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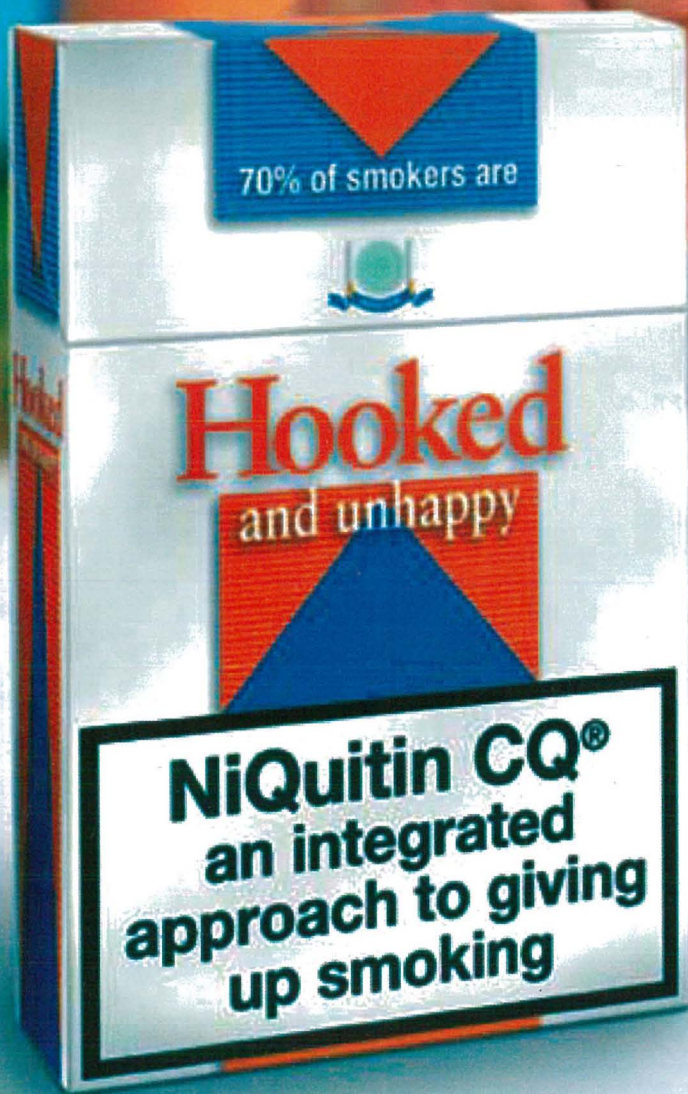
MALTA NURSING AND MIDWIFERY JOURNAL



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Il-fehmiet li jidhru f'dan il-Gurnal mhux neccessarjament li jirriflettu l-fehma jew il-policy ta' l-MUMN.

Il-bord editorjali jiggarrantixxi id-dritt tar-riservatezza fuq l-indirizzi ta' kull min jirchievi dan il-Gurnal.

Dan il-Gurnal jittqassam b'xejn lill-membri kollha u lill-entitajiet oħra, li l-bord editorjali flimkien mad-direzzjoni tal-MUMN jiddeciedi fuqhom. Kull bdil fl-indirizzi għandu jiġi kkomunikat mas-Segretarija mill-aktar fis possibli.

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L-indafa fl-Isptar

editorjal

M'hemmx ghalfejn wiehed ikollu hafna ittri wara ismu biex jintebah bl-istat ta' telqa u traskuraġni li jinsab fih l-isptar ċentrali ta' Malta, b'mod speċjali f'dak li ghandu x'jaqsam ma l-indafa. Żgur li f'kull sala jew post li tghaddi minnu jew tidhol fih ghandek tara u tmiss in-nuqqas ta' ndafa u iġene kważi kullimkien b' eċċezjoni ta' postijiet żagħar u għalhekk maniġibbli jew b'numru adegwat ta' 'cleaners'. Possibli anqas ta' din il-ħaġa daqshekk importanti ma nagħtu każ biżżejjed? Jew kollox sar jgħaddi, basta ma nidhlux fi spejjeż żejda? Dan la hemm ghalfejn tkun xi Professur u l-anqas Nurse jew Midwife biex tintebah li fi sptar l-indafa hija xi ħaġa kruċjali. Li hu żgur hu li l-istess hmieġ jiddemoralizza mhux ftit lin-Nurses u l-Midwives waqt ix-xogħol tagħhom.

Bl-ebda mod dan l-Editorjal ma jrid jagħti xi tort lill-'cleaners' li l-maġġoranza tagħhom qed jippruvaw jagħmlu dak kollu li jistgħu, biex ilaħħqu mad-domanda ta' xogħol li żdied mhux ftit. Xogħol bħall-sodod fil-korsiji u kuraturi u għalhekk aktar pazjenti li bilfors iġibu aktar hmieġ. L-anqas dawn ma jistgħu jagħmlu l-mirakli.

Għaddejna minn wisq taqlib fl-indafa, mingħajr hadd ma ġie kkonsultat kif suppost; bħal xiri ta' makni tal-ħasil li ma jistgħux inadddu taħt is-sodod tal-marid, u dan bi spiża mhux żgħira! X'sar minnhom?; Bdil f' 'policies' u harsien ta' regolamenti tal-'Health and Safety' bħal per eżempju ma jtnadddux hġieġ ta' twieqi li jagħtu għal barra u li jkunu fil-ġholi. Prosit, hekk ghandu jkun, pero' min ser jagħmlu dan ix-xogħol u meta? Jew ser inhallu l-hmieġ jakkumula b'tali mod li l-hġieġ għal barra ma tarax minnu, kif fil-fatt ġara? Issa ilna wisq b'dal-hmieġ u mhux 'fair' la għall-pazjent u l-anqas għal min jaħdem kontinwament fih. Biex taxxaqha il-hmieġ fl-isptar jirdoppja wkoll bil-problema tal-ħamiem u ċ-ċumnija tal-ċineratur li ġiddmu kull m'hemm.

Xi ngħidu għal kemm il-darba, ġibna kuntratturi biex jissupplixxu 'cleaners'? Imbagħad ergajna koppi, b'konsegwenza li 'cleaners' mhux tal-kuntratt u li kienu draw fil-post qabel, ċaqlaqnihom minn posthom b'detriment għall-Ward. Dawn kienu skossi żejda li żgur affetwaw l-indafa.

Xi ngħidu għall-famuži sodod u kif dawn għandhom jtnadddu. Anke dawn irnexxielna nivvintaw formula kif jtnadddu: il-parti ta' fuq tas-sodda titnaddaf minn Nursing Aide jew Health Assistant jew Carers (jekk ikun hemm) u l-parti t'isfel mill-'cleaners'. Assurdità. Daqs kemm m'hix assurda l-kwistjoni ta' min ghandu jnaddaf sink tal-pazjenti. Hadd ma jista' jaqbel. Il-'job descriptions' għandhom ikunu ċari għal kullhadd.

Ma nistgħux ma nsemmux ukoll is-sistema tal-aħħar tal-ġbir tal-platti wara l-ikla ta' fl-ghaxija lill-pazjenti. Il-'cleaner', bir-roster il-ġdida jkun telaq, għalhekk Nursing Aide, Health Assistant jew Carer irid jiġbor il-platti hu u jbattal kollox fil-'bins'. Tajjeb infakkru li dawn qegħdin hemm biex jgħinu fix-xogħol tan-Nursing u ta' sikwit jew ikunu qegħdin b'xi qadja oħra jew mhux dejjem ikun hemm minnhom minhabba diversi fatturi. Ir-riżultat hu li dan il-ġbir ikollu jgħamlu xi hadd! U għalhekk jispiċċa jagħmlu n-Nurse, għax in-Nurse fin-natura tiegħu ma jhobbx il-hmieġ. Din ta' l-aħħar l-anqas hi sew għax allura vera n-Nurse irid jagħmilha ta' kollox! X'qiegħed jiġri wara, kullhadd jaf, għax barra storbu żejjed mix-xift ta' 'cleaners' ta' bil-lejl, it-tindif in ġenerali jista' jkun ferm aħjar minn kif ġie mwieghed. M'għandna l-ebda kritika għal sistemi ġodda iżda f'kull mument l-ilment tan-Nurse irid jigi mismugh.

U fl-aħħar, il-famuża 'cross infections', li minn meta konna studenti, dejjem nisimghu lill-hafna jippridkaw fuqha! U bir-raġun. Però mbagħad tosserva lil min per eżempju jiġbor il-'laundry' l-maħmuġa, diehel f'xi sala tal-maternita' b'karru mikxuf mimli daqs bajda b'lożor ta' swali oħra, u addio 'cross infections' u addio kollox biex imbagħad ma nhallux hlief lir-raġel tal-omm iżur fl-istess ward biex ma 'ndaħhlux' infezzjonijiet. Ma nafx kemm aħna kredibbli f'dawn iċ-ċirkostanzi!

message from the president

Dear Colleagues,

The year 2005 has started with a bang, meetings and discussions on reform and new collective agreements are the order of the day. Just to mention one episode, in mid-January all Unions including MUMN formed a round table marathon of discussions to try and find common ground for a National Pact. The hours of discussion were uncountable and unfortunately the outcome was not a success from the point of view of concluding an agreement, but I believe that the fact that all Unions gathered together was a first in our Island.

Other issues in the pipeline are the never ending story of the Sectoral Agreement were MUMN is building up pressure on the Government to conclude otherwise we shall not be taking part in discussing new working conditions brought up as part of the Health Reform. There is also the General Agreement for the Public Service, which is still to be concluded. I admit that when I mention this agreement I feel a shiver down my spine, as the proposals presented by the Government are a deterioration of working conditions. It was proposed that no more increments shall be given to government employees during the term of this Agreement, the pre-retirement incentive shall be abolished and the maximum overtime rate of pay shall be capped to salary scale 11. Mind you, there were some family-friendly proposals too, such as increasing the age limit for children so that an employee will have an increase in the entitlement for paternal leave. All in all the entire package was unacceptable and we made our counter-proposals. First of all by not accepting the measures and we also insisted that the Government must keep to his promise made in the previous collective agreement to adjust the agreed salary proportion to 1:4 from salary scale one to twenty. MUMN will definitely call for a general meeting with its members when the time is right and as I always promised MUMN will never sign an agreement before you approve.

With regards to the Sectoral Agreement we made head with issues regarding continuing education incentives, specialisation, but no common ground was found for discussions related to improved salary structure and early retirement. No deadlock for discussion was registered as yet and we insist that talks shall continue and be concluded.

MUMN was also at the forefront for the formation of the now established FOR.U.M. which is composed by eight Unions who are precluded from having a voice within the Maltese Council for Economic and Social Development (MCESD). The Unions within this forum are working together to exert pressure on the relevant entities in order to be given representation within MCESD. It was agreed that no Union will lose its individual identity but the only objective shall be focused on representation in MCESD.

The MUMN Council unanimously approved to contest the coming elections for the post of Board of Directors representing our Area in the International Council of Nurses (ICN). I am pleased to announce that the Council nominated me to contest this honourable post. The elections shall be held next May in Taiwan and all 125 ICN affiliates are entitled to vote. Malta shall be contesting the post with Cyprus and Morocco.

So as you can see this year seems a very busy one and exciting. We need to consolidate our unity in such a turbulent moment and be rest assured that no changes whatsoever should be accepted without your consent. We must keep strongly together in this difficult moment were all workers nationwide are struggling to maintain rather than improving their standard of living.

I end my message by wishing you and all your family a Happy Easter.

