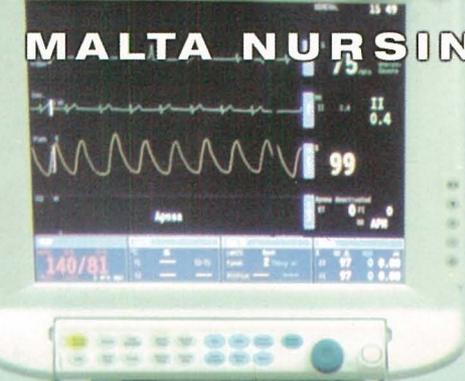


IL-MUSBIEH

MALTA NURSING AND MIDWIFERY JOURNAL



Recovery Care The Importance of Observation

- Safe or Sorry
- Missjoni Sri Lanka
- Dementia and Spirituality
- L-Istorja ta' l-Aids (2)
- Skin Problems
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MALTA UNION OF MIDWIVES AND NURSES
Fjarġa Nru. 30 - Marzu 2006



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

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Bi żvista, l-artiklu **Patient Safety-Making it happen! The 'Luxembourg Declaration on Patient Safety'** li deher f'pagna 23 tal-harġa Nru. 29 ma kellux isem l-awtur. **Maria Cutajar** Midwife Labour Ward KGH u Vici-President Kunsill MUMN kitbet dan l-artiklu.

Pjani ta' Kontingenza għall-Influwenza Pandemika

editorjal

B'xi mod jew ieħor, sal-llum kulhadd huwa nfurmat mhux ħazin dwar l-Influwenza Pandemika u għalkemm għall-bidu kulhadd kien xi ftit imħasseb kif din se toqot lill pajjiżna, l-istess *media* għamiltha faċli għalina biex ninfurmaw ruġna aħjar (jew t'allarmana aktar!).

Fil-fatt l-informazzjoni li tinghata hija li din ix-xitwa hemm ċans li ma taħkimx iżda ma rridux ninsew il-fatt li fi żmien ta' madwar xahrejn, il-viru jista' jersaq lejn pajjiżna wara li jkun ħakem f'xi pajjiż ieħor. Dan ifisser li l-preparamenti kollha għall-pandemija jridu jkunu f'posthom fuq skala nazzjonali għaliex il-marda teskala gradwalment iżda b'impatt goff.

Rigward l-*antivirals* nafu li l-Gvern se jkollu *stock* għal 25% tal-popolazzjoni. Meta jiġi pproduċut il-vaċċin u jkun f'idejn l-awtoritajiet, il-Ministeru tas-Saħħa għandu jara li jitqassmu lill-gruppi bi prijoritajiet speċjali bħall-*health professionals* kollha u ħaddiema oħra f'servizzi essenzjali.

Dan mhux qegħdin ngħiduh biex noħolqu xi ammont t'allarm iżda l-fatt li l-pjan ta' kontingenza għall-Pandemija b'mod partikolari fil-qasam ta' preparamenti għall-*Infection Control* fl-Isptarijiet għadu ma ħariġx b'mod uffiċjali, jinkwetana mhux f'it. L-awtoritajiet tas-Saħħa għandhom jintensifikaw l-isforzi kollha tagħhom għall-preparamenti infrastrutturali u oħrajn li jinħtieġu. Nafu li diġa sar ħafna xogħol minn nies kompetenti ħafna iżda x'imkien dan il-Pjan wehel! Dan m'għandux ikun meta nafu li jrid isir ħafna preparamenti u deċizjonijiet serji ħafna. Bħal ma nafu li kieku taħkem il-pandemija fi żmien xitwi fejn diġa jkun hemm il-mard tal-influwenza u mard ieħor, bħal f'kull sena, l-isptar ġenerali tagħna jkun mifqugħ bix-xogħol, se jixpakka minn kullimkien bl-iffullar tal-pazjenti u għalhekk m'hemmx fejn tpoġġi labra. Aħseb u ara jekk eventwalità ta' dan it-tip taħkem lill-pajjiżna b'mod partikolari fl-Isptarijiet tagħna. Dan jinħass aktar wara li ħadd għadu ma solva xejn u jekk kien hemm xi attentati kif jiġi kkontrollat l-iffullar speċjalment fis-Swali tal-Medicina, dawn fallew jew għal xi raġuni jew oħra poġġejnihom fuq xkaffa. Għalhekk f'kundizzjonijiet bħal dawn il-problemi se jolqtuna b'aktar saħħa. Fil-fatt fl-eqqel tal-pandemija 42% tas-sodod fl-Isptar iridu jintużaw mill-morda milquta b'dil-marda. Wisq propabbli xi deċizjonijiet diffiċli jridu jittieħdu f'dan il-kuntest: bħal limitazzjoni ta' minn jinħtieġ kura fl-isptar u minn naħa l-oħra min għandu jintbghat lura d-dar biex jagħmel wisgħa prezzjuż fil-kuraturi tal-Isptar.

Lilna n-Nurses pjaniet bħal dawn se jaffetwawna zgur għaliex nafu li haġa bħal din mhux rutina ta' kuljum, għalkemm il-'pazjent' tas-soltu hemm se jibqa' bil-bżonnijiet kollha tiegħu. U għalhekk malajr kemm jista' jkun iridu jinħarġu struzzjonijiet fuq diversi fatturi: bħal flessibilita' fis-siġħat ta' xogħol; risk assessments; arrangamenti dwar segregazzjoni ta' xogħolijiet u pazjenti; Nurses li jimirdu huma stess u x'jiġri meta jfieu; kif jaħdmu n-Nurses fil-Primary Care u Kliniċi oħrajn; l-uniformi u l-ħasil tagħha; kwarantina; kif jopera l-Emerġenza; u l-effett fuq il-familji tagħna jekk inkunu nistgħu mmorru lejn djarna.

