' Malta waqt is-snin tal-gwerra u l-Malta Memorial District Nursing Association (MMDNA) ġiet imwaqqfa f' Settembru tal-1945. Is-servizz beda jahdem fi Frar tal-1947 meta sitt 'Queen's Nursing Sisters' kienu sekondati għal Malta mill-'Queen's Institute of District Nursing in England'. Ghaxar 'Assistant Nurses' Maltin, li qabel kienu mharrġa mill-'Little Company of Mary' f' San Hiljan, ingħaqdu mal-organizzazzjoni f'dik l-istess sena. Sa minn dak iż-żmien 'l hemm, tfajliet Maltin kienu mharrġa l-Ingilterra bħala 'State Registered Nurses' u 'District Nurses', bl-ewwel nurse Maltija kkwalfikata f'kollox tibda taħdem mal-Assoċjazzjoni f' Mejjun tal-1952. Kien isir kull tip ta' nursing ġenerali u midwifery, u kemm l-Assoċjazzjoni kien hemm b'żonnha jidher minn numru ta' viżti li għamlu n-nurses. Fil-fatt minn 'l fuq minn haxx il-elf viżta fl-1947, in-numru żdied għall-hamsa w sebghin elf fl-1958.

IS-SORIJET TAL-KARITÀ

L-irġiel kienu jiffurmaw il-parti maskili fl-Ordni ta' San Hwann ta' Herusalem waqt li l-parti femminili kienet fis-Sorijiet Ospitalieri. Dawn is-sorijiet jidher li kellhom funzjoni, li originarjament, jgħinu lill-Kavallieri fin-nursing tal-morda u biex jospitalizzaw lill-pellegrini femminili. Kien x'kien l-ghan originali, nafu fiċ-ċert li dawn is-sorijiet, li illum huma rrapreżentati f'Malta fl-Ordni ta' Sant Ursola, qatt m'għamlu nursing f'Malta iżda kienu biss jiehdu hsieb it-trabi fil-Creche tal-Ursolini f'Tas-Sliema.

L-ewwel sorijiet li ddedikaw ruħhom għan-nursing f' Malta kienu s-Sorijiet tal-Karità. Il-komunità tagħhom ġiet imwaqqfa minn Sister Joan Anthide f'Besañon ġewwa Franza, f'April tal-1799. Fil-bidu tas-seklu dsatax is-Sorijiet tal-Karità nfrxu minn Besañon għall-Italja u pajjiżi Ewropej. L-ewwel proposti biex jiġu mpjegati sorijiet f'istituzzjonijiet tal-gvern ġiet mill-Gvernatur, l-Unur Tiegħu Richard More O'Ferrall, lejn nofs is-seklu dsatax. Is-suggeriment biex is-servizz tas-Sorijiet tal-Karità jiġi uttilizzat sar fl-1868 minn Ms. Charlotte Butler, is-Supretendent tal-Orfanatrofji, meta kellha tirtira mill-kariga tagħha minhabba li ma kienitx tifla. Il-proposta tagħha intlaqgħet tajjeb mill-Kontrollur tal-Istituzzjonijiet Karitattewoli li kien qed isib diffikultajiet biex jagħzel nisa addattati għall-impjeg fid-diviżjoni femminili tal-Orfanatrofji. Fil-bidu kienu ddeċidew li joffru t-tmexxija tal-Orfanatrofji lis-Sorijiet ta' San Hużep, iżda m'aċċettawx l-offerta għaliex ma kellhomx soru bil-kwalifika f'dak iż-żmien propju. L-applikazzjoni saret lis-Sorijiet tal-Karità, li aċċettaw t-tmexxija tal-Orfanatrofju. Dawn ġew mill-Italja u hadu t-tmexxija tad-Diviżjoni Femminili tal-Orfanatrofju fl-ewwel ta' Diċembru 1868.

F' Mejjun tal-1885 ġie deċiż li s-sorijiet li jaħdmu fin-nursing għandhom ikunu nurses biċ-ċertifikat

Is-servizz tant intlaqgħa tajjeb minn nies li ġie estiż biex jaqdi distretti oħra u n-numru ta' nurses żdied għal seba' sal-aħhar tal-1923 u sa tnax sal-1929. Ix-xogħol tagħhom f' dan il-perjodu kien l-aktar mixhut fuq it-trattament tat-tfal u l-adulti morda bit-trakoma. Sal-1942 it-titlu ta' 'District Nurse' inbidel għall-dak ta' 'Health Visitor'. Ix-xogħol tagħha kien jinkludi li żżur iċ-'Child Health and the Antenatal Clinics', billi tassisti lid-'District Medical Officer' fil-Bereġ u mat-tfal tal-iskola taht is-superviżjoni tal-'iSchool Medical Officer'.

L-ewwel attentat biex jintroduċu s-Sorijiet tal-Karita' fi Sptarijiet tal-gvern ġie minn Dr.G.Xuereb, is-Supretendent Mediku tal-Manikomju, u l-Kummissarju tal-Karita' li, wara li triegħxu bit-traskuraġni u ksur ta' dixxiplina fil-Manikomju, kellhom, waqt laqgħa tal-15 ta' Diċembru 1869, jitolbu l-impjeg tas-Sorijiet tal-Karita' fid-Divizjoni Femminili fil-Manikomju wara l-approvazzjoni tal-Gvernatur. Il-hatra tas-Sorijiet tal-Karita' fl-Orfanatrofji kienet suċċess kbir u għalhekk kien hemm titjib fil-moralita', dixxiplina u l-ekonomija tad-Divizjoni Femminili ta' din l-istituzzjoni li mingħajr dubju jhallu frott mixtieq. Minhabba din l-esperjenza, il-proposta ta' Dr.G.Xuereb u l-Kummissarji kienet milqugħa mill-Kontrollur tal-Istituzzjonijiet Karitatevoli u l-Gvernatur ukoll li, f'minuti tas-16 ta' Settembru tal-1890, awtorizza li jiġu appuntati s-Sorijiet tal-Karita' f'dawk is-sitwazzjonijiet li ġew vakanti fl-Istituzzjonijiet Karitatevoli kollha. Numru ta' sorijiet Taljani waslu fit-13 t'Ottubru 1871 u bdew xogħol immedjament bħala Matrons, Ward Mistresses, Portresses u Chief Laundresses fl-Isptar Ċentrali, il-Manikomju u l-Ospizio. Fl-1873 marru l-Isptar Saura u fl-1878 ġewwa Santu Spirtu. L-introduzzjoni tas-Sorijiet tal-Karita' f' dawn l-isptarijiet ġiet dikjarata bħala 'innovazzjoni ta' min jammirha' minn Sir Penrose Julian, li dak iż-żmien kien l-aġent tal-kuruna tal-kolonji. F' Mejju tal-1885 ġie deċiż li s-sorijiet li jahdmu fin-nursing għandhom ikunu nurses biċ-ċertifikat. F' Lulju tal-istess sena l-ewwel sorijiet ikkwalifikati waslu Malta wara li kienu mharrġa fl-Isptar Santo Spirito ta' Ruma.