RUDOLPH CINI
President.

message from the secretary general

Nowadays, wherever you go, there might be somebody to rob you, even the very shirt off your back, if you're not careful enough. Walking into a meeting has become a nightmare! Knowing that after the meeting you're empty-handed is already a problem but the worst is that what already has been achieved is threatened, and this adds to everyone's tension.

This is the reality in our country today! It is not my intention at this stage to highlight the reasons that have brought us to this unfortunate position. We are being asked to take an active role in the rehabilitation of our country's economy, and we agree that we should. But there are two conditions that are worth mentioning before one accepts such a role completely.

First we must recognise that the current situation of our country is by no means the fault of the Nurses and Midwives. On the contrary, we have always given an honest days work, sometimes even more than one should expect. We've also had to do work that was not our job to do, simply because there was no one else to do it. Apart from all this, our wage is completely declared for tax purposes, obviously with no chance of tax evasion. It's good to make these points clear and at the same time assume that all employers in this country, including the government, should take on any economic measures. At any point in time, should not expect the workers to take on the burden alone.

The second condition is that we have to be careful so as not to devaluate and demotivate professionals by the measures we are to impose; otherwise it is better not to do anything at all. Unfortunately it seems that slowly but surely we are heading that way. Financial experts who know nothing about our profession and all that pertains to it are pushing through legislations. It would be a shame to see all that's been built so far goes up in smoke in just a matter of months.

This brings me to the National Pact, Sectoral/Collective Agreements and meetings relating to autonomy that were all going on at once! Rudolph is going to give further details about the National Pact in his article, even though we more or less know how the story ends! While in the Sectoral Agreement talks are pending, in relation to better salaries for the scale of Deputy Nursing Officers upwards, there is also the Early Retirement Scheme to discuss.

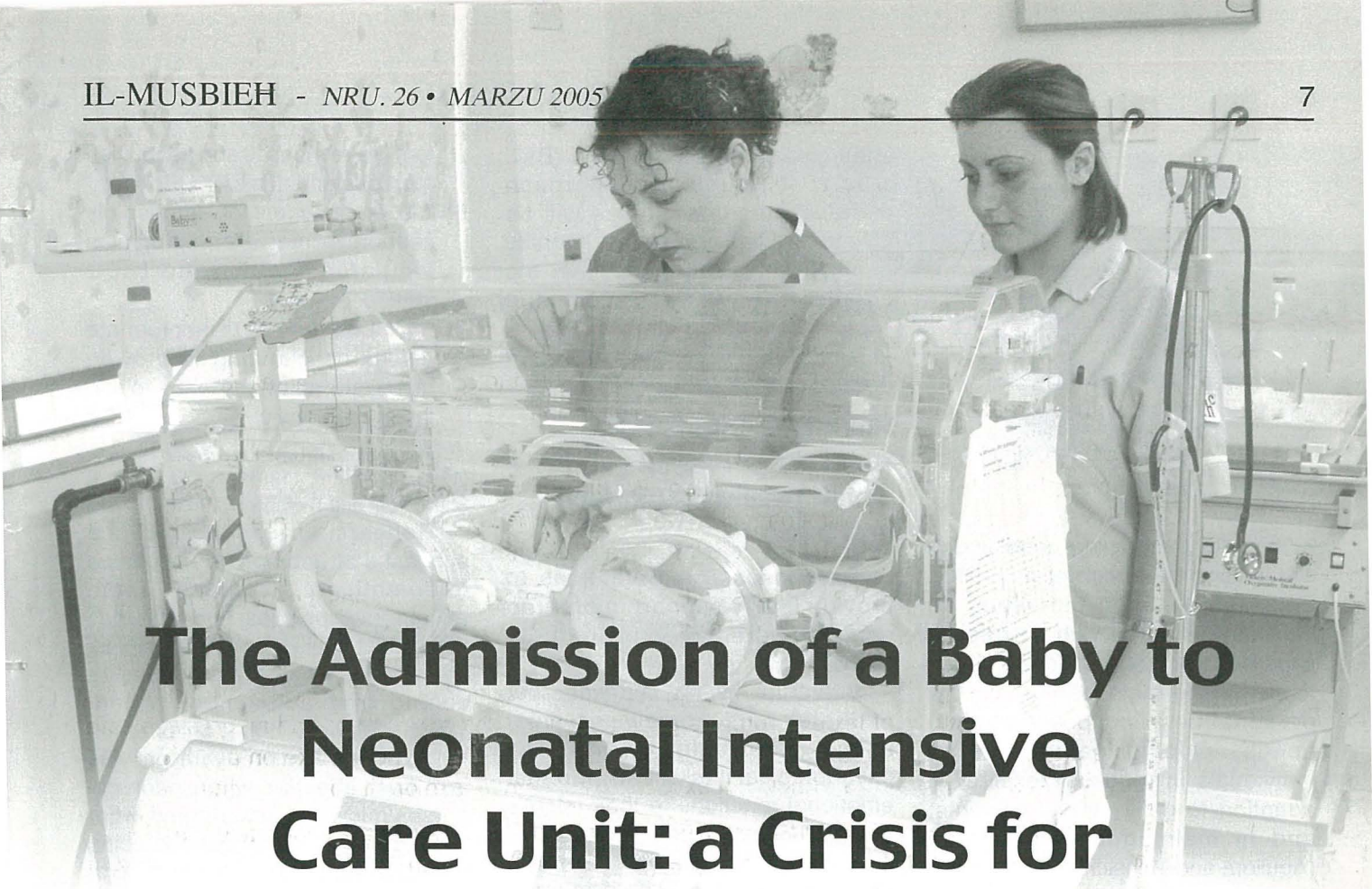
A few weeks ago, during a meeting on the Collective Agreement, the Minister Louis Galea, who I might add, has genuine respect for the Nurses and Midwives and the work that we do, asked the Government Directors to finalise the pending issues and for discussions to proceed in relation to the Early Retirement Scheme. In truth the National Pact did for a while take centre stage, but we are still waiting to continue discussions. With regards to the government proposals in relation to the Collective Agreement, the President will be informing us in his article.

Negotiations have also started on the Health Reform, nowadays better known as the Autonomy. Till now matters don't look too grim but there's a long way to go. We sincerely hope that such an issue is not like that wolf dressed as a lamb.

A new Group Committee has been set up within the Union to tackle Policy & Guidelines. Everybody is harping on about the importance of accountability, but in fact there are no proper guidelines to follow. A few policies do exist, but almost all, focus on infection control. This is why, once again, MUMN is pushing to get things moving in this area.

For the first time in as many years, the Administration at St Luke's has finally decided to take a serious look into the problem of overcrowding. Both the Nurse and the Patient have been given dignified consideration. One should not dare say that there isn't more room for improve, but at least we have started to acknowledge and tackle a situation that our country cannot ignore anymore. We also accept the fact that we have only one general and acute hospital. However MUMN will not accept a reduced Nursing Compliment then the one which we signed for. On this issue there is no compromise.

Enough said for today. I wish you all a very Happy Easter.



The Admission of a Baby to Neonatal Intensive Care Unit: a Crisis for Family Members

Maria Cutajar (*Midwife-Labour Ward KGH, Vice-President MUMN*)

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Introduction:

The admission of a baby to the neonatal intensive care unit (NICU) is often a difficult process for the whole family, and has appropriately been referred to as 'the crisis of neonatal intensive care' (Affleck et al., 1990). Haut et al. (1994) stated that parent-infant attachment and bonding in the NICU is often a difficult process, and this may often evolve over a stressful period of time (Kirby, 2000). Research-based evidence suggests that as the infants in the NICU fight for their lives, their parents also struggle with the psychological consequences of a different aspect of parenthood (Haut et al., 1994; Persoon, 1993; Smith, 1999; Wereszczak et al., 1997).

Bond (1999) implied that instinctive nurturing is a quality that is vital for parenting, and should not be undervalued and overlooked, by the nursing and medical staff

working at the NICU. Since the seminal work of Bowlby (1953), Rutter (1972) and Klaus and Kennel (1976), who all highlighted the social and emotional needs of parents', there has been a gradual progression from encouraging family visiting, to parental participation and family-centred care (cited by Beresford, 1997). Literature review suggest that nursing care at the NICU calls for new model of care which refines the existing model of care by attending to the psychological needs of infants and parents (Allen, 1995a; Allen, 1995b; Orford, 1996; Pray and Hoff, 1992; Wylly and Allen, 1990). These ideas are reflected in the philosophy of care in most units today, where the service is designed first and foremost to meet the needs of the infants, and where partnership with parents refers to a recognition that parents are the primary carers and should be supported by staff in that role. It is important that neonatal nurses/midwives understand the family's

loss and the potential crisis that this event creates (Orford, 1996), and offer concrete suggestions for interventions to make psychological adjustments to this crisis (Miles et al., 1996).

Psychological adjustments to a sick newborn baby:

Ball (1990) argued that childbirth is a life event. Life events produce changes in a person's circumstances or relationships, and whether 'desirable' or undesirable by the individual concerned these can provoke change and thus some degree of stress. Niven (1994) stated that stress can be regarded as a stimulus which disturbs normal functioning and to which an individual respond in some way. Although not all stress is harmful, the degree and intensity of the stress being experienced by an individual affects the nature and outcome of the coping process (Ball, 1990; Atkinson et al., 1990). Coping is the effort to master a situation that is perceived as being



harmful, threatening, conflicting or challenging (Atkinson et al., 1990). Ball (1990) stated that when an individual is faced with a stressful situation, the first reaction is to use those coping methods that suit his personalities and psychological needs. Coping methods assist individuals in reducing tension, in adapting to daily stressful events, and in maintaining equilibrium (Aguilera and Messick, 1990). Stress theory suggests that personal, situational, and environmental variables all affect overall stress response and influence the process of coping and adjustment (Allock, 1995; Graham, 1995).

The birth, diagnosis and, hospitalisation of an ill infant acts as a stressor on the family system (Brunssen and Miles, 1996; McCluskey-Fawcett et al., 1992; McFayden, 1998; Miles et al., 1992; Spencer and Edwards, 2001). During this period parents are faced with the task of balancing the painful realities of confronting a possible loss against their hopes of the intact survival of their infant (Siegel et al., 1998). In addition to this crisis, the parents must master the normal developmental process of parenthood. For the involved family this stressful event results in a period of psychological disorganisation, as anxiety can affect perception and understanding, which in turn can affect a person's ability to cope (Allen, 1995a; Ball, 1990; Haut et al., 1994). It is therefore vitally important that health care professionals help the couple to come in terms with this crisis. Stress management and psychosocial interventions can be used to help the couple identify their stressors, evaluating the effectiveness of existing coping mechanisms, and in the identification of appropriate

strategies to deal with crisis (Ball, 1990). Through this approach midwives/neonatal nurses will be able to facilitate adaptation, learning and growth to the extent that the couple can benefit from the experience and face up to any future potential crisis using skills they have developed in previous ones.

Having an infant at the NICU is a stressful event, which parents must face and master

Psychosocial interventions to provide family support in order to enhance parental bonding in the NICU:

Literature review suggests that neonatal nurses/midwives must have knowledge on the psychological tasks and parental emotional reactions to their infant's hospitalisation in the NICU. Such knowledge will assist neonatal nurses/midwives in identifying and integrating interventions that support parental bonding in the NICU (Allen, 1995b; Bass, 1991; Haut et al., 1994). Neonatal nurses'/midwives' interventions are extremely important because they lay foundation for subsequent interactions between parents, infants and health professionals (McFayden, 1998; Wyly and Allen, 1990). Situational factors (see Table 1) can have an important bearing on the family's ability to cope with the crisis and thus affect the overall outcome.