Inhossu wkoll li t-tagħmir protettiv jinghata mportanza assoluta biex l-ewwelnett jiġi mixtri l-aħjar prodott fis-suq bħal *respirators* ta' standard u b'*fit testing* tajjeb u jkun hemm biżżejjed minn kull haġa għal tul ta' żmien u mhux nisimgħu il-famuża 'out of stock'.

Wieħed ukoll isaqs jekk l-awtoritajiet ħasbux għall xi forma ta' *insurance scheme* biex kulhadd ikun kopert f'każi estremi. U nisperaw li ma kienx hemm xi *double-standards* fuq din l-*issue*.

Irid isir ukoll taħriġ intensiv b'xenarji fittizji rigward kull aspett. Edukazzjoni bażika trid tinghata anke sempliċiment kif tikkontrolla l-għatis, ħasil sew tal-idejn, użu ta' tagħmir etc. Nurses mħarrġa sew jistgħu 'l quddiem ukoll jgħinu b'pariri li jagħtu fuq 'health lines', 24 siegħa servizz ta' telefon biex jitnaqqas il-kuntatt wiċċ'imb wiċċ ma' GPs u wkoll Nurses.

Pjaniet interpandemiċi għandhom jerġgħu jiġu riveduti skond dak li mar tajjeb u dak li mar ħażin u f'kull żmien iridu jinħarġu struzzjonijiet ġodda mill-aktar fis lil kulhadd.

In-Nurse f'Malta dejjem ta l-almu tiegħu f'kull żmien, f'kull hemm u f'kull diżgrazzja li ġrat. Mhux se jieqaf li jagħmel dan jekk tinqala' xi haġa bħal din. Biss irid jiġi nfurmat, mħarreġ u jinghata l-ġhodda meħtieġa. Inheggu 'l awtoritajiet jipublikaw u jattwaw dan il-pjan ta' kontingenza jekk jinqala' l-bżonn.

message from the president

Dear colleagues

I am sure that you all agree with me that time flies, and in this world we are living, time management is becoming more and more important in order to maintain a balance with our life styles. We are living in a hectic world and living in the Maltese Islands is no exception. I remember as if it was yesterday when I delivered my first speech in an auditorium at Zabbar to launch our organisation the Malta Union of Midwives and Nurses. Some believed that this flame within us is going to die and no such organisation will continue to represent our professions. Those who thought as such were proved wrong very wrong indeed. MUMN not only represents the Nursing and the Midwifery professions locally but now is also directly representing the professions on an international level. Not only MUMN did not cease to exist but this year we are celebrating our tenth anniversary.

A schedule of activities are being organised to commemorate our decade together, these included an evening organised by the Florence Nightingale MUMN Benevolent Fund (FNBF) for retired nurses and midwives, a Conference on Women's Health and a Conference on Health and Safety. Other activities to be held throughout the year include the Nurse/Midwife of the year award, an Educational Conference and also some entertaining events such as a football tournament, a three-act play and a billiard marathon. As you can see this year shall be very a exciting one full of activities. Definitely it was a right decision to choose the ceremonial evening for retired nurses and midwives as the kick-start for these events. Who else can we praise more than our dear colleagues who gave their whole life practising the professions and delivering care in the best possible ways under the circumstances they worked in. Unfortunately the Health Authorities do not give any form of recognition to their contribution and when the day comes they just cease to attend to their duties. MUMN through its' Benevolent Fund is annually organising an evening event to thank our colleagues and present them with a small but significant memento for them to treasure. Allow me to take the opportunity to congratulate all retired nurses and midwives and thank them for their professional service.

Time flies and even though MUMN have been told for at least these last five years that proper and intense negotiations were to start to discuss the new working conditions in relation to the New Hospital until now these negotiations never materialised. This situation is adding the possibility for more unfounded speculations that are being generated from time to time causing unnecessary tension to all staff concerned. It is not the first time that members turn to us to ask if certain new measure that they heard of are going to materialise such as new working hours, signing of a working contract and so on and so forth. I insist and reassure all members that we shall not accept any new working conditions with out calling an extra ordinary general conference where you approve such conditions. I conclude by once more emphasising that when discussion shall commence for new working conditions the issue for early retirement incentives shall be high up in our agenda.

Rudolph Cini

President



kelmtejn mis-segretarju ġenerali

Għeżież Kollegi,

Dawn l-aħħar xahrejn kienu veru movimentati b'ħafna laqgħat ta' natura differenti. L-aktar tnejn li ħallew frott kienu żewġ laqgħat separati dwar il-kundizzjonijiet tan-Nurses li jaħdmu fis-swali ta' l-Ortopedija u s-sala tal-Ġinekologija. Kienu laqgħat li kulħadd ried jilhaq oġġettiv wieħed: dak li l-pazjenti jingħataw kura aħjar u għalhekk trid Nurses aktar motivati. Ġew finalizzati żewġ ftehim li jinkorporaw żieda fin-Nursing Compliment, fis-support staff, kundizzjonijiet aħjar u ambjent aktar xieraq.

Mhux l-istess diska nista' ndoqq għas-swali tal-Medicina u l-Kirurgija. Ma nistax nifhem kif bi sptar wieħed f'pajjiżna u għalhekk bl-istess problema ta' iffullar kull sena, il-Ministru tas-Saħħa u d-Diretturi kollegi tiegħu, ma jieħdu l-ebda azzjoni konkreta biex din l-istess problema tal-iffullar tissolva jew għallinqas tibda tittaffa. Ma tantx jidher li qed jimpurtahom ħafna! Jidhru li mhux huma jħabbtu wiċċhom mat-tneħħija tad-dinjita' umana tal-pazjenti u ma l-aggressjoni tal-qraba li jaraw il-familjari tagħhom f'dik is-sitwazzjoni. Jidhru li mhux huma jmorru d-dar fil-għaxija bil-kemm jifilħu jitekellmu u jimxu u ħafna drabi l-membri familjari ta' dawn in-Nurses jkunu wkoll involuti f'dan it-tkissir fiżiku u psikologiku. Inutli li l-MUMN tilhaq ftehim għal aktar Nurses jew support staff, is-soluzzjoni hija waħda: dik li tnaqqas il-pazjenti, fattur li l-Union ma tistax tagħmlu imma jista' jsir biss jekk il-Ministru u l-kollegi Diretturi għandhom ir-rieda li jagħmluh.