Ix-xogħol prinċipali tagħhom kien jikkonsisti fin-nursing ta' pazjenti taż-żewġ sessi, li jiehdu hsieb l-istrumenti, li jgassmu l-ikel, li jagħmlu superviżjoni fuq in-nurses ta' bil-lejl u li jgħallmu n-nursing prattiku lill-attendenti. Bil-ghan li jgħollu l-awtorita' tas-Sorijiet u għalhekk tibqa l-influenza tagħhom fuq in-nurses u impjegati oħra, sar ftehim li jiehdu status ta' uffiċjali li baqqu igawduh sas-sittinijiet. Wara, kien ovvju li s-Sorijiet kienu ġew Malta biex jibqgħu għal żmien twil. Matul iż-żminijiet urew il-kapaċitajiet li ġew assenjati lillhom. Hafna tfajliet Maltin ingħaqdu ma din l-Ordni reliġjuża. Uħud minnhom, wara li ġew imharrġa hawn Malta bħala nurses, marru r-Renju Unit għal aktar taħriġ u studju għall-kwalifikazzjonijiet fin-nursing Brittaniku.

IL-BLUE SISTERS (LITTLE COMPANY OF MARY)

F' April tal-1877, Mary Potter waqqfet il-Little Company of Mary ġewwa l-Ingilterra u l-iskop tagħha kien li tipprovi komunita' ta' nurses reliġjużi mharrġa b'mod xjentifiku. Fl-1894 ġew Malta wara stedina ta' Mons. Pietro Pace, Arcisqof ta' Malta. Għall-ewwel ftit ta' snin kienu joqgħodu f' dar żgħira f' Tas-Sliema; kienu jagħmlu xogħol ta' 'out-patients' sakemm infethet dar oħra akbar u magħrufa bħala Casa Leone XIII li infethet uffiċjalment fil-bidu tal-1901. Is-sulari ta' fuq kienu jintużaw bħala sptar żgħir u fil-fatt parti minnu u l-isptar li nbena wara bl-isem ta' Zammit Clapp intuża waqt l-ewwel Gwerra Dinjija bħala sptar militari.

Is-Sorijiet u dawk li jgħinuhom kellhom l-ammirazzjoni tal-awtoritajiet militari li, f' rapport li pprezentawh lill-Eċċellenza Tiegħu il-Gvernatur iddikjaraw: 'Hieh lil Madre Superjura u l-istaff tagħha ta' kif jitmexxa l-isptar u unur għas-servizz li jingħata minn dawn in-nisa. Dawn reġġu kellihom parti mportanti waqt it-Tieni Gwerra Dinjija meta dewnew nies ċivili feruti. Ix-xogħol tagħhom fi żmien ta' paċi fin-nursing privat f' każijiet ta' medicina, kirurġija u maternita' ta' min ifahharhom ukoll'.

Fl-1922 fethu 'nursing school' iżda kellihom jieqfu minhabba it-Tieni Gwerra Dinjija. Wara ġiet miftuħa u rijorganizzata fl-1950 u l-Mary Potter School of Nursing ġiet rikonnoxxuta bħala skola ta' taħriġ mill-General Nursing Council tal-Ingilterra u Wales.

IS-SORIJET DUMNIKANI

Fl-1888 Ms. Carolina Cauchi, inkoraġġuta mill-Isqof t' Ghawdex, Mgr. Pietro Pace, bniet kunvent fir-Rabat, Ghawdex, għall-konvenjenza ta' xi sorijiet li kienu jahdmu fin-nursing domicilari. Minn hemm harġu s-Sorijiet Dumnikani u wara l-gvern halla l-kura tal-pazjenti tal-Lazzarett t'Ghawdex f'idejhom, wara li hadu taħriġ fl-isptar ġenerali t'Ghawdex taht id-direzzjoni tal-uffiċjali mediċi u s-Sorijiet tal-Karita' fl-1900.

L-ewwel 'nursing home' f'Malta-magħrufa bħala 'St.Peter's Home', kienet miftuħa fl-1919 f'dar kbira f'Hal Lija. Meta nhass il-bżonn ta' aktar sodod, ġie mibni sptar għal mitt sodda f' 'Tal-Mirakli' hdejn H'Attard, bl-isem ta' 'Santa Katarina ta' Siena' u nfetħa fl-1959.

ST. JOHN AMBULANCE BRIGADE

Taht it-titlu ta' 'The Grand Priory in the British Realm of the Venerable Order of the Hospital of St. John of Jerusalem', fl-1826, in-Nursing sar fattur importanti u fl-1878 kien iffurmat id-Dipartiment tal-Ambulanza, li wara sar magħruf bħala St. John Ambulance Association. L-ghan kien li jipprovdu trasport għall-feruti. Is-St. John Ambulance Brigade għalhekk harġet minn din l-Assoċjazzjoni bħala organizzazzjoni volontarja biex tagħti l-ewwel għajjuna (first aid) lill-pubbliku u biex jiffurmaw numru ta' individwi mharrġa fix-xogħol tal-ambulanza u tan-nursing.

Ix-xogħol karitatevoli tas-St. John Ambulance Association (1878) ġie ntroduċut f'Malta minn Lady Houlton, il-mara ta' Sir Victor, iċ-Chief Secretary tal-gvern fi żmien il-Gwerra tal-Eġittu. Fl-1907 il-branch ta' Malta ġiet rijorganizzata. L-ewwel diviżjoni

tas-St. John Ambulance Brigade kienet il-Valletta Ambulance Division. Għall-bidu kellihom l-habbtu wiċċhom ma hafna diffikultajiet għax n-nies kienu għadhom ma fehmux l-importanza tal-ewwel għajjuna, iżda grazzi għall-isforzi ta' min waqqafha, il-moviment kiber b'tali mod li fl-1911 rappreżentanti tal-Malta Corps setgħu jiehdu sehem fil-festi tal-Koronazzjoni tal-Majestà Tagħhom ir-Re George V u r-Reġina Mary ġewwa Londra.