Table 1. Situational factors affecting parental coping.

1. The behaviours and attitudes of the hospital staff (Physicians, nurses, and allied health professionals)
2. The sensitivity used in the process of separation and transfer of the infant to the NICU.
3. The flexibility of hospital policy concerning parental and sibling involvement and visitation in the NICU.
4. The instruction of parents in their infant's individual behaviours and characteristics (thus facilitating appropriate parent-child interaction and reciprocity).
5. The staff's comprehension and appreciation of the psychosocial functioning of families and the

family's responses and adaptation to stress and crisis.

6. The employment of emotionally supportive intervention programs for parents within the NICU setting.
7. The development of appropriate discharge planning to provide adequate follow up care to the infant and family.

Reference: Browne and Smith-Sharpe, (1995); Gennaro, (1991); Griffin, (1990); Shellbarger and Thompson (1993).

Researched based evidence suggest that appropriate supportive interventions coupled with enlightened policies and attitudes that reflect family-centred principles, can positively influence the family's coping and adjustment (Allen, 1995b; Gennaro, 1991; Miles et al., 1996). Interventions with parents are most effective when neonatal nurses/midwives understand what the parents of a sick baby is going through and can respond with empathy (Holditch-Davis and Miles, 2000; McFayden, 1998). Clement et al. (1998) stated that the most appropriate supportive care by health care professionals to parents is listening, acknowledging and responding to their needs and preferences.

Supporting the family in the antenatal period:

Antenatal diagnosis may alert the couple that their baby may be admitted to the NICU. This diagnosis provokes feelings of anxiety and fear in the couple, and they need knowledge as regards the events surrounding the birth of their baby. To reduce the risk of crisis and help the couple maintain equilibrium midwives /neonatal nurses must provide help in order to help the couple make a realistic perception of the event and view the situation in perspective. Aguilera and Messick (1990) stated that the meaning an individual attaches to an event influences the perception of it, and realistic perception reduces the chance that emotions will bias decision-making and thus avert a crisis. In the antenatal period, the couple may be offered a preparatory visit to the neonatal service, and will be provided with information to gain a realistic perception to the event.

continued on page 11



Donation mostly appreciated by SCBU children

This year Milupa –“The Mother and Child Company”, has donated a pram and pushchair to SCBU (Special Care Baby Unit) for their patients’ needs. Both pram and pushchair are being utilised by sick children who need to undergo investigations that have to be performed in other wards in St.Luke’s Hospital.

Milupa and SCBU staff worked 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.)
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This type of coping pattern is known as direct coping where positive action is being undertaken to resolve the situation (Fayram and Christensen, 1990).

Parental control during this time can be achieved through active participation in decision-making, as regards their child's birth and surrounding events. Siegel et al. (1998) stated that parents' attitudes about labour and birth experience affect their reactions to the infant. Simkin (1991) found that the psychological effects of control in childbirth could be very long lasting. A birth experience that does not meet parental expectations may have negative effect on the self-concept of the couple, their perception of their abilities as parents, and their relationship with their baby (Sullivan-Lyons, 1998; Weaver, 1998).

Assessing the family's need prior planning the care:

Parents are individuals and for each family the experience of having an infant on the neonatal unit's are different. Henson (2000) stated that it is important that neonatal nurses/midwives understand the cultural differences, and background of the family (Allen, 1995a; Dawson, 1994). Understanding parent feelings about and reactions to their infant's admission to the NICU is only the beginning of assessing the need for and integrating interventions that can support bonding in the NICU.

Huges et al. (1994) stated that it is important for NICU staff to see each family as distinct in order to not to prejudice and categorise people unfairly. Allock (1995) argued that 'categorisation' is the process used in stereotyping and refers to the way in which people fit things into categories. Clarke and Keeble (1990) stated that stereotyping and labelling might distort perception and it can be very difficult to modify impressions even in the light of new and changing information. During care planning and delivery of care it is important to avoid stereotyping as stereotyping can affect the quality of health care delivery, (Allock, 1995; Niven, 1994).

The identification and integration of parental values are important if neonatal nurses/midwives are to enact professional practice standards based on philosophical beliefs of holistic, individualized care for the neonate and the family (Allock, 1995; NMC, 2002; Raines, 1996). If the values of parents remain unknown, they can't be incorporated into the caring process, and truly holistic care is impossible. Accurate interpretation of personal information about a client and his/her behavior, enhance the practitioner to avoid mistaken judgments and therefore interact more effectively with him/her (Allock, 1995a; Allock, 1995b; Clarke and Keeble, 1990; Smith, 1999).

Information giving:

Henson (2000) argued that at times neonatal nurses/midwives decide to talk to parents, but this may not necessarily 'fit' in with the parents' needs for information. A good 'fit' between staff and parents is often apparent in the ease of communication and the relaxed but competent care given by both parties to the baby (McFayden, 1998; Wheatley, 1998). In particular a good caregiver-parent relationship will facilitate the development of the parents' confidence and sense of relatedness to their baby. Whenever possible it is important that neonatal nurses/midwives talk to both parents at the same time when discussing the infant's condition. This decreases their distortions, misconceptions, increases the communication and support between parents, and prevents either parent from

feeling excluded (Siegel et al., 1998). In discussing the infant's condition with the parents, reference to the infant by name, helps to personalize the infant and establish the infant's unique identity and lessened the effects of separation. In the beginning of any discussion with parents, it is essential to determine and assess the parent's perceptions, in order to correct any misinformation or misconceptions and to listen to their concerns'. When there is a good person-environment fit, similar perceptions of the exchange are held by the source and the recipient (Henson, 2000). In these situations psychosocial support will have a positive influence upon the person's emotional well being, as parents will feel more in control, and prepared for both the best and the worst scenarios.

Being aware of the profound effects of infant-parents' separation:

The admission of a baby to the NICU separates the baby from his parents and this represents a crisis for family members who then find themselves having to cope with an experience which might be quite unfamiliar. To reduce the effects of separation and the risk of crisis the couple must be encouraged to make use of adequate situational supports. Individuals rely on significant others to assist them in times of need (Aguilera and Messick, 1990). Through social support the parents can learn how to cope with their emotional swings and crisis. Researched based evidence suggests that a lack of adequate social support (as perceived by the individual using her own terms of availability and acceptability) from significant others has been found to result in loss of self-esteem (Aguilera and Messick, 1990; Niven, 1994; Oakley, 1992). Social support is important in the development of attachment behaviours; as it encourages psychological well being and thus supports positive parental role function (Bass, 1991; Quinn, 1992). Social support can also be provided



through parent-to-parent support, which is a key element in family-centered care. The use of "graduate parents," can be extremely valuable, as they provide support to parents by sharing common feelings, reactions, and experiences about having a hospitalised infant. Parent support groups can help families feel less isolated and provide empathy and understanding (Hughes et al., 1994), as they shared similar experiences in the NICU, fostered problem solving and new approaches concerned with issues of infant hospitalization.

Affonso et al. (1992) found that separation prevents a mother from getting to know her baby and often threatens her perceptions of her ability to become a 'good mother' to her child. In the beginning of this life event the mother's self-esteem and confidence can be shattered by feelings of inadequacy. Allock (1995) stated that psychological well-being is frequently linked to self-concept and positive perceptions of self-image, self-esteem and self-efficacy. A person's self-efficacy will determine the extent to which this person believes he/she can exert control over a situation. Health care professionals can inadvertently damage self-image and self-esteem of a client by failing to treat the client as an adult. Mastery of the role of new parent cannot be achieved if direct participation in the provision of care for the baby is not possible. To avoid imposing unrealistic expectations on the couple, the parents must be in partnership with their child's care.

Henson (2000) argued that partnership involves giving control back to the child and family and acting with, rather than for them, supporting rather than dominating, and sharing the caring. Neonatal nurses/midwives can help the couple identify special roles to fill in meeting their infant's needs such as breastfeeding, holding and care-giving. In order for the parents to be involved in the care of their infant it is important to ensure that parents are able to visit as frequently as they wish and to identify any factors which may adversely affect their ability to visit (Laurie, 1995). Clark and Keeble (1990) stated that parents must be reassured that the separation caused by the admission of the baby to the NICU, will not permanently affect their relationship with their baby.

Supporting the family during discharge preparation and working in partnership with them:

For families of infants nursed in a NICU environment, the transition from hospital to home is a long anticipated event. Despite this, among family members the transition to home can evoke fears and doubts about their ability to care for their infant on their own (Smith, 1999). Effective discharge planning will decrease parental anxiety, increase parental coping and caring skills and consequently assist in preventing readmission (Turrill, 1999; Vecchi et al., 1996). Discharge planning must start gradually over the baby's stay at the NICU. It is important that at all time the parents are partners in care.

During this period parents will be provided with consistent teaching and assessment, and enhanced with parental confidence in their ability to handle and care for their baby (Victor and Persoon, 1994). Adequate teaching of care-giving skills allow the parents to develop a sense of mastery, competence and a recovery of self-esteem, while minimising the threatening aspects of instruction. Support and positive perceptions

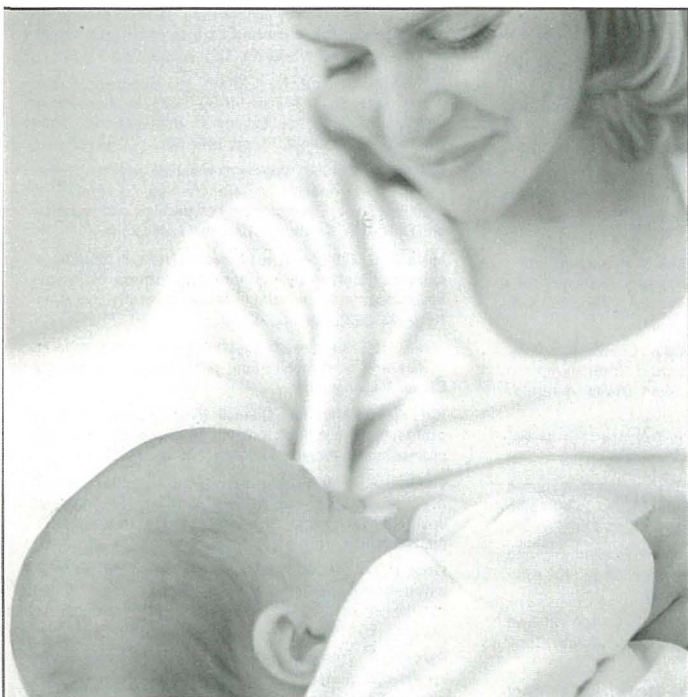
assists parents to achieve their identity as parents of the infant, as well to be partners in care (Appelton, 1997). The preparation of the couple to their infant's homecoming is to redress the balance of responsibility and allow them to assume the dominant role gradually before they will be faced with full responsibility at home.

Conclusion:

Having an infant at the NICU is a stressful event, which parents must face and master. Family bonding in the NICU is often a very difficult process, which is interrupted by separation of parent and child at birth and continued by the physical constraints of this highly complex critical environment (Haut et al., 1994). The transition to new roles and responsibilities require a psychosocial and emotional adaptation, and therefore neonatal nurses/midwives need to help parents discover useful ways to transcend this stressful encounter (Cussons, 1993). The goal of neonatal care is far more than the discharge of a healthy baby into the care of the parents (Drake, 1995; Laurie, 1995). Instead neonatal nurses' responsibility is to facilitate family-centred care, so that parents be in control of the situation and able to cope with the rigours and demands of parenting (Bass, 1991). Psychological knowledge suggests that families vary in their psychological needs and resources, and therefore care should be tailored accordingly (Allock, 1995). A clearer understanding of strengths and weaknesses, conflicts and support within the family network enable neonatal nurses to enhance the existing helping potential and to identify strategies appropriately for the individual family to cope with the crisis. Offering the right kind of support and facilitating informed decision-making, enhance parental control, emotional well-being, and self-reliant rather than dependent (Allock, 1995; Clement, 1998). A successful outcome of the coping process means mastery over this stressful situation, and results in a happy, well-adjusted mother, father and baby.