Ix-xahar id-diehel se jkollna fostna rappreżentanti minn kull organizzazzjoni tan-Nurses mill-25 pajjiż fl-Unjoni Ewropea sabiex flimkien niddiskutu u niddeċiedu l-proposti li jiġu mressqa quddiem il-Kummissjoni Ewropea sabiex in-Nurse u n-Nursing jimxi l-quddiem anki f'dan il-livell. Fl-istess waqt ser ikollna fostna iċ-CEO ta' l-International Council of Nurses (ICN), Ms. Judith Oulton sabiex tiġi diskussa l-possibilita' li f'Mejju 2011 jiġi organizzat f'pajjiżna l-Kongress ta' l-ICN fejn aktar minn 2000 Nurse mad-dinja kollha jżuru pajjiżna u jithalltu flimkien.

Għall-okkażżjoni ta' l-10 Sena Anniversarju mit-twaqqif tal-Union ilhaqna ftehim mal-Middle Sea Insurance sabiex jiġu offruti tlett pakketti differenti u separati li jkomplu jserħulna moħħna fl-eventwalita' li niġu bżonn. Huwa mportanti li nżommu f'moħħna li qed jiġu offruti prezzijiet irħas peress li qegħdin fi grupp u għalhekk nistgħu nibbenifikaw minn dan l-aspett u minn din l-opportunita'. Kull wieħed u waħda minna ser nirċievu d-dokumenti d-dar. Nistedinkom tarawhom sew u tibgħatu r-risposti tagħkom mill-aktar fis possibli.

Colin Galea

Segretarju Ġenerali





Response of Music to Stress, Anxiety and Pain (Part 2)

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Perhaps one of the most environments that are fraught with anxiety for the patient is certainly the hospital. The patient is faced with new challenging or life-threatening situations (Smeltzer and Bare, 2000). Furthermore fear of the unknown and pain can further jeopardise the patients' anxiety. Thus it is the role of the health care professionals to ensure that the patient's health is restored. Relief from anxiety and pain are important issues in the care of patients.

During stress the body reacts by stimulating the autonomic nervous system. The response involves a co-ordinated discharge of the sympathetic and parasympathetic nervous system and by the secretions of hormones, especially adrenaline and cortisol (Edlin, Galanty and Mc Cormack, 1999). As a result of sympathetic stimulation, the heart rate, the pulse and temperature will be elevated (Tortora and Grabowski, 2000).

Research is suggesting that music could offer a good alternative to stress-relieving methods. Music allows the parasympathetic system to over-ride the sympathetic system resulting in a relaxed response state (Coughlin, 1994). This brings about a reduction in the heart rate, regular breathing, muscular relaxation and sleep (Updike, 1990).

Furthermore, music affects the neuroendocrine system by releasing endorphins. Endorphins are the body's natural opiates, which are released from the pituitary gland. They also influence mood-state and memory (Coughlin, 1994). On hearing a tune, the serotonin level accelerates (holisticonline.com). Serotonin is a neurotransmitter that plays an important role in the regulation of mood (Atkinson, Atkinson, Smith, Bem, and Nolen-Hocksema, 2000). Music also decreases the secretion of adrenal corticosteroids as well as corticotrophin-releasing hormone (CRH) and adrenocorticotrophic hormone (ACTH) that are secreted during stress.

Miluk-Kolasa, Obminski, Stupnicki, Golec (1994)

recommended the use of music in the waiting rooms of hospitals and health clinics as they found that music reduces anxiety during the waiting period since it could have a direct influence on the serum cortisol levels.

Furthermore pain could place an extra burden on the body's reaction to stress and anxiety. The exact mechanism of pain control is not fully understood yet. Pain is a subjective phenomenon as it is whatever the patient says it is and occurs whenever the patient says it does. This implies that each individual has different pain tolerance and different pain experience. However there are many pain theories that try to explain this phenomenon.

Psychologist Ronald Melzack and anatomist Patrick Wall first proposed the gate control theory in 1965. They suggested that there is a "gating system" in the central nervous system that opens and closes to let pain messages through to the brain or to block them.

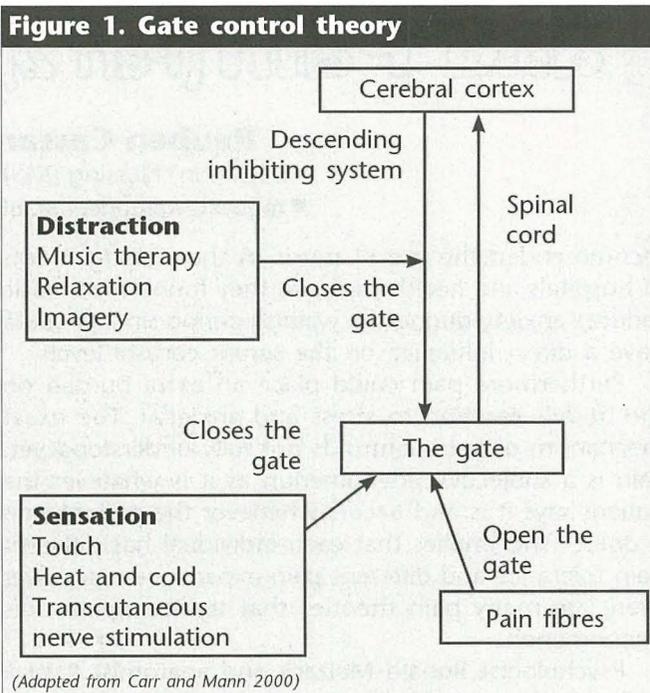
According to the gate control theory of pain, our thoughts, beliefs, and emotions may affect how much pain we feel from a given physical sensation. The fundamental basis for this theory is the belief that psychological as well as physical factors guide the brain's interpretation of painful sensations and the subsequent response.