Meta fil-25 ta' Novembru 1908, l-S.S.Sardinia ha n-nar barra l-Port il-Kbir, bit-telfa ta' mija u tnax-il ruħ, in-nurses tas-St. John ġew hdejn id-Dwana li malajr inbidlet fi sptar tal-emergenza għall-kura ta' dawk li salvaw. Il-hegga tan-nurses waqt li kienu jattendu 'l midruba gabet tifhir lill-professjoni medika

u ringrazzjamenti tal-gvern. Ir-rispons kollu entużjażmu reġa' spikka fl-istess sena meta terrimot qawwi laqat lil Messina fi Sqallija u wiehed u tletin membru kienu voluntiera għas-servizz fejn kien hemm id-disastru meta għajtilhom l-Eċċellenza Tiegħu il-Gvernatur. Xi snin wara, waqt l-Ewwel Gwerra Dinjija, il-fuq minn mitt membru tal-ambulanza u erbghin kirurgu kellihom x'jaqsmu mal-Isptarijiet Navali u Militari f'Malta. F'Novembru tal-1915 xi membri siefru barra minn xtutna biex iservu ma' units tal-army Maltin f'Mudros, il-Macedonia u postijiet oħra.

Fi snin ta' wara l-Ewwel gwerra Dinjija, il-Brigade għenet f'okkażjonijiet pubbliċi bħall-festi reliġjużi u f'mases ċivili u militari. Meta faqqgħet it-Tieni Gwerra Dinjija il-Brigade reġgħet kienet attiva u n-nurses tagħha servew f'diversi sptarijiet ta' emergenza li twaqqfu għat-trattament tal-feruti ċivili. Erbgha 'Voluntary Aid Detachments' kienu fformati. Dawn servew fl-Isptar tal-Imtarfa, u wara f'diversi kampijiet militari fl-Italja, fejn ġew imfahhra għad-devozzjoni tagħhom waqt xogħolhom minn Field Marshal H.R. Alexander. Il-Brigade kienet rijorganizzata fl-1945 u ġew iffurmati wkoll il-Malta Police Ambulance Corps u l-Ambulance Corps fil-Baži Navali.

Ktejjeb fuq l-ewwel għajjuna bil-Malti kien ippublikat fl-1916 mill-Kurunell R. Samut taht l-awspiċi tal-Brigade.

Ikompili għall-harġa oħra...



Nurse b'uniformi tipika tas-snin erbghin

To Advocate For The Voiceless in Humanity

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The United Nations High Commission for Refugees (UNHCR) Statistical reports (2004) point out that there are over 17million people of concern to UNHCR which include refugees, asylum-seekers, returned refugees, internally displaced and stateless persons in more than 150 countries. However The Jesuit Refugee Service annual report of 2003 claims that by conservative estimates there are at least 40 million refugees and internally displaced people throughout the world. Many lives in refugee resettlements, others are living simply hidden in cities and towns. Irregular migrants and asylum seekers are kept in detained centres that often are overcrowded.

Asylum and Immigration was a high issue in the agenda of the last November European Council Summit in Brussels. The UN High Commissioner for Refugees Mr Ruud Lubbers indicated that the notion that Europe is being flooded with asylum seekers is not true. He argued that in 1992 around 680,000 people claimed for asylum in the 25 EU states while last year the number was under 350,000. Notwithstanding that this is manageable, the Crisis rhetoric continues which is often fuelled by thinly disguised xenophobia and political opportunism.

Public opinion is not very favourably towards influx of undocumented migrants who happens to end up on our shores. These intolerable attitudes are being felt also locally, the Jesuit Refugee Service Malta has spoken openly about the danger of a racist attitude towards illegal immigrants among the local population (Times of Malta, 2004)

Unfortunately health professionals are not immune to this intolerant attitude. These attitudes may vary from inequity to one of pity that neither of which is appropriate. As nurses and midwives we have obligations to safeguard the human rights of migrants, refugees, displaced persons amongst which many are forcibly detained (ICN 2000).

It is common scene to observe a client coming to hospital accompanied by a soldier or guarded by police officials during their stay in hospital which gives the assumption that these are criminals, at times even denied to be visited by their friends. They are referred by the number the army officials give them when being registered as detainees and this unfortunately is noticed when browsing the hospital wards census. One also can pinpoint the culture difference and how

they are obliged to comply with treatment that they do not understand and are not fully aware to make their own decisions. Notwithstanding that, language barriers can be very distressing; the fact that they might feel embarrassed to expose themselves with the possibility that they are not understood.

Lacking knowledge about this plight could be a disservice to these unfortunate people. The Nurses code of Ethics specifies the importance and the responsibility the nurse have as an advocate to the voiceless in humanity (Maltese Code of Ethics for Nurses and Midwives, 1996)

Even so the ICN position encourage nursing professional bodies to take active role in assuming responsibility in the immediate and long term of their health needs.

Chimni (2000) argue that the issue of global justice can no longer be left to other fields of knowledge and action. It must be placed squarely on the agenda of the practitioners of humanitarianism. If not, then humanitarianism must be denounced for not being humanitarian enough.

As health professionals we are bound to go beyond the xenophobic rhetoric attitudes when we are giving care to refugees or as they are more often referred as Clandestine and the Number. We have to give holistic care by acknowledge that they have feelings and they are more than mere bodies that need our care. It is important to ignore any prejudices felt towards these people; the role of the health professionals does not allow prejudice or judgemental attitudes. Although many times language is barrier to do so, to enable this we have to listen by observing and give appropriate care to their physical and psychological and spiritual scars. We have much to reflect about the pains that these people have paid in their ordeal to find meaning and purpose to live.

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Position Statement

Health Services for Migrants, Refugees and Displaced Persons

ICN Position:

ICN and national nurses associations (NNAs) have particular concern for immediate and long-term health and nursing care needs of migrants, refugees displaced persons (MRDPs), and have a special responsibility to assist non refugees.

Programmes that address the needs of MRDPs must be coordinated with involvement and cooperation of governmental and non-governmental agencies international and national levels.

ICN will work in all appropriate ways to promote the development of health and similar programmes for MRDPs, e.g. emergency treatment, care and maintenance repatriation / integration / resettlement, bank of nursing experts.

ICN condemns the frequent violations of MRDP human rights and promotes strategy that support social justice.

ICN encourages NNAs to examine the extent of the problem in their countries and undertake cooperative action to provide adequate health services for MRDPs by participation in:

- Raising public awareness on the existing problems of MRDPs;
- Identifying the specific health and nursing needs of MRDPs;
- Lobbying governments to provide adequate health services;
- Assisting in efforts to mobilise the necessary resources;
- Helping with emergency assistance and resettlement programmes for refugees. giving special attention to vulnerable groups;
- Urging adoption of appropriate policies and legislation;
- Assisting nurse refugees with their problems as refugees and members of profession
- Planning for the provision and the evaluation of the health services provided;
- Implementing appropriate educational programmes for nursing personnel;
- Facilitating the rapid contact and cooperation of nurses with agencies address the needs of MRDPs in the field; and
- Addressing the major causes of forced migration, e.g. poverty, human rights violations.

Background:

Unprecedented numbers of people have become migrants, refugees or displays persons in recent decades. On 1 January 1999, there were 21.5 million refugees in the world - that is, one out of every 280 people on the planet. Another 30 m classified as internally displaced persons.