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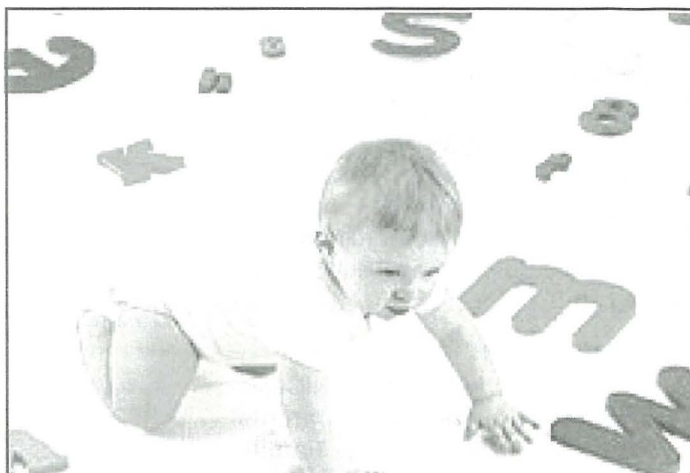
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Mental illness and the Media

Kevin Gafà RMN. Diploma to Degree in Psychiatric Nursing Student

Introduction:

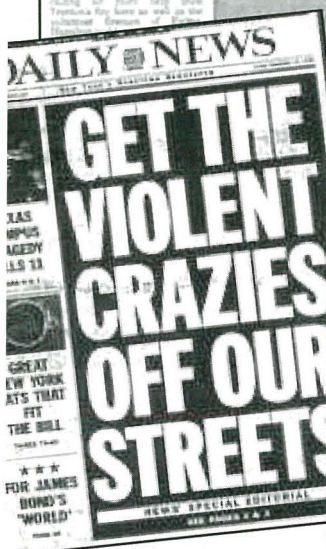
Over the past 30 years a great amount of research has been conducted to determine the effect of the mass media on the public's belief systems. These studies concluded that the media representations combine to make the mass media one of the most significant influences to develop societies.

In 1986, the National Institute of Mental Health (NIMH) reported that stigma was the most debilitating handicap faced by former mental patients" (Granello & Pauley, 2000, p. 162). In 2001, the Australian government published a large-scale literature review examining portrayals of mental health in the media. After considering dozens of studies that had analysed news and entertainment media (like cinema) from around the globe the review determined that media representations of mental illness promote negative images and stereotypes in particular the false connection between illness and violence. Though there are many sources associated with stigma against individuals with mental illness, I believe the media's portrayal of the mentally ill significantly contributes to this stigma. I see this in my own work almost every day. Working in an admission ward like MAW exposes me to various types of mental illnesses. The fears of the patients from being hospitalised take many forms from worrying about their employer finding out about treatment to patients asking if getting treatment makes them "crazy". The one thing that continues to amaze me is the number of patients that will ask me if being hospitalised is anything like the film "One Flew Over the Cuckoo's Nest" which was released in 1975. I have had patients who (like me) were not even born when the movie was released who ask me this. This just further supports the idea that the media's impact on the stigma against the mentally ill is tremendous.

Media: the primary source of information

Considerable research has concluded that the media are the public's most significant source of information about mental illness. In a study conducted in 1990 identified that a majority of American's identified the mass media as their primary source for information on mental illness. This is of particular concern due to the inaccuracies and misinformation associated with media's portrayal of people with mental illness.

The media play an influential role in shaping people's attitudes about the world they live in and about the individuals who inhabit the world with them. Stories about or references to people with mental health



In reality, people suffering from a mental illness who do not have a concurrent substance abuse disorder are no more likely to commit a violent crime than anyone else (Steadman et al., 1998). In fact, one study found that people commit 95–97% of violent episodes in the United States with no mental illness (Monahan, 1996).

The following newspaper cutting is an example of how local newspapers report violent incidents, which involve mentally ill patients. In my opinion this particular headline reflects a very negative stereotyping view of mentally ill patients. Furthermore this incident happened in the premises of Mount Carmel Hospital, which contributed, to further labelling an already grossly stigmatised mental hospital.



issues are rarely out of the headlines in news stories or plotlines in film and television, yet research indicates that media portrayals of mental illness are often both false and negative. Throughout the 1990's, papers in the United Kingdom increased their attention on issues surrounding governmental community care legislation and the discharge of people from institutional care. This resulted in a stream of news reports on homicides involving persons known to be suffering from mental illness.

Violence = Mentally Ill

The most common description of mental illness in the popular media has involved mentally ill people who are violent and criminal. Rose (1998) argues that psychosis is portrayed on television, as well as generally in the media, as an unclassifiable experience, and one that poses a threat. Mental illness is pictured as resisting clear meaning, and thus as incomprehensible, unpredictable, and unstable. Simultaneously, the recurring theme of extreme violence at the hands of mentally ill characters is the norm in mass media portrayals. As a result of this people with psychiatric diagnoses (or those assumed to be mentally ill) are generally portrayed as unsafe, dangerous, and violent.

Children's media

Over the past years many studies aimed to identify the effects of television viewing on children and the portrayals of mental illness. Researches examined various media in different countries using different analysis methods. Results consistently reported that representations of mental illness are overwhelmingly negative. The commonest terms used in children television are crazy, mad and losing your mind. The word Crazy is generally utilised to judge actions, ideas and character's behaviour as unreasonable, irrational, illogical or unpredictable. References to mental illnesses, particularly in cartoons included: barking mad, cracker, crazy dotty, fruitcakes, loony, nuts, weirdo, and screw loose. Mental illness was also often used in jokes and for other humour purposes. Even researches found that in cartoons stereotypical signs for insanity such as motion of the head and rolling eyes also occurred.

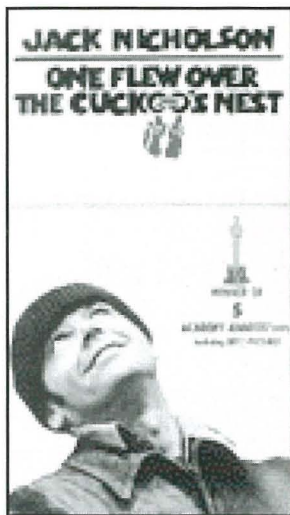
Nicky Singer is an author of books for children; titles from her include Doll and Feather's boy. In her books Nicky Singer portrays mental illness in a non-stigmatised manner. The Journal of Mental Health recently acclaimed her books, in fact they describe these books as portraying mental health in such a way that children can have a better understanding of mental illness.

Cinema Portrays

According to Schneider (2003), some of the stereotypical views of people with mental illness which originated from films include the following: rebellious free spirit; violent seductress; narcissistic parasite; mad scientist; sly manipulator; helpless and depressed female; and comedic relief. The following slides illustrate some films, which contributed to the origin of these stereotypes.

Rebellious Free Spirit

(One flew over the cuckoo's nest and Shine)



From the research I performed on the Internet one flew over the cuckoo's nest is the most cited example of representation of madness. This film shows R.P MacMurphy (played by Jack Nicholson) rebelling against a total institution. The film leaves the audience questioning if MacMurphy was really insane or if he used the mental institution to gain mental infirmity in a court case. What is certain is that MacMurphy became a product of the system. The images of

MacMurphy experiencing ECT remain one of the most shocking and influencing scenes, which portray mental illness and treatment involved.

Shine(1998) presented some sensitive images of individuals living with a serious mental health problem. The film illustrates the psychosocial decline of a talented pianist, David Helfgott with what appears to be schizophrenia.

Homicidal and Maniac

(Hannibal, Halloween and Psycho)

Alfred Hitchcock's 1960 production Psycho together with Halloween (1978) and the most recent Hannibal produced in 2001, push forward the experience of psychopathology in the form of split personality with terrifying effects like murders. These films are examples amongst many others, which have the theme of mental illness in a terrifying and horrifying manner.

Enlightened Member of Society

(A Beautiful Mind)

The study performed by Schneider (2003) aimed to identify the positive and negative images of mental illness from films. A Beautiful mind (2001) is one of the few films which according to Schnider represents a Positive but inaccurate representation of mental illness. Wilkinson (2002) challenges this by saying that a beautiful mind reinforces many of

the enduring myths about severe mental illness. A beautiful mind is a story of Nobel Prize mathematician, John Nash, played by Russell Crowe. Nash suffers from schizophrenia and through out the film he is faced with the struggle to fight against visual hallucinations and compliance to treatment. Different from many other films involving mentally ill individuals a beautiful mind has a happy ending.



Narcissistic Parasite

(Analyze this and What about Bob)

In films like analyze this and what about Bob? Mentally ill patients are pictured as overly attached to persons and sometimes as a threat to those who care for them. In what about Bob, the story pictures around a neurotic phobic, OCD and schizophrenic man who causes havoc for his new therapist. Bob is very attached to his therapist and at one point the therapist starts exhibiting insanity behaviour himself.

Comedic relief (Me, Myself and Irene)

A special mention in this category is very much

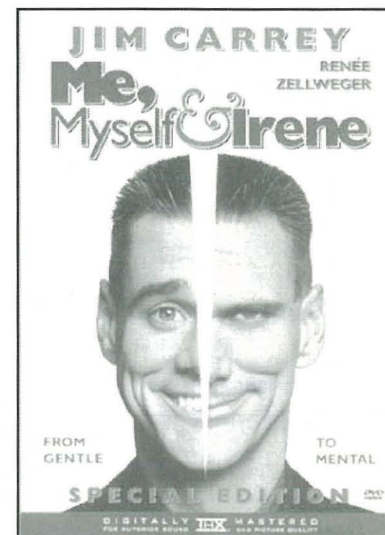
deserved for Me, Myself and Irene (2000). Its depiction of a policeman with schizophrenia, played by Jim Carrey, is almost entirely devoid of accuracy, sensitivity and complexity.

His behaviour is clownish, obscene, violent and sexually assaultative.

He is referred to as 'schizo' and 'psycho'. It was criticised by SANE Australia, the US

National Alliance for

Mental Illness and the UK Royal College of Psychiatrists amongst other organisations.



Victimised/Helpless/Depressed Female

(Girls Interrupted and The Virgin Suicides)

Females are often a target of negative labeling in films with a mental illness theme. Virgin suicides and Girl interrupted are two examples in which females are pictured as helpless and victims of their deviant personality

Mental Health Practitioners/Facilities/Treatments (Good Will Hunting, As Good As It Gets and I never promised you a rose garden)

Movies, which portrayed therapists sympathetically, are *I Never Promised You a Rose Garden* (1977) and "Good Will Hunting" (1997). In *Good Will Hunting* although Robin Williams portrays a sensitive, understanding therapist struggling to help a gifted, but troubled, youth, the vision of outrageous and preposterous therapy detracted from the overall positive images in the film. "Therapy is seen as helpful and maybe some people will go to therapy because they see it as being helpful." *As Good as it Gets*, produced in 1997 is what researchers described as the only movie in the history of filmmaking, as far, that suggests that medications could be helpful in the treatment of mental illness.