First, sensory messages travel from stimulated nerves to the spinal cord. There, they are reprocessed and sent through open gates to the thalamus. Once the nerve signal reaches the brain, the sensory information is processed in the context of the individual's current mood, state of attention, and prior experience. The integration of all this information influences the perception and experience of pain, and guides the individual's response.

The brain's response to this information will determine the extent of pain one gets. If the brain sends a message back down to close the gate, the pain signals to the brain are blocked and lower pain could be experienced- that message may be carried

by endorphins. On the other hand if the brain orders the pain gates to open wider, the pain signal intensifies and one can often feel debilitating pain (en.wikipedia.org/wiki/Phantom_limb_pain)

Although pain-relieving medications may diminish the severity of pain, they may not provide adequate pain relief or they may present with many side effects that could be distressing to the patient. Various studies are showing that when music was applied the pain threshold increase. (Schorr, 1993; McCaffery and Freeman, 2003; Zimmermann et al, 1996). It is well proven that music could be a good alternative in pain relief management. Relaxation techniques such as music could decrease pain as it has a direct influence on the gating system by closing the gate (fig 1).



Choosing the right music has been shown to be a critical issue in developing music as an effective treatment. On choosing the music, it is important to select the appropriate genre, taking into account era, tempo, volume and tone (Biley, 1992). Halstead et al, (2002) illustrated that tempo is the major cause of physiologic response to music. Beats of 70 to 80 beats per minute are considered soothing. According to Mynchenberg and Dungan, (1995) the goals of relaxation and music therapy as nursing interventions are to decrease the negative psycho-physiological responses associated with anxiety, to promote independence, and to increase the patient's perception of well-being. However there are converging ideas among researchers on what type of music is best suited to have the desired effect. Some researchers applied music according to their preferences (Mc Caffery and Freeman, 2003; White, 1999; Zimmermann et al, 1996; Barnason et al, 1995; Elliot, 1994) while others attempted to use country and classical music (Bally et al, 2003; Orton, 2000; Elliot 1994). A word of caution came from Harcourt (1989 in Fischer, 1990) since not all classical music is suited as certain pieces of classical music can evoke specific emotions such as anger, sadness or love. Others

suggest that music should be chosen according to the patient's preference. According to Fischer (1990) the patient's sociocultural background and mood should be assessed when selecting this type of music. Infact, Mok and Wong (2003) used Chinese popular music, contemporary popular music and classical music to evoke relaxation. Identifying the patient's music preference and the importance of music in the patient's life before hospitalisation was also highlighted (Gerdner and Swanson, 1993). Fischer (1990) suggested that elderly people who are presumed senile could sing words and tunes of songs or hymns that they remember from their childhood. Music reminded them of their past and then conjure up memories of important places, people and events. Other genre of music is being used. Oncology nurses are using nature sounds as these induce relaxation, meditation and sleep. New age music is another genre of music that could be used for relaxation and spiritual connection (Halstead and Roscoe, 2002; Fischer, 1990).

To conclude, one may consider starting reflecting on the possibility to introduce music in his unit.

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PRESS RELEASE

The Malta College of Family Doctors has recently held its Winter Continuing Professional Development Meeting at The Westin Dragonara Resort. The theme was an Update in Community Child Health where 8 papers dealing with interesting variations were delivered by specialists and family doctors with experience in child health.

Among the 8 speakers was also Prof. Claudio Maffei a distinguished paediatrician and prominent infant nutritionist from the University of Verona whose paper focused on nutrition from the 6th to the 12th month of life. Professor Maffei was purposely brought over from Italy by Plasmon Italia to deliver his important paper to the Maltese medical community. The meeting was very well-attended by family doctors, paediatricians and community pharmacists; health professionals who directly deal with child health on a daily basis.

Vivian Corporation Ltd and Plasmon Italia kindly sponsored the publication of a book carrying all the papers delivered during this meeting; this book is in fact a vital tool for the Continuing Development Programme being run by the College. Copies of the book were available at the Plasmon stand which was purposely set up for the event. Health professionals involved in childcare who would like to obtain a copy of this publication are urged to contact Ms. Rosanne Debono on 21344610.

This event was kindly sponsored by Vivian Corporation Ltd, exclusive agents and distributors of Plasmon Infant Foods in Malta in collaboration with Plasmon Italia.



Tal-Familja

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NURSING MATTERS

Nursing Matters fact sheets provide quick reference information and international perspectives from the nursing profession on current health and social issues.

INFECTION CONTROL

Prevention of infections has become a primary concern of health policy makers, health professionals, employers and patients. The emergence of life-threatening infections or conditions, such as severe acute respiratory syndrome (SARS), HIV, antimicrobial resistance and re-emerging of other infectious diseases such as TB, has highlighted the need for efficient infection control programmes in all health care settings.

Infection control refers to all policies, procedures and activities, which aim to prevent or minimize the risk of transmission of infections, whether health care acquired (HAI) or those representing a public health concern.¹ Infection prevention and control are often perceived as being limited to health care facilities and to the surveillance and control of health care associated infections. However, the scope is much wider, including among others: patient safety, occupational health, food safety, biosafety, injection safety, blood safety, and containment of antimicrobial resistance.

Fighting infectious conditions is not easier now even though the health care systems and technology are more advanced. However, appropriate hygiene and infection control measures, in addition to numerous vaccines and rapidly advancing medical technology, allow people to be better prepared to avoid infections.

INFECTION CONTROL MEASURES

Poor health practices and procedures or unclean environments contribute to the transmission of infections. Transmission of infections in health care facilities can be prevented and controlled through the application of infection control measures, which interrupt the transmission of infectious diseases from patients to health care providers, other patients and families. The main aim of infection control measures is to create health care facilities that are safe for patients as well as for health care providers.

Infections and antimicrobial resistance complicate the treatment and the care of millions of patients every year. As a result, many patients' conditions become worse; they stay longer in the hospitals, and some

experience long-term disability. Health care-associated infections increase health care costs to both patients and the health care system.