These populations' often poor health status may be aggravated by depriva physical hardship and stress. The lack of resources in the country of asylum/resettlement may compound the problem.

Nurses, as citizens of their countries, patient advocates and care providers, can give a great contribution to resolve the health problems of MRDP and help them adjust new way of life.

The human rights of MRDP are often violated which adds to a precarious unhealthy living environment/conditions, e.g. sexual violence, long-term detention babies born with no citizenship, limited access to education, child prostitution and malnutrition.

Adopted in 1983

Revised and updated in 2000

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Related ICN Positions: • Nurses and Primary Health Care

The International Council of Nurses is a federation of more than 120 national nurses' associations representing the millions of nurses worldwide. Operated by nurses for nurses, ICN is the international voice of nursing and works to ensure quality care for all and sound health policies globally.

Violence and Harassment at Work is on the Increase in the European Union (EU)

About 10% of the EU's working population has experienced physical or psychological harassment in their workplace. A similar percentage report themselves to be aware of the existence of physical violence in their work place, according to a new report by the European Foundation for the Improvement of Living and Working Conditions. The report also highlights the important financial benefits to companies of reducing violence and harassment in the workplace and reveals the problem to be on the increase in the EU.

"Both men and women experience violence at work, but women remain more vulnerable than men, with women often concentrated in "highrisk" jobs such as nursing, social work and teaching", says Raymond-Pierre Bodin, the Foundation's Director. "Women are also most often victims of intimidation and psychological abuse while men are more frequently exposed to physical violence and assault". The report shows that sexual harassment at work, particularly against women, is commonplace in all European countries, but often goes unreported due to fear of being ostracised, job loss and other factors.

Although faced with a persistent lack of data on this controversial issue, the report shows that worker productivity can be reduced by at least 2% as a result of psychological violence alone. Results also highlight the significant negative financial and productivity implications of violence and harassment at work. These are reflected in higher absenteeism rates, ill health and early retirement, high staff turnover and increased insurance premiums. Both physical and psychological violence also has serious implications of health and well-being, causing stress disorders and suicidal tendencies.

SEW NEWS • N°2 - April-September 2003

Ejjew nieqfu ftit ...

KLIEM TAD-DEHEB

U Alla halaq il-hmar u qallu: "Int hmar, se tghaddi hajtek tahdem u tbat minn filghodu sa filghaxija. Biex tghix trid tiekol il-haxix. Mhux se jkollok intelligenza u se tghix ghal hamsin sena."

Il-hmar wiegeb: "Biex nghix hamsin sena f'dik it-tbatija naraha wisq. Tista' thallini nghix sa 20 sena?" U hekk kien.

Imbghad Alla halaq lill-kelb u qallu: "Int kelb. Trid iżżomm l-ghassa mad-djar tal-bniedem, li tieghu se tkun l-ikbar habib. Se tiekol minn dak li jhalli u se tghix 30 sena." Il-kelb wiegeb: "Mulej, li nghix ghal 30 sena bhal kelb naraha wisq. Tista' thallini nghix sa 15 il-sena?" U hekk kien.

Il-Mulej imbghad halaq lix-xadin u qallu: "Int xadin, trid tixxabbat mas-sigar. Trid tkun tač-čajt u se tghix ghal ghoxrin sena." Ix-xadin wiegeb: "Mulej, ma tahsibx li 20 sena huma wisq?" Hallini nghix ghal ghaxar snin". U hekk kien.

Fl-ahhar Alla halaq lill-bniedem u qallu: "Int bniedem, l-uniku hlejqa li tirrağuna. Trid tuza l-intelligenza tieghek fuq il-hlejjaq l-oħra. Trid tiddomina d-dinja u se tghix 20 sena". Il-bniedem qallu: "Mulej, ghaliex daqshekk biss?" Jekk jogħğbok tini t-tletin sena tal-hmar, il-hmistax tal-kelb u l-ghaxra tax-xadin,. U hekk kien.

U Alla ghamel il-bniedem jghix 20 sena ta' rağel, imbghad jizzewweğ u jghix 30 sena ta' hmar, jahdem u jbat. Imbghad ikollu t-tfal u jghix 15 il-sena ta' kelb, jiehu hsieb id-dar u jiekol dak li jhallu t-tfal wara li jkunu żarmaw il-frigğ. Imbghad jghix l-ahhar 10 snin ta' hajtu bhax-xadin, jikkummiedja biexiżomm lin-neputijiet kwieti.

U hekk kien.



EARN TO CARVE YOUR HURTS IN THE SAND AND TO CARVE YOUR BLESSINGS IN STONE

A story tells that two friends were walking through the desert. During some point of the journey, they had an argument, and one friend slapped the other one in the face. The one who got slapped was hurt, but without saying anything, he wrote in the sand:

"TODAY MY BEST FRIEND SLAPPED ME IN THE FACE"

They kept on walking, until they found an oasis, where they decided to take a bath. The one who had been slapped got stuck in the mire and started drowning, but his friend saved him. After he recovered from the near drowning, he carved on a stone:

"TODAY MY BEST FRIEND SAVED MY LIFE"

The friend, who had slapped and saved his best friend, asked him, "After I hurt you, you wrote in the sand, and now, you carve on a stone, why? The other friend replied: "When someone hurts us, we should write it down in sand, where the winds of forgiveness can erase it away, but when someone does something good for us, we must engrave it in stone, where no wind can ever erase it."

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MCH Group Committee Report 2004

II-Group Committee tal-Isptar Monte Carmeli baqa' għaddej bil-hidma tieghu fl-isptar

Peress li xi membri tal-kumitat kienu ireżenjaw minhabba diversi raġunijiet, saret sejha biex jinhatar kumitat ġdid. Il-membri l-ġodda li lahq għas-sentejn li ġejjin huma:

Chairperson: Frankie Mifsud

V/chairperson: M'Anne Bugeja

Segretarja: M'Anne Bonello

A/Segretarja: Mary Azzopardi

Kaxxier: Ronald Pavia

I-Chairperson Frankie Mifsud baqa' jieh u sehem attiv fil-laqqgħat li t-task force qiegħed jagħmel biex iressaq il-proposti tiegħu għal reviżjoni tal-'ward compliment' ġdid minflok dak tal-2001. Ix-xogħol mexxa għali u sa l-aħħar ta' din is-sena huwa previst li t-task force tlesti x-xogħol kollu. Wara, r-rapport jiġi ppreżentat lill-Kunsill tal-MUMN u tal-Unions l-oħra kif ukoll lid-Dipartiment. Nisperaw li meta jitlesta l-'compliment' il-ġdid ikun ta' benefiċċju kemm għall-istaff kif ukoll għar-residenti.