Conclusion

Pilo et al. (1994) argue that if there is to be a move towards destigmatisation of mental illness, and a more positive and accurate images of mental illness and if more positive and accurate images of mental illness are to be developed, than more work needs to be done with the media. This must involve ensuring that newspaper and broadcasting organisations do not produce stereotypical images of people with mental health problems. Media representations should include the views of individuals and this should begin at a local level where mental health promotion departments can work more closely with the local media.

Food for thought

If the public considers people with mental illnesses to be violent and/or unable to care for themselves, government policies and resulting legislation will look more toward containment and control than towards recovery and community living. If public perception of mental illness is based on negative and false images perpetuated by the media, there is a danger that government responses to systems and people in the mental health field will also be based on these false realities, rather than on the true needs and issues of people suffering from mental illness (Cutcliffe & Hannigan, 2001; Rose, 1998).

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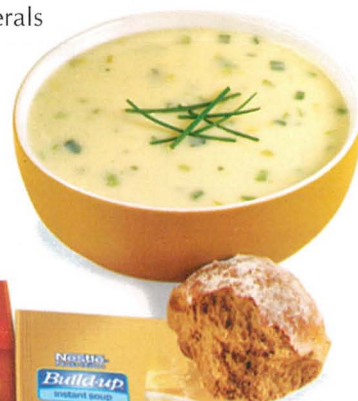
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1. MUMN, together with other Unions on the FOR.U.M. participating in the Demonstration organised by the GWU against the Government's decision to deduct vacation leave on those Public Holidays who fall on Sundays.

2. An important annual activity organised by the Florence Nightingale MUMN Benevolent Fund in collaboration with the Pensioners' Group Committee, is the Memento Awards to those Nurses and Midwives who retire from work as a sign of appreciation for their dedicated work with the patients.

3. MUMN with the other 7 Unions forming the FOR.U.M. held a press conference to explain their objective to for part of MCESD where, topics that also effect Midwives Nurses without MUMN being present, are being discussed.

4. 20 Unions including MUMN participated in several marathon discussions regarding the National Pact. Although an agreement was not reached it was encouraging to see all the Unions on our Island, for the first time, discussing common issues.

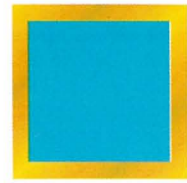
5. After several protests that MUMN organised for the recruitment of the newly qualified Nurses, an agreement was reached with the Health Division, so that all Nurses would be employed.

6. The winners of last year's Paul Bezzina Shield were the St. Vincent de Paule's Residence Group Committee chaired by Raymond Chircop. Runners Up were the Entertainment & Cultural Group Committee chaired by Simon Vella. Well done guys for the hard work and dedication!

7. Every 6 months MUMN Administration organises a half-day Seminar for the Council Members and all Chairpersons (14) of the various Group Committees to discuss current and internal issues and also to plan and adopt strategies regarding National items on the agenda.



Silky smooth...



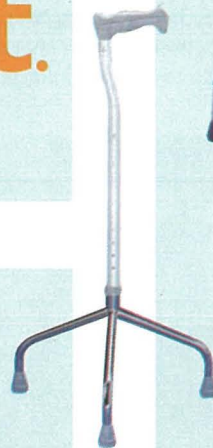
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Approaching a Child for Surgery

TONIO PACE

Staff Nurse, Anaesthetic Nurse in the
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Surgery is a medical intervention that each one of us can go through at any time in life. I am of the opinion that whoever the patient is, there are moments where the patient is worried and afraid mainly because of the 'unknown'. Those of us who work in operating theatres encounter these patients day after another, witnessing various types, ages and genders. Each one of us, especially if we have undergone surgery at a very young age, recall the fears and worries and the fixed look at our parent's eyes. We, nurses have to place ourselves in the patient's frame, so that we can be able to sympathise and show understanding.

Surgeries come in various types, where these may be planned or unplanned. Planned surgeries can be categorised as: *optional* – where surgery is arranged completely at the preference of the client, *elective* – where it is for the client to decide, and *required* – where there is a time limit of when surgery is needed to be done. *Unplanned* surgeries are usually classified as *urgent* – where surgical attention is required in the first 48 hours, and *emergency* – where immediate surgical intervention is essential⁽¹⁾. The key to success towards perioperative nursing is good multidisciplinary communication⁽¹⁰⁾.

Research suggests that children waiting for surgery tend to have high levels of anxiety^(9, 11). Children were found to demonstrate less anxiety, once they were prepared psychologically and their families should be well supported with a good nursing effort throughout the whole surgical experience. The importance on explaining to children all procedures they will undergo beforehand in order to keep children's behaviour sound⁽⁶⁾. In order to reach a good level of communication with children, it is often better to use words they know. For a

child to be in hospital is already a psychological trauma. Children should be aware that after surgery they might feel slightly uncomfortable. Illness and hospitalisation might affect the child's emotional well being⁽¹¹⁾. Children should also be reassured that the operation itself does not remove important parts of their body, and they will not look any different afterwards.

Children exceed when they are well prepared and know what to expect⁽²⁾. It can be argued that a child, before reaching the transfer area at the operating theatre, should know what the environment looks like. Children should even be allowed to play with some form of equipment in order to familiarise with what is around them⁽⁹⁾. Should a theatre nurse visit the child in the ward, a day before surgery or on the day itself in order to assess the child? Separation anxiety is a normal reply for children and even parents⁽⁵⁾. If the patient identifies with a familiar face or voice, it may help more in reducing any fears he/she may have⁽³⁾. Premedication is a 'tool' normally encouraged by various anaesthetists on children who from the anaesthetist's point of view is deemed as a helping

hand for reducing anxiety. The effects of premedication on pre-operative anxiety have also been examined. It was discovered that out of 85 children from ages one to six, 90% of children who were premedicated in the pre-operative phase showed less anxiety during separation from parents and entering the operating room, than those children who received only parental comforting ⁽⁴⁾.

The child at this point is encouraged, to take his/her favourite toy alongside him/her to the theatre. Through experience, it could be said that a problem met within the transfer area in the operating theatre, is that most children between 3 and 8 years of age, undergoing surgery, look somewhat puzzled and in need of reassurance. It can be argued that the little knowledge, which they may normally possess, is that of going to the doctor so that they feel better. The patient is a person whose family members are eagerly awaiting the outcome of surgery ⁽³⁾.

Here the nurse checks the child's notes, ensuring that a guardian has signed the consent for operation. Other assessments involve the physical status, such as the level of understanding, allergies, sensory impairments, loose teeth and so on. This assessment is normally carried out to reduce risks, which could develop during surgery and postoperative complications. Surgery is viewed as a painful action

taken on one's own body, hence outlining the importance of the preoperative assessment, which recognises the danger, it entails ⁽⁷⁾. Additionally it can be argued that a positive relationship exists between the pre-operative phase and the intraoperative phase.

This is the time where the child reaches the transfer area accompanied by a parent and a ward nurse. The family member, who accompanies the child to the operating theatre, is given theatre clothes to wear so that he/she will be there when the child is being anaesthetised. The parent usually holds the child on his/her lap, while the anaesthetist prepares for the mask induction anaesthesia, ⁽²⁾ where the child falls asleep while breathing the anaesthesia medication via a mask. Often parents need support after this, and the theatre nurse can accompany the parent to the recovery area, in order to wait until the operation is over. The parent should be reminded that a long interval of waiting does not mean that something has gone wrong with the child's operation. Normally the recovery procedure takes a while due to continuous monitoring, in an attempt to demonstrate a successful operation.

As soon as the surgery is over, the child is transferred to the recovery unit on a stretcher, where observations of the vital signs take place. The theatre / recovery nurses normally take safety measures, in



order to ensure that pillows on both sides support the child. Assessments here are continuous and ongoing by monitoring the airway, breathing and circulation (ABC) and by observing the child's skin colour. The child's position is preferably in the lateral position, to prevent respiratory obstruction due to secretion accumulation and usually with neck extended in order to permit the best possible expansion of the lungs⁽¹⁾. The main aim after surgery is to retain a clear airway in order to prevent asphyxiation due to inhaled blood⁽¹²⁾. The recovery nurse verifies the child's identity, documents and all recordings. The data is then placed into the client's file, and this is also the time where the child regains consciousness. It is now when the child realises that he/she is waking from the operation. The recovery nurse will repeatedly inform the child that the operation is over and that he/she will soon be with his/her mother or father again. Children usually cry for their parents at this stage, and it is here where a family member is asked to step in to be with the child. Recovery nurses should be aware at this stage that other patient's privacy should not be violated, hence the child is moved to an area accompanied by the family members.

A survey was performed on whether parents were effective at managing children's pain after surgery. 90% out of a sample of 450 parents of children undergoing paediatric surgeries performed on an out-patients basis claimed that they had no problems in caring for their child after surgery and 72% stated that they administered medications as instructed by the doctor⁽⁸⁾. The findings in the survey suggest that parents' views should be considered, as they tend to know their child better than the medical team. It is suggested that parents appear to be the appropriate devise for their own child's calm behaviour. The anaesthetist will then review the child in the recovery room before suggesting that the child could be transported to the ward. The theatre nurse calls the

ward nurses in order to come and transfer the child and the parent.

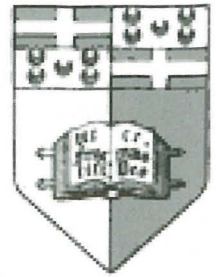
Fear is viewed on most children's faces who need to face surgery, and this is not the ideal way to expect children's psychological preparation. Some other children, who arrive at the transfer area of the operating theatre, might expect to discover a new Disney World. It is our duty as nurses, both at the ward and theatre that need to facilitate the pathway to surgery. Out Patients nurses should note, that it needs to be emphasised to parents that their children need to be well informed regarding their hospitalisation and surgery. Parents should also be told that they can look up information from the internet in a language understandable for children. This may be a beginning, or let's say a continuation towards success.

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S.LUKE'S SCHOOL FOR NURSES THE INSTITUTE OF HEALTH CARE



Forty Years of Training for Nurses

Catherine Sharples SN BSc(hons)Nurs

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1965 – 1989 – St. Luke's School for Nurses

In October 1960, the building of a new school for nurses in the grounds of St. Luke's Hospital was begun. Lady Dorman officially inaugurated the new nursing school building on Saturday 5th June 1965. It had a capacity of 120 students. At that time, the school had also a residential function for female students who enjoyed the best facilities for studying and resting when off duty. A hundred and seven students started training then. Sr. Federica Galea was assisting Sr. Aldegonda Farrugia in organising the St. Luke's Nursing School.

Courses followed the general trend for nursing instruction in the U.K., mostly based on the medical model of nursing in which patient care was affected according to their presenting complaint. Student nurses were taught how to prepare for, assist or perform procedures according to prevailing policies. They worked alongside qualified nurses and were given increasing responsibilities according to their progress in the course. Nurse-tutors gave lectures in these procedures whereas they had other lectures on signs and symptoms and treatment of specific conditions, by medical doctors and surgeons.

The Malta Nursing programme reciprocity was ended in 1977 after a series of political decisions taken in Malta, with which the General Nursing Council (UK) did not agree. There was also a change in the student nurses' working hours whereby student nurses were expected to work according to the qualified nurses' roster, being released only for six hours a week and having to attend lectures during their off days. Nurse tutors were scarce on the wards and so teaching was mainly done by qualified staff nurses if time and circumstances permitted and according to the individual nurse's level of education

and experience. Extra lectures were given to students during their own free time according to when medical consultants were available to lecture. The Curriculum was still comparable to those in the best schools of Nursing in London as well as the level of exams, which students had to sit for.