INFECTION CONTROL PRECAUTIONS

Infection control involves a series of activities and measures that include both standard and universal precautions, which aim to reduce the risk of disease transmission in the health care setting, even when the source of infection is not known; and additional precautions, which may be needed for diseases that are transmitted by air, droplets and contact.

STANDARD/UNIVERSAL PRECAUTIONS

Standard precautions require that health care providers assume that the blood and body fluids of all patients are potential source of infections, regardless of the diagnosis, or presumed infectious status. Precautions include:

- Hand washing and antisepsis (hand hygiene);
 - Use of personal protective equipment when handling blood, body substances, excretions and secretions (gloves; protective eye wear; mask; gown; shoe covers; hair cover);
 - Appropriate handling of patient care equipment and soiled linen (transport and process used linen with care to ensure there is no leaking of fluid);
 - Prevention of needle stick/sharp injuries; and
 - Environmental cleaning and spill-management, and appropriate handling of waste.
- Additional precautions (in addition to standard/ universal precautions) include:
- Airborne precautions (to reduce the transmission of diseases spread by the airborne route, e.g. TB, measles, chicken pox, pulmonary, etc.);
 - Droplet precautions (to reduce the transmission of mumps, pneumonias, diphtheria, meningitis, etc.);
 - Contact precautions (to reduce the transmission of skin infections,

infection with multiple antibiotic resistant organisms).

Most of the activities include keeping patients in a single room, keeping doors closed, requiring either the visitor or the patient to wear a mask, limiting the movement in to and out of the patient's room and wearing gloves when appropriate.

HAND WASHING AND ANTISEPSIS (HAND HYGIENE)

Hand hygiene is the most effective way to prevent the transmission of infections. Proper hand washing minimizes the transmission of the micro-organisms acquired on the hands during daily activities or while performing patient care. Hand washing breaks the transmission of the infection from person to person. Because nurses are in close contact with patients, they are exposed to a variety of microbes, some of which may cause disease. By adhering to appropriate hand washing guidelines nurses can prevent infection transmission.

HAND WASHING IS RECOMMENDED:

- After handling any blood, body fluids, secretions, excretions and contaminated items;
 - Between contact with different patients;
 - Between tasks and procedures on the same patient to prevent cross-contamination between different body sites; and
 - Immediately after removing gloves.
- Hand hygiene involves using a plain soap, or antimicrobial agents such as an alcoholic hand rub or waterless antiseptic agent.

In order to prevent transmission of infections, it is important for health care providers and patients to follow infection control guidelines appropriate to their settings.

GLOBAL INITIATIVES

ICN has signalled its interest in supporting the recently launched World Alliance for Patient Safety. This initiative, spearheaded by the World Health Organisation, works to develop solutions to improve safety and reduce risk by focusing on five action areas in particular:

- Clean hands;
 - Clean practices (safe clinical procedures);
 - Clean products (blood safety);
 - Clean environment (safe water and sanitation in health care);
 - Clean equipment (injection safety).
- ICN is encouraging national involvement in this important undertaking.

L-ISTORJA TA' L-AIDS:

Kif bdiet, fejn sejra?

IT-TIENI
PARTI

Minn **Amante Darmanin**

■ amante@onvol.net

1984-87

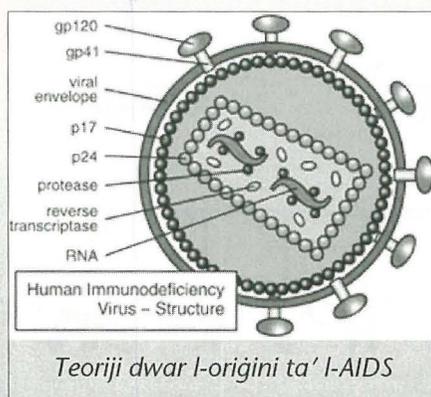
Fit-22 t'April, 1984, rappreżentant mis-CDC (*Centers for Disease Control*) ħabbar li kellhom il-kawża ta' I-AIDS. Dan kien qed jirreferi għall-*virus* li kienu sabu l-Franċiżi s-sena ta' qabel u li ġie msejjaħ LAV. Ġurnata biss wara, s-segretarja Amerikana għas-Servizzi tas-Saħħa u Riżorsi Umani, Margeret Hackler, ħabbret li x-xjenzat Robert Gallo kien sab il-*virus* ta' I-AIDS u kien imsemmi HTLV-III. Hija kompliet tgħid li ma jdumx ma jinstab *vaccine* għal dan il-*virus*. Għalhekk, issa kellna possibilita' ta' żewġ ismijiet għall-*virus*. Is-sejba ta' HTLV-III ġiet ippubblikata fil-ġurnal *Science* minn Gallo stess fl-4 ta' Mejju permezz ta' erba' artikli. Li jkollok l-*virus* b'żewġ ismijiet kienet ambigwa u għalhekk xi xjenzati bdew isejġu dan il-*virus* LAV/HTLV-III. Sa Mejju ta' l-1985, l-Amerikani kellhom brevett (*patent*) għat-test ta' I-AIDS, iżda l-Franċiżi akkużawhom li huma kienu sabu t-*test* qabel, u għalhekk tellgħu lill-Amerikani l-qorti. Mhux hekk biss, iżda meta xjenzati oħra qabblu ż-żewġ *virus* flimkien, sabu li dawn kienu identiċi. Meta tqis li l-*virus* ta' I-AIDS jinbidel kważi minn bniedem għall-ieħor, aħseb u ara mill-Amerika sa Pariġi, fi żminijiet differenti, allura dan kien iffisser haġa waħda; li Gallo kien seraq il-*virus* ta' Montagnier. Jekk dan ma kienx biżżejjed, kien instab li wieħed mir-ritratti tal-*virus* li ippubblika Gallo, fil-ġurnal *Science*, kien l-*virus* wieħed tar-*retrovirus* li Montagnier kien ippubblika.