Din is-sena l-Group Committee impenjat hafna speċjalment:

1. Bil-ftehim mad-Dipartiment·biex illum kull ward tkun bil-'full compliment'.
2. Bil-ftuh tad-'Dual Diagnosis Unit' għall-pazjenti bi problema ta' mard mentali·u abbuż ta' droga, u
3. Bil-problema akuta ta' numru kbir ta' 'asylum seekers' li kienu qed jiġu ammessi fil-MW1. Il-ftuh ta' unit apposta għalihom solviet il-problema.

Dan minbarra problemi u każi ta' dixxiplina tal-membri li minn żmien għal iehor il-group committee jiffaċċja.

F'ismi u f'isem il-membri l-oħra tal-grupp nagħti l-awguri lill-membri tal-MUMN, partikolarment dawk ta' l-isptar Monte Carmeli.

FRANKIE MIFSUD NO

Chairperson - MUMN MCH Committee

Il-Pesta f'Malta

AMANTE DARMANIN

EN SVPR

■ amante@onvol.com

IT-TIENI PARTI

F'Malta kien hawn hames epidemiji tal-pesti: fl-1592-93; fl-1623; fl-1655; fl-1676 u fl-1813. Il-pesti tal-1676 kienet l-aghbar waħda.

Il-Pesta tal-1676

Kien hemm rapporti li f'Konstantinopli, Rodi, Tripli u Tunes kien hemm il-pesti u għalhekk l-awtoritajiet sanitarji f'Malta qagħdu b'seba' għajnejn.

Fis-sebgha ta' Awissu 1675 wasal xini tal-gwerra Inġliż bi 68 skjav (l-Inġilterra kienet fi gwerra kontra Tripli). Dawn tpoġġew fi kwarantina għal 28 ġurnata. Fl-24 ta' Awissu wasal ix-xini *Santa Caterina* u miegħu ġab l-ahbar li, fil-25 ta' Ġunju, fi Smyrna (Illum Izmir, Turkija) faqqgħet il-pesti. Għalhekk il-merkanzija kollha ġiet maħżuna f'kwarantina. Fis-6 ta' Settembru waslu tlett xwieni oħra Inġliżi u sitta oħra dahl fuq fil-21 ta' Ottubru. Fl-24 ta' Ottubru wasal ix-xini *Madonna del Rosario* minn Acre (Illum Akko, Israel) u dan kellu katavru fuq. Għalkemm it-tabib tax-xini qal li l-katavru ma kellux pesti, ix-xini tpoġġa taht kwarantina u fit-8 ta' Diċembru l-merkanzija ġiet imħallija. Sa l-ewwel ta' Diċembru kien hawn sbatax-il vapur Inġliż fil-port il-kbir.

Xi wiehed minn dawn ix-xwieni seta' ġab il-pesti għalkemm ma nafux liema. Li nafu hu li fl-24 ta' Diċembru, 1675, Anna Bonnici, ta' hax-il sena, it-tifla ta' Matteo u Maria Bonnici qabadha d-deni u meta t-tabib Giacomo Cassia, eżaminha, sab li kellha xi tikek homor u boċċa fuq in-naħa tal-lemin tal-*groyin*. Matteo Bonnici kien negozjant tad-drapp, speċjalment tal-ghazel (linen) bl-ingrossa u spiss kien jixtri id-drapp minn fuq ix-xwieni. Il-familja Bonnici kienet toqgħod il-Belt u Matteo kellu sebat itfal, tnejn mill-ewwel

żwieġ u hamsa mit-tieni. Matteo kellu wkoll ilsira u żewġ imħażen fix-xatt tal-Belt. It-tabib avża il-*protomedico* (CGMO). It-tabib Cassia iċċertifika l-marda bħala deni malinn (malignant) komuni. Anna mietet fit-28 ta' Diċembru u ġiet midfuna fil-knisja ta' Ġiezu l-Belt.

Ma ninsewx li l-pesti kienet meqjusa kastig t'Alla u hadd ma jixtieq jammetti li laqqgħat dan il-kastig.

Iżda dan kien għadu bidu għall-familja Bonnici għax ġimgha wara l-mewt ta' Anna, huha ż-żgħir, Giacchino, marad u miet fl-10 ta' Jannar 1676. Giacchino kellu biss sentejn u skont it-tobba il-kawża kienet ta' komplikazzjoni wara hrug ta' snien (*teething*). Dan minkejja li t-tifel kellu tlett petechiae (tikkek skuri u tbenġil) fuq idejha il-leminija. Fl-istess ġurnata li marad Giacchino, mardet waħda mill-ilsiera ta' 18-il sena u din ukoll kellha boċċa fuq il-lemin tal-*groyin*. Din l-ilsiera baqgħet hajja. Issa kien imiss lil Teresa, tifla oħra ta' Matteo li kellha seba' snin li fit-13 ta' Jannar mardet ukoll. Hawnhekk l-awtoritajiet kienu qed jissuspettaw xi haġa u għalhekk imbarraw id-dar ta' Matteo u ta' Domenico Agius li kien joqgħod f'parti separata iżda fl-istess

binja. Domenico kien miżżewweġ lil Caterina, oħt Maria. Teresa mietet wara erbat ijiem. Il-mewt issa żaret lil Grazia, ilsiera oħra ta' 60 sena u lil Antonia ta' seba' snin, it-tifla ta' Domenico Agius.

Matteo irnexxielu jipperswadi, bi hlas, kirurgu jismu Carolo Bugdan biex ighix mal-familja halli jipprova jikkura il-marda. Raġel iehor kien iwassal l-ikel, il-mediċina u provizjon iehor. Is-servizz ta' tabib kien għalxejn għax fil-25 ta' Jannar, Matteo stess marad u miet tlett ijiem wara. Ftir wara miet tifel iehor ta' Matteo, Giovanni, u miet tifel mill-familja ta' Domenico Agius.

Il-*protomedico* għamel laqgħa biex jaraw x'jista' isir. S'issa kienu inċerti jekk kinetx il-pesti. Ma ninsewx li l-pesti kienet meqjusa kastig t'Alla u hadd ma jixtieq jammetti li laqqgħat dan il-kastig. Li kieku kienu ċerti li kienet il-pesti kieku ma kienux jidfnu l-mejtin tal-familja Bonnici u Agius fil-knejjes. Il-laqgħa saret fit-28 ta' Jannar u rapport ġie presentat lill-Gran Mastru, Nicholas Cotoner u l-Kunsill ta' l-Ordni. Dan ir-rapport irrakkomanda li ż-żewġ familji jiġu trasportati fuq il-gżira ta' *Isolotto* (Illum Manoel Island) biex jinżammu fi kwarantina fil-*Lazaretto* kif fil-fatt sar. Il-kunsill ordna li jitwaqqaf Tribunal għas-saħħa pubblika. Dan kien jikkonsisti minn erba' kavallieri. Dawn ordnaw ukoll li l-affarijiet fiż-żewġ idjar u anke fil-hanut ta' Matteo Bonnici jiġu trasportati għall-*Lazaretto*. Ordni stretta, piena ta' mewt, inħarġet biex ma jintmissux jew jittiehdu l-affarijiet tal-morda. Il-gwardji fuq *Isolotto* ordnawhom li jisparaw lil min jipprova jahrab mill-gżira. Inħareġ *bando* (*avviż*) li kull min jimrad irid javża l-awtoritajiet mediċi.