The number of students continued to increase during the early eighties, a time when Malta was passing through an economic recession. In 1986, the curriculum was changed from a block system to a modular one. This was the last major change undertaken by Sr. Federica Galea who was Principal Nurse Tutor before the setting up of the Institute of Health Care in 1989.

The Institute of Health Care 1989 -

The Institute of Health Care was set up in with the explicit intent of organising Nursing courses at a tertiary education level. Miss Barbara Burkey was identified to take up the challenge of introducing Nursing at the University of Malta. She was greatly supported by Profs John Rizzo Naudi and Profs. A. Serracino Inglott.

The first course offered in 1988 to already qualified nurses as well as undergraduates, was that of B.Sc.(Hons.) Nursing. Only one undergraduate student, Marc Caruana applied, who was later offered a placing in Luther College U.S.A. to continue following the B.Sc. Nursing course there. The rest were all qualified nurses, chosen on their merit as qualified nurses as well as academic qualifications. The first group consisted of a number of nurses some of whom were in management, some were junior staff nurses and some were tutors. It was deemed important that the tutors would be the ones to be offered this opportunity first. These tutors had to be admitted into the course in order for them to be better equipped to impart knowledge to the nursing students of the future. Therefore, the School of Nurses was going to be deprived of these tutors for the duration of the course and would thus be detrimental to the nursing students already studying to become SRNs and SENs. The practical consequence of having so many members of the profession being absent from the service and at University all at once, posed a great problem. The health authorities and Principal Nurse Tutors were consequently very concerned about the potential disruption in care giving and tutorship, which could ensue. The creation of the Institute of Health Care (initially at the Pharmacy Department) did not coincide with the closure of the School for Nurses. The Health Authorities at first did not approve the release of the qualified nurses to follow the



course during working hours. By this time, the students had attended only one day of lectures in October 1988. A compromise was reached through which the University students were released from their place of work for 14 hours per week in order to attend all the lectures that a full-time student had to attend as part of the full time course. This ensured that the wards and nursing school, from which the prospective BSc students had to be released to follow the course, would not be very much undermined by their absence. Arrangements were also made such that hours of practice in particular areas of nursing, which were lacking in the previous training of those qualified nurses, would be taken during the Summer Recess. These areas included Community care, Obstetric care and Mental Health. This was done in order to have the course in line with the EEC (European Economic Community) mutual recognition of professional qualifications for General Nurses 452/77. This made sure that the degree course for nurses in Malta was one of the very first University Courses who were in line with EEC directives making it much easier for University and Health authorities to streamline nursing education with EU requirements in 2002.

Nursing tutors were also brought over from the UK to help in the teaching of nursing components. One of them was Dr. Audrey Miller, who also took the commitment of setting up a research unit in the new Institute of Health care. The first research project carried out by Dr. Audrey Miller was a study on International Comparisons of Nursing Manpower and Nursing Officer's Opinion's of their Work in Malta (1999) followed by a study on Patient Dependency and the activities carried out by nursing personnel in Maltese hospital wards. This was based on a similar study carried out in Cheltenham and used a modified version of the methodology used in the Cheltenham study. The research unit was in operation till 1993. It has recently been revived and is now run by Dr. Donia Baldacchino who is also a lecturer at the IHC.

In 1990, Diploma courses in nursing and midwifery were initiated to last three and a half years each. The first year was to be a common foundation course and students were thereafter to take up nursing or midwifery for the remainder of the course. The Diploma in Nursing course was to replace the SRN course of which the School for nurses produced no less than 100 courses or groups. SRNs nowadays very often identify themselves with the group in which they trained e.g. Group 66, 75 etc rather than the years when they trained.

A certificate in Nursing Practice course to last two and a half years was also initiated in 1991. This was eventually to replace the SEN course, which was started in 1962, and the last intake was in October 2000 with the last group qualifying in November 2003.

A diploma in Psychiatric Nursing course began to be offered in February 1995 when student nurses who were



successful in the Foundation Course of October 1993 intake could choose to take up Psychiatric Nursing for the rest of their course. However, the number joining and qualifying from these courses was quite low. In February 2004, a conversion programme from Diploma to a Degree in Mental Health Nursing was offered by the IHC under the headship of Mr Martin Ward, an international expert in Mental Health Nursing. 12 students who are also psychiatric nurses are currently on this programme. Registered nurses who qualified prior to 1992 were given the opportunity to follow the Degree Course in the third year as from October 2004.

The head of the IHC Nursing studies at present is Ms Grace Jaccarini. The IHC has a Post-Registration Department, which offers a multitude of courses to nurses and midwives every year. At present Ms Rita Borg Xuereb, a lecturer in midwifery studies at the IHC, heads this section. The IHC also runs Master Degree Courses, the latest one being the Master in Health Science (Nursing and Midwifery). The latter course was a breakthrough in nurse education in Malta, as previously, all nurses trying to follow a MSc (Nursing) had to study with a university abroad mostly in the UK. The IHC today has a good number of nursing lecturing staff and a number of clinical mentors most of whom have continued their studies to a Master's level. The IHC nursing division has two doctoral nursing staff and a good number of nurses/midwives are reading for a PhD as well.

During the last decade, the Institute of Health Care has moved forward in its scope. Besides the nursing studies, it also houses courses for other health care professional such as radiographers, physiotherapists etc. At present it has around 500 nursing students following various courses. This surge in large numbers has resulted in the University's decision last October 2004 to restrict the number of students on the diploma course to 30 per course in order to be able to ensure the quality of education for nurses and to encourage students to move to a degree level of nursing.

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my experience...

The Benefits of Conversion: From S.E.N. to D.N.O. To ...?

It all started in September of 1977 when after finishing my G.C.E exams I applied for a course that led me to become an S.E.N. in January 1980. After nearly 17 years of service without any hope of enhancing my Nursing and personal career, the Health Department together with the Institute of Health Care organised the first S.E.N –S.R.N conversion course which opened new frontiers for this category of nurses.

After applying and being chosen for the first conversion course in 1998, together with my fellow students we embarked on a two-year struggle into the unknown. Many of us had abandoned their studies for more than 15 years and only a few of us had any I.T. knowledge. This did not dampen our confidence and with sheer perseverance and hard work we reached our goal and in June, 2000 when we successfully completed the course and embarked on our new roles as S.R.N's.

After enjoying this success and relaxing for a few months, the yearn to increase our knowledge in

connection to our place of work and also to achieve a childhood dream, together with three of my colleagues we commenced a Post Graduate Diploma course in Geriatrics & Gerontology. This was another year of long hours of studying and sacrifices for us and our families but the day we were presented with our Diplomas in November 2001 was certainly a day we will never forget and something we are really proud of.

The next challenge was when again, together with my two friends, we enrolled for the Middle Management Course which we completed in June 2002.

Today together with my friends and colleagues Mr. Mario Aquilina and Mr. Carmel D'Amato we are working as Deputy Nursing Officers at S.V.P.R. This all started when seven years ago, not really knowing what we were going into we commenced the Conversion Course. This course instilled in us the urge to continue our studies and broaden our knowledge not only as Nurses but also in society in general.

I honestly, strongly recommend that all S.E.N's go for the conversion course not only for the personal satisfaction and work promotion one eventually gets but more so for the improvement of our profession in the best interest of our patients and colleagues.

Good Luck,
George Saliba S.N. Dip, Ger.

Position Statement



Informed Patients

ICN Position:

ICN strongly believes that everyone has the right to up-to-date information related to the maintenance of health, and the prevention and treatment of illness. Such information should be easily accessible, timely, accurate, clear, relevant, reliable and based on evidence or best practice. Additionally, everyone should have access to accurate, reliable and transparent information on scientific research, pharmaceutical care and technological innovations.

People have a right to privacy and to confidentiality of information about their health. Appropriate sharing of information is a pre-requisite for nurses and other health professionals to establish honest, collaborative relationships with patients and their families or carers.

People are entitled to access to information, in an appropriate format and to the level of their own choosing, that enables them to participate actively from an informed position, in decisions regarding their health. Information for individual patients and carers should be responsive to their needs and circumstances including their religious, ethnic and cultural needs as well as their language skills and health literacy levels¹. Risks and benefits of healthcare interventions and options should be explained to patients and, where appropriate, to their families and carers.

Nurses and other health professionals should work in partnership with all interested parties to ensure that patients and the public have access to appropriate information about health and health services. Inherent in this is the expectation that nurses will be involved in research into the nature, quality and impact of patient information on health outcomes and nursing practice.

Supporting concepts

People who take an active role in their health make better informed decisions to self-treat, engage in healthier lifestyles and are more likely to be satisfied with their care and health outcomes.² Nurses and other health professionals should acknowledge individuals' rights to make informed decisions about how to manage their own health and to accept or reject health care or treatment.

International Council of Nurses

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¹ Health literacy is defined here as the ability to understand, internalise and use effectively, health information in everyday life.

² Department of Health. Chronic Disease Management and Self-Care. National Service Frameworks. (2002). A practical aid to implementation in primary care. Expert Patient Programme. Progress Report. February 6, 2003. www.doh.gov.uk/cmop/progress/expertpatient/index.htm



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The Expectations of Patients in a Psychiatric Hospital — Review of Literature

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Cohen (1994) described psychiatric hospitalisation as an "experience of trauma". She associated the core experiences of emotional trauma - terror, disempowerment and isolation, with the heart of a stay in a locked psychiatric unit. In corroboration with this are Joseph-Kinzelman et al's (1994) findings of a research carried out to study the patients' perceptions of their involuntary admission to a psychiatric hospital. This team of researchers uncovered feelings of psychological pain, fear, vulnerability, anger, sadness and "being trapped" which were experienced by their research participants (Joseph-Kinzelman et al, 1994).

In the above study, all the patients interviewed expected the nursing staff to offer emotional support by being flexible, conducting timely admission procedures, taking time to listen and exploring situations at the participants' pace. They also suggested that the staff should be attentive to their physical and emotional needs, answer questions, offer explanations and reevaluate their medication (Joseph-Kinzelman et al, 1994).

Breeze and Repper (1998), McLaughlin (1999) and Talseth et al (1999) are in agreement with Joseph-Kinzelman et al's (1994) findings, which highlighted the patients' need to communicate with staff members as a crucial aspect throughout their hospitalisation. On a similar vein, Reynolds et al (1999) argued that clients could inform nurses about what is effective, or ineffective about the nurse-client relationship.

Forchuk and Reynolds' (2001) research results substantiated the findings of the above-mentioned authors. In their research, they attempted to answer the question "How do clients perceive the evolving therapeutic relationship with nurses?" Their participants described a positive nurse-patient relationship as the cornerstone of their in-patient care. Listening, availability, and a friendly approach were identified as critical in the nurse-client interaction. They wanted nurses to listen, be sensitive to feelings, seek clarification of confused messages, help them to anchor accounts of problems in the personal time and setting of the problem, help them focus on solutions to problems, and to sound warm and genuine (Forchuk and Reynolds, 2001).

Further research by Miller and Poggenpoel (1996) and Ricketts (1996) showed that most psychiatric patients were dissatisfied with their interactions with nurses. The former study showed significant findings within the psychological dimension of psychiatric patients' internal environment with specific reference to their perception of the interaction with nurses. These included the negative aspects of stereotyping, custodialism, rule enforcement, lack of intimacy and lack of empathy (Miller and Poggenpoel, 1996).