Din il-polemika baqgħet tkarkar għas-sni ta' wara, meta fil-ħarifa ta' l-1996, il-Prim Ministru Franċiż Jacques Chirac baqgħat messagġ lill-President Amerikan Ronald Reagan biex isolvu l-problema. F'Marzu 1987, ġie deċiż li s-sejba tal-*virus* tinqasam bejn l-Amerikani u l-Franċiżi

u l-isem jibda jissejjaħ HIV (Human Immunodeficiency Virus).

Sadanittant, sa l-aħħar ta' l-1994 kien hemm 7,699 każ fl-Istati Uniti biss, li minnhom mietu 3,665 u, fl-Ewropa kien hemm 762 każ. Fl-1995 saret l-ewwel laqgħa internazzjonali mill-WHO dwar l-AIDS.

Xi xjenzati li żaru l-Afrika kienu iddeterminaw li l-marda 'slim' u 'Guljana' kienu ismijiet lokali għall-marda ta' I-AIDS. Sabu wkoll li fl-Afrika, mis-Sahara 'l isfel, il-*virus* kien mifrux mhux ħazin. Meta fittxew lura fiż-żmien, sabu li fl-1959, il-Professor Belgjan Vandepitte kien ġabar 672 kampjuni tad-demmi mill-Kongo u kien refaġġhom, u 25 sena wara, ġew ittestjati għall-HIV. Wieħed mill-kampjuni kien positiv għal dan il-*virus*. Il-kampjun kien minn Leopoldville, il-kapitali tal-Kongo Belgjan (illum ir-Repubblika Demokratika tal-Kongo). Dan ifisser li l-*virus* kien ilu jicċirkola għal mill-inqas mill-1959. Meta wieħed jistudja r-rata li biha jinbidel dan il-*virus*, jekk dejjem kien kostanti, allura wieħed jista' jmur lura fiż-żmien meta dan kien jixbaħ il-*virus* simili, SIV (Simian Immunodeficiency Virus), li nfetta lil xi speċi ta' xadini. Minn studju li sar fuq dan, permezz tal-kompjuter ġie deċiż li l-*virus* beda jvarja mill-1931 'l hawn. Iżda x'giegħel biex jisplodi hekk f'daqqa? Probabbli, kien il-mod ta' kif il-bniedem biddel il-mod ta' l-għixien tiegħu. Maż-żmien is-soċjeta' saret aktar permissiva u



Teoriji dwar l-origini ta' I-AIDS

l-meżzi tat-trasport saru aktar faċli. Dawn għamluha aktar faċli biex jinfirex il-*virus*. Barra minn dan, l-użu tas-siringi mhux sterilizzati u trasfuzzjonijiet tad-demmi aktar spessi, ukoll għenu biex il-*virus* jinxtered. Uħud minn dawk li xerrdu l-*virus* kienu *flight attendants* peress li dawn kienu jieqfu f'ħafna postijiet. Każi oħra bikrin kienu meta: l-HIV instab f'*tissue sample* ta' ġuveni li miet minn mikrobu misterjuż f'St Louis, l-Istati Uniti, fl-1969. L-HIV instab ukoll f'*tissue sample* ta' baħri Norveġiż li miet fl-1976. Fiż-Żaire, *serum* miġbur fl-1997, minn fuq mara li kienet marida sew, ittestja wkoll positiv għall-HIV. Sa l-1995, l-iRwanda rrapportat li kellha 319 każ ta' I-AIDS, li 86 minnhom kienu tfal żgħar, il-Kenja kellha 10 każi, li 4 minnhom kienu barranin. Iż-Żaire rrapporta li 6 fil-mija tan-nisa fis-swali *antenatal* kienu seropositivi. Iż-Żambja rrapportat li minn 143 mara li welldu fl-Università ta' Lusaka, 17 minnhom kienu seropositivi, kif ukoll kienu l-15 mit-trabi tagħhom. Ħafna minn dawn il-każi ġew infettati mit-trasfuzzjoni tad-demmi jew labar infettati. Fiż-Żambja biss, 29 fil-mija tal-popolazzjoni kienu seropositivi.

Il-problema li kienu qed jiffaċċjav ħafna gvernijiet, mill-punto di vista ekonomika, kienet u għada, li l-AIDS ma tattakkax lid-dgħajfef, bħax-xjuħ jew it-tfal. Iżda, l-iktar li tattakka, huma n-nies li huma l-mutur tas-soċjeta'; l-iktar persuni li jaħdmu fl-età ta' bejn 20 u l-40 sena.

Nies Prominenti

Kien fit-3 t'Ottubru 1985, li l-attur magħruf Rock Hudson miet bil-marda ta' I-AIDS. Nies oħra prominenti li mardu jew mietu bil-marda kienu; l-player tal-basketball Amerikan Magic Johnson, li ħabbar li kellu I-AIDS fl-1991, il-kantant magħruf tal-grupp Queen, Freddie Mercury, li ħabbar li kellu I-AIDS ftit siegħat qabel ma miet. Il-ballerin Russu Rudolf Nureyev li miet fl-1993 u l-player tat-tennis Arthur Ashe li probabbli kien ħa l-*virus* mit-trasfuzzjoni tad-demmi li kien irċieva fl-1983.