Miż-żewġ familji, tlieta jew erba' biss salvaw, fosthom Maria, il-mara ta' Matteo u binha Fabrizio. S'issa l-pesti ma kienetx għada bdiet tinfirex iżda ma damitx wisq għax fil-31 ta' Jannar mardet mara jisimha Giovanella u din kellha boċċa (*bubo*) taht aptha. Ġimgha wara miet tifel, li għalkemm ma kellux sinjali ta' pesti ommu kienet mietet hmistax-il ġurnata



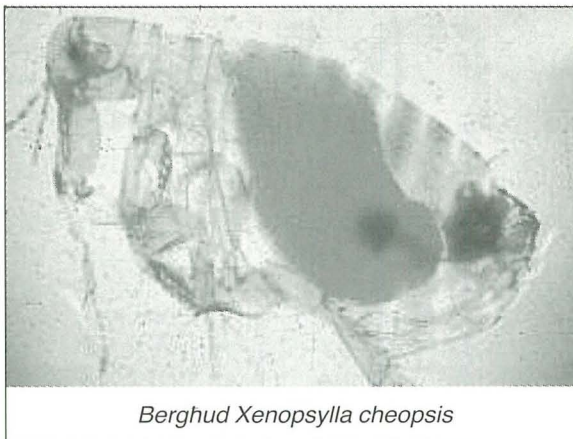
Tifla marida bil-pesti bubonika

qabel u din kienet xtrat xi drapp, xi erba' xhur qabel, minghand Matteo. Il-familjari ta' dawn ittiehdu Lazzarett u djarhom inghalqu. Sa issa l-pesta kienet ghada fil-Belt biss.

Issa kien imiss lil Grazia, mara minn H'Attard u binha li mietu fit-8 ta' Frar. Grazia, x'aktarx kienet xtrat xi drapp minghand Matteo jew mill-hwienet li kienu jixtru minghandu. Grazia mietet wara ġimgha u binha wara biss erbat ijiem. Fuq il-ġisem tagħhom kellhom il-marki tal-*petechiae*. Ghalkemm Grazia indifnet ġo ghalqa it-tifel indifen hdejn il-bieb tal-knisja ta' H'Attard. Ftit wara mardu l-familja tad-deffien li kien difen lit-tifel infettat. Fi Frar biss il-pesta qerdet il-hajja ta' 42 ruh, fil-Belt, H'Attard u Lazzarett. Għall-ewwel darba il-bord mediku indika li d-deni malinn seta' kien kawża tal-pesta. Issa l-pesta bdiet tinxtered bħan-nar minn dar għal ohra, minn villaġġ jew rahal għall-iehor.

Fl-14 ta' Frar il-pesta dehret fl-Isla u ġimgha wara miet tifel f'Sant Anġlu (dak iż-żmien kienet separata mill-Birgu). Fit-8 ta' Marzu, Bormla messa l-ewwel vittma u Birkirkara jumejn wara. Issa hafna min nies bil-biża bdew jaharbu lejn irhula aktar il-bogħod jew f'xi ghorfa fil-kampanja u saħansitra waqqfu kampijiet fl-ghelieqi. Ohrajn issakkru ġo djarhom. Fil-11 ta' Marzu kemm il-Birgu kif ukoll ir-Rabat kellhom l-ewwel imwiet. L-ghada miss lil Hal-Kirkop u lill-Qrendi. Hal-Qormi fis-16 u Hal-Balzan fl-24 ta' Marzu. Fil-25 mess lis-Siġġiewi u Haż-lebbug. Iż-lurrieq fid-29. Fl-4 ta' April kien imiss lil Hal-Lija u, Hal-Tarxien fit-8. Ġurnata wara kien imiss lil Hal-Luqa u fit-13 lill-Għarghur. L-Imqabba fit-22. Fl-4 ta' Mejju il-pesta waslet sal-Gudja u fis-17 waslet iż-lejtun. Kien fl-24 ta' Mejju li l-pesta waslet il-Mosta.

Fit-19 ta' Marzu il-kunsill tal-Ordni hareġ regolamenti ġodda. Ma setghux isiru purċissjonijiet, kull laqgħa reliġjuża jew ċivika ġew issospenduti. Il-fontijiet ta' l-ilma mbierek ġew imbattla. Il-kavallieri setghu jattendu xi knejjes waqt li l-poplu jattendi ohrajn. Ma setax isir transport ta' affarijiet min naha għall-ohra. Gwardji ġew ippustjati bejn



Berghud Xenopsylla cheopsis

rahal u iehor biex ma jhallux lil xi hadd jghaddi jekk ma jkollux permess. Gwardji ohra qagħdu maxxtut biex ma jidhlux affarijiet bid-dghajjes. Kull kuntatt ma' Ghawdex kien maqtugh, barra dak tal-provizjon ta' l-ikel. Hafna drabi dawn ir-regolamenti kienu jiġu miksura.

Sadanittant il-bord mediku kien maqsum fi tnejn. Kien hemm il-fehma ta' G.D. Xeberras, il-*protomedico* u shabu, li dan kien il-flagell tal-pesta (pestilential) filwaqt li minn naha l-ohra kien hemm it-tabib Giuseppe Del Cosso u shabu li kienu tal-fehma li kienet epidemija ta' xi mard jittiehed komuni hafna fl-Ewropa minn influwenza tal-pjaneta Saturnu. Dan id-diżgwiit bejn it-tobba holoq hafna inċertezzi u xi azzjonijiet li segħtu ntużaw biex iwaqqfu l-pesta damu wisq. Del Cosso kien l-uniku barrani fil-bord mediku u forsi għalhekk kien aktar emmnut mill-Ordni u l-fnkwiżitur. Huwa kien tal-fehma li d-deni kien sa jieqaf wahdu u għalhekk ma kienx hemm għalfejn jingarru l-morda lejn Lazzarett. Fl-ahħar ta' April, l-Inkwizitur kien għadu jilmonta li dawn għadhom ma waslux għal konklużjoni jekk kinetx pesta jew le. Fis-27 ta' April it-tabib Gio Francesco Bonamico, li ma kienx fil-bord mediku, baġhat erba' ittri bid-deskrizzjoni tal-marda lill-Akademja Medika ta' Ruma, Pariġi, Firenze u Valenzja. Dawn kienu kollha tal-fehma li l-marda kien flagell tal-pesta. Iżda sakemm irċieva r-risposta l-pesta kienet ġa nxtendet kwazi ma' Malta kollha.