Relevance of literature

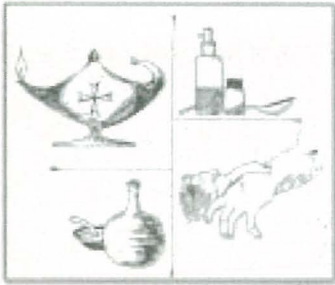
This literature revealed an insight into how people who are mentally ill perceive their hospitalization and what they want from the nurses. Nurses may not have sensitive

awareness of the patients' world, unless they possess certain attitudes and skills that are considered to be necessary to investigate the patient's experience in a relationship that is said to be therapeutic.

Thus there is an urgent need to develop nurses who are highly empathic and have an extensive knowledge of the therapeutic relationship. This presents a considerable challenge to nurse educators, so that it is ensured that the needs of mental illness sufferers are met with dignified and holistic care.

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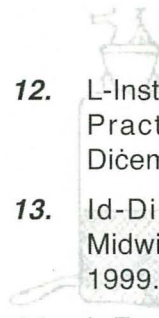
L-ISTORJA TAN-NURSING F'MALTA

MIS-SITTAX IL-SEKLU SAS-SITTINIJIET

...Ġabra ta' storja riċerkata dwar l-evoluzzjoni tan-Nursing f' Malta mill-egdem żminijiet sa era aktar moderna. Harsa analitika dwar kif in-Nursing stabilixxa ruħu fil-hajja medika Maltija ta' Gżiritna...

Matul is-snin kien hemm diversi liġijiet li jaffetwaw direttament u ndirettament ix-xogħol tan-nurse jew il-midwife. Fost il-liġijiet l-aktar importanti li nsibu huma:

1. Il-Medical and Kindred Professions Ordinance tal-ewwel t' Awwissu 1901 fejn giet emendata f' diversi snin differenti permezz ta' Ordinanze, Avviżi legali jew Atti. Din il-liġi titratta direttament ix-xogħol tal-Midwives u r-Registered u l-Enrolled Nurses, fost affarijiet oħra ta' mportanza kbira.
2. Id-Department of Health (Constitution) Ordinance tal-ewwel ta' Novembru 1937 li wkoll giet emendata f' diversi snin anke permezz ta' Proklama jew Ordinanza t' Emergenza fejn l-aktar parti sinifikanti hija dwar in-Nursing and Midwifery Board.
3. It-Training School for Midwives Regulations tat-13 t' Awwissu 1971.
4. Il-Hospital and Clinics Wages Council, Wage Regulation Order tat-22 t' Awwissu 1977.
5. L-Elections for the Nursing and Midwifery Board Regulations tal-24 t' Awwissu 1982.
6. It-Training School for Registered Nurses u Enrolled Nurses Regulations tas-16 ta' Settembru 1986.
7. Id-Diploma in Nursing or Diploma in Midwifery Course Regulations tat-18 ta' Settembru 1992.
8. Il-Bachelor of Science (Honours) in Nursing/ Midwifery Studies-B.SC (Hons.)-Degree Course Regulations tat-3 ta' Novembru 1992.
9. Il-Procedure of the Nursing and Midwifery Board for the erasure of Names from the Register Rules tal-ewwel ta' Novembru 1994.
10. Id-Diploma in Psychiatric Nursing-Dip.Psych.Nurs.-Course Regulations tal-4 ta' Novembru 1994.
11. Il-Post Qualification Diploma in Health Science-PQ Dip.H.SC.-and Degree of Master of Health Science-M.SC. (Health)-Course Regulations tas-6 ta' Novembru 1998.
12. L-Institute of Health Care Certificate in Nursing Practice Course Regulations tal-15 ta' Diċembru 1998.
13. Id-Diploma in Nursing and Diploma in Midwifery Course Regulations tal-15 ta' Ġunju 1999.
14. L-Employment and Industrial Relations Act (Act XXII tal-2002) fejn barra li jitratta b' mod ġenerali, f' Artiklu 64 (6) jelenka lista ta' diversi servizzi essenzjali tal-Gvern li għandhom jiffunzjonaw b'mod kontinwu u l-hin kollu. Insibu dettalji saħansitra tan-numru ta' Nursing Managers, Nurses fi swali ġeneral akuti, Units Speċjali, Swali tal-Operazzjonijiet u dak kollu li għandu x' jaqsam mal-Midwifery.



Dawn il-liġijiet juru attivita' kbira fin-Nursing f'dawn l-aħhar hmistax-il sena apparagun ta' perjodi oħrajn. It-twaqqif tal-Institute of Health Care ta' l-Università ta' Malta għandu mertu kbir għal dan l-istess attivita'.

~ TMIEM ~

Il-Pesta f'Malta

AMANTE DARMANIN

SN SVPR

■ amante@onvol.com

IT-TIELET PARTI

Il-Pesta ta' l-1813-1814

Ighidu li ż-żmien jirrepeti ruhu, u hekk ġara fil-każ tal-Pesta ta' l-1813. Il-pesta ta' l-1676 bdiet mill-belt Valletta, minn tifla ta' negozjant. L-istess ġara fil-każ tal-Pesta ta' l-1813, għax din ukoll bdiet minn tifla ta' skarpan, fi Strada Sant' Ursola fil-Belt stess. Għalhekk, hawnhekk qeghdin naraw tlett affarijiet komuni fiż-żewġ epidemiji (il-belt, negozju u tifla), u dan forsi mhux b'kumbinazzjoni, għall-inqas fi tnejn minnhom.

Ta' min ighid li l-Belt huwa l-post li l-aktar li kellu kuntatt ma' barra minn Malta peress li hemm il-Port il-Kbir, kif ukoll kien l-aktar popolat. Il-pesta kienet ġa faqqgħet f'Konstantinopli, Ċipru u Lixandra (Eġittu). Malta kienet fil-bidu tal-hakma Ingliża u l-Ingilterra kienet fi gwerra mal-Franċiżi. Hekk insibu li fl-1811 kienu żaru lil Malta 165 bastiment. Dan peress li l-Ingilterra imponiet imblokk navali fuq Franza, u allura hafna mill-imriekeb hteġilhom li jidhlu hawn Malta. M'għandniex xi nghidu, dan ġab prosperita' kbira għal Malta u għalhekk il-liġijiet ta' kwarantina li kienu imposti fuq kull vapur li kien jidhol fil-port bdew jillaxkaw. Izda l-prosperita' ma damitx wisq.

F'April ta' l-1813, il-Kummissarju ċivili Sir Hildebrand Oakes, kiteb lis-segretarju ta' l-Istat fl-Ingilterra fejn fahhar il-ġid li Malta kienet qed tirrendi. Izda xahar biss wara,

fit-tlieta ta' Mejju 1813, faqqgħet il-pesta. Din x'aktarx inġiebet f'Malta mill-mirkeb *San Nicola* li kien għadu kemm wasal minn Lixandra. Fis-sebgha ta' April kienu diġa mietu żewġ membri ta' l-ekwipaġġ ġo Lazzarett. Għalkemm il-bastiment kien fi kwarantina jinghad li xi hadd seraq xi pezez tad-drapp u dan bieghhom lil skarpan fil-belt. Wara li haditha bintu, mardet u mietet ukoll ommha. Għall-ewwel, l-awtoritajiet hasbu li ma kinetx sa tinfirex għax ġa kienu bdew jieħdu xi miżuri, izda l-pesta malajr inxterdet mal-Belt. Hawnhekk qeghdin naraw it-tieni haġa in komuni ma' dik ta' l-1676. Peress li negozju hu mezz biex jiltaqgħu hafna nies, il-pesta kienet diġa bdiet tinfirex qabel ma l-awtoritajiet hadu l-miżuri kollha. Il-Belt ġiet maqsuma fi tmien distretti u barrikati ġew imtella' bejn distrett u iehor biex ma jkunx hemm kuntatt. Kmamar ta' l-injam u kampijiet ġew inwaqqfa mas-swar biex jilqgħu fihom il-foqra. Il-

kummerċ ġie ssospendut, kull kuntatt li ma kienx neccessarju, bejn terzi persuni ġie pprojbit. Il-morda ttieħdu ġo Forti Manoel. L-Arcisqof ordna li jingħalqu l-knejjes u l-abitanti kollha ġew ordnati li jibqgħu d-dar, hlief għal dawk li kien hemm bżonn li jagħtu l-ġhajnuna.

Mill-Belt il-pesta nfirxet mal-Furjana kollha u saħansitra mietu xi suldati barranin. Il-habsin inharġu mill-habsijiet u ġew imġghela jgħorru l-morda u l-mejtin. Dawn kien ikollhom il-ktajjen ma' saqajhom u kienu mghassa mis-suldati, izda, b'kundizzjoni li jekk jibqgħu hajjin wara l-pesta, kien jinħafilhom kollox. Sfortunatament ftit kienu dawk il-habsin li salvaw, b'tali mod li kellhom anki jinġiebu habsin ohrajn minn Sqallija u, anki minn dawn mietu ukoll. Hafna mill-habsin kienu jisirqu mid-djar tal-morda li jkunu jżuru u forsi għalhekk mietu hafna minnhom, għax il-briegħed kienu jispiċċaw fuqhom.

Wara li l-Forti Manoel intela' bil-morda infethu sptarijiet ohra bħal Villa Bighi, fil-Kalkara u San Duminku, fir-Rabat. L-agħar li ntlagtgħu kienu Hal-Qormi, Haż-Żebbuġ u Birkirkara. Għal din ir-raġuni dawn il-postijiet ġew izolati u mghassa mis-suldati biex hadd ma jidhol jew johroġ mingħajr permess.

L-epidemija damet tkarkar sa l-aħħar ta' Awissu 1813 u fid-29 ta' Jannar 1814 l-abitanti tal-belt u l-villaġġi thallew johorġu, minbarra Hal-Qormi li dam izolati u mghasses mis-suldati sa Marzu. Fi Frar 1814 il-Pesta qasmet il-fliegu u hakmet lill-gżira Ghawdxija. Ix-Xaghra biss intmesset u nies ta' dan il-villaġġ intbagħtu jghixu ġo kampijiet fil-wesgha ta' Ghajn Lukin. Il-Gzejjer Maltin ġew iddikjarati meħlusa mill-Pesta fit-8



L-unika karru tal-mejtin tal-pesta ta' l-1813 li għad fadal f'Malta instab mirdum ġol-kennierja f'Haż Żabbar.
Maħdum minn Giacomo Xerri, issa jinstab fil-mużew tas-Santwarju.
F'Haż Żabbar kienu mietu 52 bil-pesta.

ta' Settembru 1814. Minn popolazzjoni ta' mitt elf ruh il-Pesta qerdet 4,486. Ftit wara kienu saru hafna purcissjonijiet b'ringrazz-jament għall-helsien mill-pesta. F'Hal-Qormi kienet ittellgħet l-istatwa ta' San Sebastjan, il-qaddis protettur mill-pesta. Il-pesta halliet herba finanzjarja wkoll għax qajla kien baqa' flus fit-teżor u Malta kellha tiddejjien minn barra l-pajjiz.

Żmien wara kien hemm kazijiet oħra tal-pesta iżda qatt ma kienu qliel daqs dawk ta' l-1676 u l-1813. Wara kollox kien sar magħruf minn fejn tiġi trasmessa l-pesta, u 'bniedem avżat nofsu armat' iġhid il-Malti. Barra minn hekk huwa faċli li tikkura bniedem maħkum mill-pesta bl-antibiotiċi sakemm din ma tkunx pnumonika.

Fl-1904 il-Professor Malti Sir Temi Zammit flimkien mal-Maġġur W. Broughton Alcock tar-Royal Army Medical Corps, għamlu studju tal-firien f'Malta u fi żmien tlett xhur eżaminaw madwar 1500 far. Minn dawn kien instab li hmistax minnhom kienu infettati bil-marda tal-pesta.