1986-2005 Malta

F'Malta, il-każi ta' I-AIDS bdew jidhru fl-1986. Għall-ewwel, il-każi kienu ta' nies li ħadu l-*virus* minn trasfuzzjonijiet tad-demmi,

L-aktar il-*haemophiliacs*. Iżda wara bdew jidhru diversi każi oħrajn. Sa l-2004 kien hemm 58 li mardu bl-AIDS u minn dawn mietu 46. 13-il każ kienu ta' *haemophiliacs* jew ta' każi oħra fejn id-demmm ma jagħqadx u għalhekk għandhom bżonn ħafna trasfuzzjonijiet. Fi snin disgħin bdew jidhru mediċini li b'xi mod itawlu l-ħajja tan-nies morda bl-AIDS li għalkemm ma jfiqix jistgħu jgħixu ħajja kwazi normali, għalkemm b'ħafna '*side effects*'. Fl-2002 kien hawn 55 posittivi għall-HIV u 33 minn dawn kienu qed jieħdu l-mediċina regolari għal kontra l-virus. Minn dawn il-55, 22 fil-mija huma nisa. Bejn Ġunju 2001 u Ġunju 2004 kien hawn seba' każi ġodda ta' l-AIDS. Bejn Jannar u Lulju 2005 kien hemm 3881 persuna li għamlu t-test ta' l-HIV. Minn dawn irriżulta li kien hemm 13 posittivi għall-HIV. Dan ma jfissirx li kien hawn dan in-numru biss, għax jista' ikun li hawn individwi li ma jafux li għandhom l-HIV u qatt ma ħadu test. Jista' jkun ukoll, li xi nies jagħzlu li jagħmlu t-test barra minn Malta.

Tipi Ta' HIV

Il-virus ta' l-HIV ivarja ħafna u f'għisem wieħed tista' issib diversi *strains* tal-virus. Iżda dawn jistgħu jiġu ikklassifikati f'tipi, gruppi u sub tipi. Hekk ngħidu li hawn żewġ tipi ta' HIV: HIV-1 u HIV-2. Dawn jagħtu l-istess marda għalkemm jidher li HIV-2 jiġi inqas trasmess malajr, u minn meta jinfetta sakemm toħroġ il-marda, l-HIV-2 jieħu aktar żmien. HIV-2 jinstab biss fil-Punent ta' l-Afrika. L-HIV-1 imbagħad jinqasam fi tlett gruppi M, N u O. 90 fil-mija ta'

l-HIV jaq' taħt il-grupp M, filwaqt li grupp O jinsab biss mill-Punent għall-Afrika Ċentrali. Grupp N huwa rari u nstab fl-1998 fil-Cameroon. Grupp M jerġa' jinqasam f'madwar disa' sub tipi. Kultant dawn is-sub tipi jithalltu flimkien u joħolqu *strains* ġodda. Dawn jissejġu CRFs (*circulating recombinant forms*).

It-Teorija tal-Kaċċatur

L-iktar teorija li hija emmnuta hija li xi kaċċatur qatel xi ċimpanzi u l-*virus* tas-SIVcpz daħal f'għisem, jew għax kiel iċ-ċimpanzi jew inkella għax kellu xi qatgħa li permess tagħha, d-demmm tax-xadina infettatu bil-virus. Dan seta' ġara aktar minn darba lill-kaċċaturi oħrajn u fi żminijiet differenti. Wara l-*virus* inbidel fil-forma ta' HIV-1 kif nafuh illum. Is-SIVcpz huwa l-aktar virus li jixbaħ lill-HIV-1.

It-Teorija tal-Polio Vaccine

Fil-ktieb tiegħu *The River*, il-ġurnalista Edward Hooper, issuġġerixxa li l-HIV tista' tiġi traċċata għal meta kienu jsiru t-testijiet fuq il-*vaccine* tal-polio mill-ħalq. Dan il-*vaccine* kien ingħata lill-miljun persuna fil-Kongo Belġjan, Rwanda u Burundi fl-aħħar ta' l-1950. Skond dan, din kienet ikkultivata fil-fwied tax-xadini ċimpanzi, fejn hemm seta' sar il-kontaminazzjoni bl-iSIV u għalhekk ġew infettati numru kbir ta' nies.

It-Teorija tal-labar infettati

Din tixbaħ ħafna t-teorija tal-kaċċatur, iżda flok dan kiel ix-xadini, xi labar ikkontaminati setgħu xerrdu l-iSIV *virus* lil grupp ta' nies, li wara seta' jikkumbina go fihom u jinbidel f'HIV-1.

It-Teorija kolonjali

Din ukoll tixbaħ it-teorija tal-kaċċatur. Skond Jim Moor, speċjalista tar-riċerka fuq l-imġieba tax-xadini, il-kolonjalisti kienu jisfurzaw ħafna mill-Afrikan biex jaħdmu bilfors. Dawn kienu jinżammu f'postijiet xejn sanitarji. Kienu jtaqbuhom għal kontra l-ġidri b'labar ikontaminati. Kien ikollhom ukoll il-prostituti biex dawn ma jirribellawx. Ammont kbir ta' dawn l-iskjavi kienu jmutu qabel ma kellhom l-ewwel sintomi ta' l-AIDS, iżda xi wħud għaddewha lil haddieħor.

It-Teorija tal-konfossa

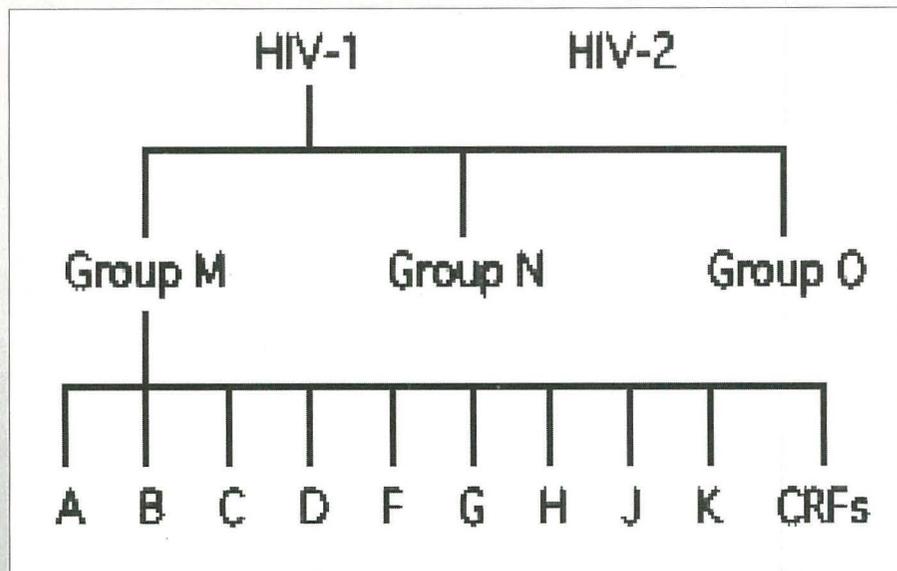
Xi wħud isostnu li l-gvern Amerikan, bil-kollaborazzjoni tas-CIA, deliberament ivvinta *virus* biex inaqqas il-popolazzjoni ta' l-Afrika jew ta' l-omosesswali. Dawn ġew infettati permezz tat-titqib għal kontra l-Hepatitis jew il-ġidri.