Hawn Interessanti ngħidu x'kien isir biex jiġi protett l-isptar ta' l-Ordni, *is-Sacra Infermeria*. Fit-18 ta' Marzu qasmu parti mis-*Sacra Infermeria* tisseejjah *Probatorio*. Il-foqra ma

kienux jithallew jidhlu fis-*Sacra Infermeria* iżda kienu jingħataw għajnunha fid-djar. Il-morda l-*'godda'* kienu jitqegħdu fil-*Probatorio* għal 3 ijiem. Jekk fit-3 ijiem jirriżulta li għandu l-pesta, il-marid jintbghat il-Lazzarett, jekk le jitpoġġa f'*Infermeria*. L-istess kien jiġri għall-isptar ta' Santu Spirtu fir-Rabat. Kavallieri morda kienu jitpoġġew f'sezzjoni għalihom biex ma jithaltux mal-bqija tal-popolazzjoni. Jekk Kavallier kien jiġi infettat bil-pesta kien jittiehed il-*Camerata*, ftit il-bogħod mis-*Sacra Infermeria*.

Iktar ma bdew jinfettaw nies iktar kien hemm il-htieġa li jinfethu sptarijiet ta' isolament (Lazarettos), billi jittiehdu xi djar. Dawn kienu qed jinfethu fl-irhula jew bliet stess. Id-deffiena kienu jissejhu *beccamorti*, u xogħolhom ma kienx biss li jidfnu l-mejtin iżda anke li jġorruhom, ighinu 'il morda, iġorru l-ikel u jiffumugaw id-djar. Hafna mill-*beccamorti* kienu jispiċċaw jimirdu huma stess. It-tobba li jiċċertifikaw il-pesta kienu jissejhu *chirurgo infetto* u ġeneralment kienu jithallsu aktar għas-sogru li jiehdu.

L-ahħar vittma ta' din il-pesta kellha 16-il sena, Elena Bartolo u mietet fil-15 ta' Lulju. Il-popolazzjoni ta' Malta qabel il-pesta kienet ta' madwar 51,114 ruh u minn dawn mietu madwar 11,278. Dan ifisser li mietu 22% jew wiehed minn kull 4.5 tal-popolazzjoni ta' Malta. Ta' min ighid li kemm Ghawdex kif ukoll Hal-Safi ma ntmessux u x'aktarx għalhekk Hal-Safi ha dan l-isem. L-iktar li intlaqat kien il-Birgu li minn 3,200 mietu 1,800 jew aktar minn 56%. Tant mietu l-Birgu li hafna mill-katavri thallew mitluqa fit-toroq. Wara l-Birgu tiġi Bormla li minn 2,950 mietu 1,500 jew 50.8% u l-Isla bi popolazzjoni ta' 4,000 mietu nofshom. Il-Belt li kien jinkludi il-Lazzarett, minn 12,064 mietu madwar 4,000 jew 33%, iġifieri wiehed minn kull tlieta. Postijiet ohra milquta hażin kien hemm Haż-labbar li minn 1,500 mietu 355 jew 23.6% kwazi wiehed minn kull erbgħa. Hal-Tarxien li kien jinkludi Paola kellu popolazzjoni ta' 850 u mietu 162, 19%. Warajh jiġi l-Qrendi li mietu 102 minn popolazzjoni ta' 850 jew 12%.

(jitektomla fil-harġa li jmiss)

FOREIGN NURSES HAVE SERVED

NWAOKORO JOAKIN CHIDOZIE (NJC)

Chairperson, Foreign Nurses Committee

■ nwaokorojc@hotmail.com

It has come to my notice about the wave of uncertainty regarding our job in Malta. Rumour holds it that the Government is threatening not to renew our contracts. Driven by personal conviction, I can tell you that this is fallacious. Against the backdrop of these wide spread rumours, I want to reassure you that our employers are human beings and they have consciences. I consider the rumour as outlandish. We shall not be intimidated by the leverage which these rumour mongers may think they have over us.

Recall the time Malta was in dire need of nurses. Foreign nurses had worked along with them in service to Maltese people and humanity in general. Should any Government (present or future) decide to revoke our contracts, it will be a monumental mistake. Foreign nurses who worked in Malta hospitals in the 80s and early 90s were like a comet. This is a time when Malta needs services of foreign nurses. Should our reward be, go to hell we don't need your services in any more? I don't think so. We have helped the Maltese healthcare system and showed strength in the face of weakness. Is now the time to throw a baby out with the bath water because the state has produced enough nurses who are citizens?

Justifying our position, foreign nurses have contributed and are still contributing to the care and well being of patients in Malta hospitals. Our efforts have not wavered and cannot be underestimated. Honestly and to say the least, we have served. In the light of this, I suggest that foreign nurses have secured an enviable place in the pages of history in Malta workforce.

Should these rumours contain elements of truth, it will be a source of anguish to foreign nurses and will precipitate a deluge of sympathisers of which MUMN would be the key player. At this point, am seeking to dissuade those who clamour about what will become of their jobs, you are not alone. God is with us and your jobs are protected.

We shall and shall continue to resist such rumours, which in my considered opinion cannot be in our interest.

Our unsolicited adulation to the Government of Malta for offering jobs to us still remains supreme. We thank you also.

I wish you all Merry Christmas and many more years of service in Malta. May God guide and protect us and may God bless the people of Malta.

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The Benefits of European Networking

MARY ANN BUGEJA

SN BSc (Hons) Nurs.
Financial Secretary, MUMN
Official Delegate EFNA

PAUL PACE N.O.

Chairperson, MUMN Education
Executive Committee
Deputy Official Delegate, EFNA

After the entry of Malta in the European Union, the Malta Union of Midwives and Nurses (MUMN) affiliates as full member within the Standing Committee of Nurses of the EU (PCN). The MUMN participated in the last meeting of the PCN in Amsterdam where the new Constitution had been approved. The name of the organisation is changed to the European Federation of Nurses Associations (EFNA) to reflect more the reality of the organisation. As at present it represents all National Nursing Associations in the European Union Member States and other European countries such as Norway, Switzerland, Croatia, Romania and Slovak Republic that have special interests in the European Union.

You may ask this question, 'What are the benefits for the Maltese Nurses in EFNA?' EFNA is the official body in the European Union for Nurses working towards three main objectives. These are:

1. To ensure that Nurses and Nursing is central to the development of Social and Health Policy and its implementation in EU and Europe.
2. To support and facilitate a qualitative and equitable health service in the EU and Europe by a strategic contribution to the development of a sufficient, effective, Competent and motivated workforce of Nurses.

3. Strengthening EFNA representation in the EU and Europe and develop EFNA key role as bridge between National Nurses Association and decision-makers in the EU institution.