It-tqarbin lill-inpestati kien jingħata bi speċi ta' mqass biex il-qassis jogħqod il-bogħod mill-marid. Minn pittura ta' Pietro Paolo Caruana.

Minkejja dan hafna pajjizi jqisu il-mikrobu bhala idejali f'każ ta' gwerra u għalhekk uħud minn dawn għandhom bombi bioloġiċi ta' dan il-mikrobu. Fis-snin tletin, fil-gwerra Sino-Ġappuniza, il-Ġappunizi ppruvaw jittfghu brieghed infettati bil-mikrobu tal-pesta liċ-Ċinizi. Hadd ma jaf x'effett kellu dan l-aġir. Jingħad ukoll li fit-2 ta' Novembru 1963 iddahhal jott bil-moħbi ġo Havana f'Kuba, bl-ghajnuna tal-mafja Amerikana.

Fuqu kien hemm żewġ Kubani eżiljati mibgħuta mis-CIA. L-għan tagħhom kien li jgħorru żewġ bozoz magħmulin apposta li fihom kellhom il-mikrobu *Yersinia pestis*. Is-CIA minn dejjem riedu joqtlu lil Fidel Castro u dan kien wiehed mill-attentati. X'sar minn dawn iż-żewġ Kubani hadd ma jaf għax dawn ma rritornawx lura u Castro għadu haj sal-lum. L-operazzjoni kienet imsejha *Operation visitation*.

• TMIEM •

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Snippets

Nurses love their work

A special campaign survey undertaken by the Nursing Standard confirms that nurses are proud of what they do and the reason that they carry on is patients. A convincing 94 per cent of respondents say they are proud to be nurses. And 74 per cent say it is the patients who inspire or motivate them to stay in the profession.

Surprisingly 76 per cent of the responding nurses still consider nursing to be a vacation. This may reflect the fact that 43 per cent feel that a characteristic most associated with nursing is that nurses are underpaid in spite of the high percentage (55%) who feel that nurses work is highly regarded.

The five most aspects of the job were considered to be under-staffing (74%), stressful work (50%), low resources (50%), inability to change the way things are done (31%) and rule or abusive patients (28%). The key attractions to the profession include job variety (60%), fello workers (45%), job security (44%), the NHS pension (33%), and on-going training (32%).

Nurses may be one of the best recruitment tools to the profession as 58% of the respondents would recommend nursing as a career to children, relatives or friends. While 32% of the respondents felt that their working condition were improving, 38% felt they had deteriorated and 29% reported no changes.

Adele Waters. "Pride at work." *Nursing Standard*. 24 March 2004. (Sew News)

International Nurses Day Messages

"In the every day practice doctors closely cooperate with nurses, both in hospital and in private practice. Thus forming a team that in the joint effort helps to improve conditions for the patients. CPME therefore welcomes the opportunity to express its appreciation between PCN and CPME", by Lisette Tiddens, Secretary General of the Standing Committee of European Doctors (CPME).

"The Dedication of nurses is key to high quality patients care. Nurses should therefore receive the best medical technology available to help them better serve the patient and to protect them from the risks that their profession incurs. Our industry is committed to providing this technology", by Maurice Wagner, Director General of Eucomed. The European Medical Technology Industry Association.

"Nurses are key actors in the delivery of healthcare and senior managers should play a leading role in the management of that care. Senior nurse managers should be strongly involved in policy making at all levels of the health system. The European Health Management Association (EHMA) welcomes collaboration with senior nurses, National nursing organisations and the PCN", by Maeve Royston EHMA Project and Development manager.

"Whether in schools, the workplace or traditional healthcare setting, nurses are at the forefront of promoting good health", by Tamsin Rose, European Public Health Alliance (EPHA)

Nurses to perform surgery?

Nurses in the UK will be trained to perform surgery in a bid to reduce waiting lists, according to a consultation paper to be published in the next month. They will either operate alone or assist consultant surgeons. After two years of training, nurses, physiotherapists and operating department assistants would be called upon to perform operations such as hernia repair, vasectomies and arthroscopies. For more on this breaking story see the UNISON website: http://www.unison.org.uk/news/news_view.asp?did=1795

Artikli f'dan il-Gurnal jistghu jigu riprodotti sakemm is-sors ikun ikkwotat.

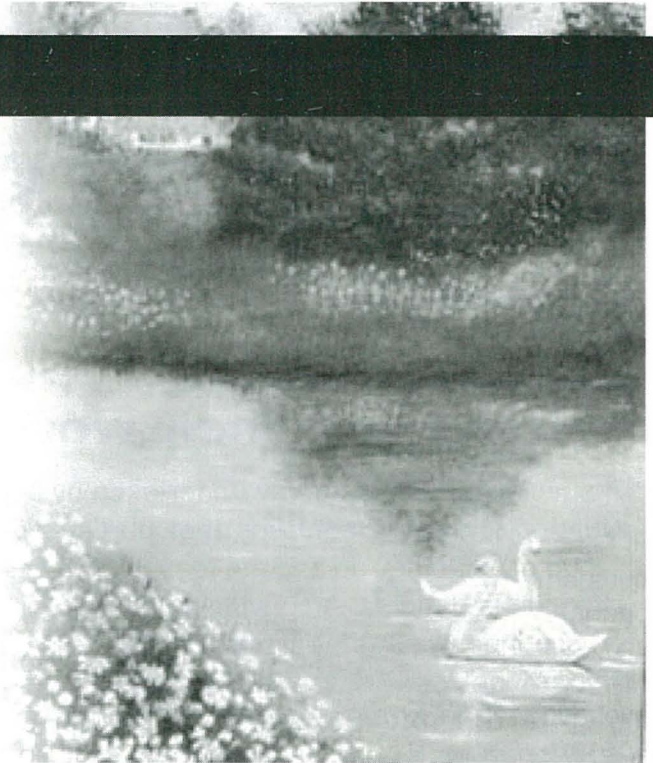
Ejjew nieqfu ftit ...

Meta taqsam il-Ferħ tiegħek ma haddieħor, Jirduppjalek...

Żewġt irġiel, it-tnejn morda serjament, kienu fl-istes kamra ta' l-isptar. Wiehed minnhom seta' jqui bilqiegħda għal siegħa wahda kulljum, hekk qal jagħmel it-tabib. Is-sodda tiegħu kienet biswit unika tieqa tal-kamra. Ir-raġel l-ieħor kellu jibq mimdud il-hin kollu. Iż-żewġt irġiel kienu jzomm kumpannija tajba lil xulxin. Kienu jitkellmu dwar in nisa tagħhom, il-familja, ix-xogħol li kellhom, fe marru għal vaganzi tagħhom u hafna suġġetti oħri. Wara nofs-in-nhar, meta r-raġel ta' hdejn it-tiec seta joqgħod bilqiegħda, kien jgħaddi l-hin billi lil sieħbu joqgħod jiddeskrivilu kulma kien ikun qed jiġri barra t-tieqa ta' hdejh. Ir-raġel li kellu jgħix mimdud kien jistenna dik is-siegħa bil-herqa, fejn id-dinja tiegħu kienet tieħu l-hajja bl-attivita' u l-kuluri sbieħ li kien jiddeskrivilu sieħbu. It-tieqa kienet tagħti għal fuq ġnien mill-isbaħ b'vaska kbira. Il-papri u ċ-ċinji komplew sebbħuh, flimkien mat-tfal jiġru u jaqbzu u jilgħabu bid-dghajjes fl-ilma tal-vaska. Mahbubin zghazagh jimxu id f'id minn qalb il-fjuri ta' kull kulur u d-dehra tal-belt fil-bogħod.

Waqt li r-raġel ta' hdejn it-tieqa kien ikun qed ifisser dan kollu fid-dettalji, ir-raġel fuq in-naha l-oħra tal-kamra kien jagħlaq għajnejh u jimmaġina dawn ix-xeni pittoreski. F'jum shun, wara nofs-in-nhar, ir-raġel ta' hdejn it-tieqa, beda jfisser lill-ieħor il-briju li kien hemm hemm isfel waqt li kienet għaddejja banda kbira. Ghalkemm sieħbu ma setax jismagħha, xorta kien qed jirnexxilu jaraha quddiem għajnejh daqs kemm iddeskrivihielu tajjeb. Ghaddew il-jiem u l-ġimgħat.

Ghodwa wahda, l-infermiera ġiet bl-ikla ta' fil-ghodu, iżda meta ppruvat tqajjem lir-raġel ta' hdejn it-tieqa sabet li kien miet fil-paċi waqt l-irqad. Kollha mnikkta sejjhet lil dawk li kellhom jiehdu hsieb id-difna tiegħu biex jiehdu l-ġisem bla hajja mill-kamra. Meta haseb li kien il-waqt, ir-raġel fis-sodda l-oħra talab biex iressquh bis-sodda tiegħu hdejn it-tieqa. L-infermiera ma rat xejn hażin f'dan u qatgħatlu xewqtu. Meta rat li kien komdu, ħallietu wahdu. Bil-mod u bi tbatija kbira, il-pazjent qam fuq minkbejh biex jagħti l-ewwel harsa lejn id-dinja ta' barra l-isptar. Bil-qajla dawwar harstu 'l barra mit-tieqa u sab li kulma kien hemm



quddiemu kien hajt ċass. L-ewwel ċans li kellu staqsa lill-infermiera x'seta' jġieghel lil sieħbu johloq dawk l-istejjer u x-xeni tant sbieħ. Din wegħbitu li r-raġel l-ieħor kien għama u lanqas il-hajt ċass li kellu quddiemu ma seta' jara.. Qattlu, "Forsi kien jgħidlek dak kollu biex jagħmillek kuraġġ."

Epilogu

Huwa ta' sodisfazzjon kbir li tagħmel lil ta' madwarek kuntenti minkejja s-sitwazzjoni li tkun fiha int. Meta tirrakkonta d-dwejjaq tiegħek tnaqqashom, iżda meta taqsam il-ferħ tiegħek ma' haddieħor dan jirduppjalek. Jekk trid thossok sinjur oghdd l-affarijiet li għandek li ma tistax takkwistahom bil-flus. "Illum huwa rigal iehor, oghżzu u qisu bhala rigal iehor li tak il-Mulej!"

L-origini ta' din l-ittra mhux magħruf.

Nurses Must Be Angles by Profession

*Nurses must be angles by profession,
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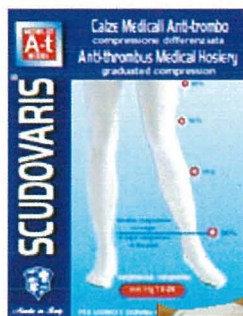


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ALDOX LIMITED 2144 5107 / 9
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SCHOLL PROFESSIONAL SHOES

Working with your body all day long

Now with unique stress-reducing insoles

The secret of our healing soles

Your body has two main balancing points: the heel and the ball of the foot. Your body is in equilibrium when the impact loads, when standing or walking, are evenly shared. This hardly ever happens, though, especially when you're working hard, so your body has to make millions of tiny compensating adjustments all through the day. It's this muscular effort that causes excess stress and fatigue. The stress-reducing insoles in every Scholl professional shoe have two special posture balancers: one directly under the ball of your foot, and one in the heel. These remarkable heart-shaped inserts actually help spread body loads more evenly across the foot, reducing muscle movement, stress and fatigue.



Balanced at the heel.

Balanced at the ball of your foot



HEART-SHAPED INSERTS, built into the sole and heel, reduce muscle movements in your legs and hips, helping you sail through the busiest working day.

Available from all pharmacies
and the Scholl Foothealth Centre, South Street, Valletta