Hence, guidelines and other regulations will emerge from EFNA, which will affect us all. Thus it is important for MUMN to be present at the meetings not only to be aware of the latest innovations in nursing regulations but also to actually participate, view the opinions and influence decisions in the interest of the Maltese Nurses.

EFNA is co-coordinating various projects on Nurses' issues. Issues, which will have direct effect on the Nursing care, which means affecting the level of service towards our consumers. For instance, such issues are Life Long Learning, Mutual Recognition, Medical Devices and Sharp Injuries, Patient Safety, Euthanasia and Bologna Position Treaty. The MUMN delegates have direct participation in the Life Long Learning project.

To conclude, it's good to know that within only three years of affiliation and thanks to the hard work that MUMN carries out at EFNA meetings, our Union Delegates succeeded to bring the EFNA General Assembly meeting in Malta for 2006. This prestigious event will invite all European Nurses Leaders in our small island for the first time in the Maltese Nursing history.





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NURSE OF THE YEAR AWARD ~ 12th MAY 2005

NOMINATION FORM

A NURSE can be nominated on one or more of these three aspects down listed by two of her/his nursing/midwifery colleagues: -

1. Demonstrates professional dedication that exceeds regular duty requirements, which resulted in significant contributions to the health and well being of patients/clients while delivering Nursing care.
2. Exemplary leadership and skill resulting in noteworthy accomplishments, productivity, creative resource utilisation and enhancement of patient/client relationships.
3. Noteworthy accomplishments in professional education/research, which stimulates development of new knowledge and practice in Nursing.

We are nominating Ms/Mr....., ID No:....., Grade:....., on aspect/s number (1, 2, 3) and are attaching all relevant documents to prove and explain in detail our nomination with this form. We understand that this form has to be sent to the MUMN's Offices in Tower Apartments, No. 1, Triq tas-Sisla, Birkirkara, BKR 13 by not later than Friday 25th February 2005.

Nominee's Signature (1)

Nominee's Signature (2)

ID No:

ID No:

Signature of Appointee

MIDWIFE OF THE YEAR AWARD ~ 5th MAY 2005

NOMINATION FORM

A MIDWIFE can be nominated on one or more of these three aspects down listed by two of her nursing/midwifery colleagues: -

1. Demonstrates professional dedication that exceeds regular duty requirements, which resulted in significant contributions to the health and well being of woman/neonatal/family while delivering Midwifery care.
2. Exemplary leadership and skill resulting in noteworthy accomplishments, productivity, creative resource utilisation and enhancement of patient/client relationships.
3. Noteworthy accomplishments in professional education/research, which stimulates development of new knowledge and practice in Midwifery.

We are nominating Ms....., ID No....., Grade....., on aspect/s number (1, 2, 3) and are attaching all relevant documents to prove and explain in detail our nomination with this form. We understand that this form has to be sent to the MUMN's Offices in Tower Apartments, No. 1, Triq tas-Sisla, Birkirkara, BKR 13 by not later than Friday 25th February 2005.

Nominee's Signature (1)

Nominee's Signature (2)

ID No:

ID No:

Signature of Appointee

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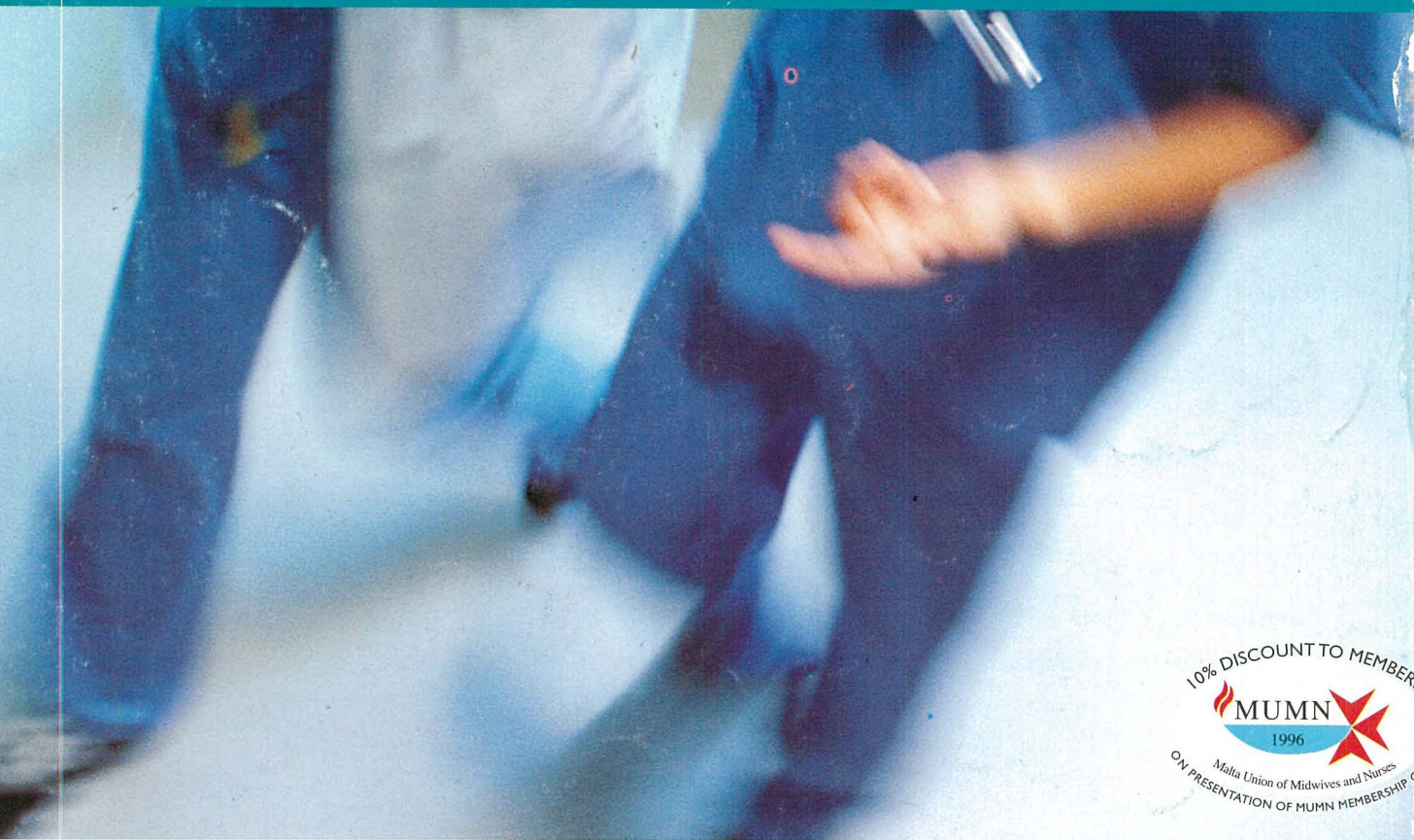


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