Hemm min isostni li l-HIV ma jikkawzax l-AIDS peress li min jimrad bl-AIDS ikollu ħafna mikrobi oħrajn. Iżda ftit huma daww is-serji li jemmnu f'dawn it-teoriji.

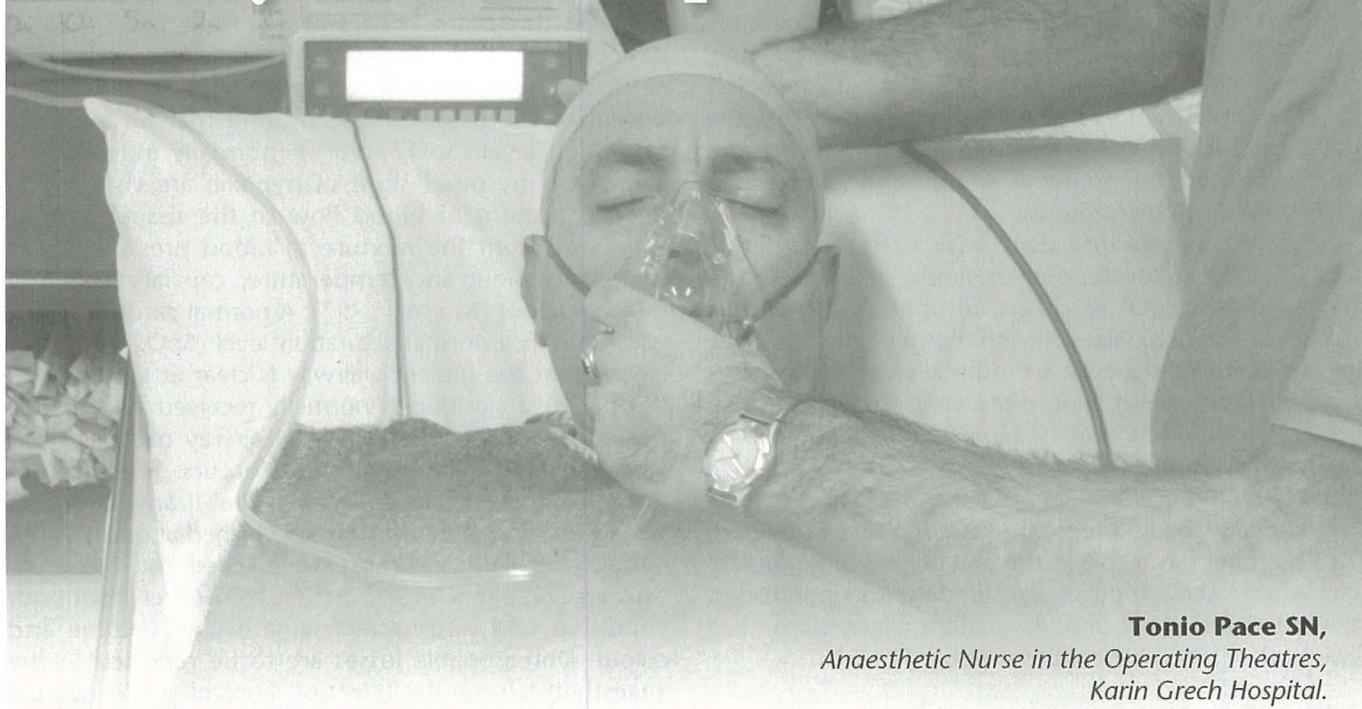
Kien x'kien l-orijini ta' l-HIV forsi qatt m'afna se nkunu nafuh. Li forsi wieħed jista' jgħid hu, li dan ħareġ minn x'imkien mill-Afrika, 'l isfel mid-deżert tas-Sahara. L-orijini ta' l-HIV-2 huwa wkoll maħsub li nxtered mix-xadini. Iżda, din id-darba, ix-xadini huma tar-razza *sooty magabeys*.

Il-Futur

Skond il-Ġnus Magħquda, sa l-2050 l-AIDS ikun naqqas iż-żieda tal-popolazzjoni dinjija b'480 miljun jekk ma jinstabx fejqan malajr. Huwa maħsub li minn dawn ikun hemm 47 miljun fl-Indja u 40 miljun fiċ-Ċina. Postijiet oħra li se jintlaqtu l-iktar huma, r-Russja u Niġerja. Huwa maħsub li madwar miljun persuna bejn il-15 u 49 sena għandhom l-HIV fir-Russja, għalkemm ċifri oħrajn juru minn 600 000 sa 1.5 miljuni. Kawża ta' l-AIDS, xi pajjiżi huma mistennija li jnaqqsu il-popolazzjoni flok iżiduha. Fil-Botswana, fejn kwazi wieħed minn kull tlieta huwa infettat, it-tul tal-ħajja niżel minn 65 sena fl-1990 għal 39.7 fis-sena 2000. Skond il-Ġnus Magħquda l-popolazzjoni tal-Botswana se tilhaq il-1.4 miljuni sa l-2050, li hija b'20 fil-mija inqas mis-sena 2000. Tnaqqis fil-popolazzjoni huma mistennija wkoll għas-South Africa, Lesoto u Swaziland.



Recovery Care - The Importance of Observation



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"A recovery room is a specialist area providing specific individualised care for all postoperative patients with a high ratio of trained nursing staff to patients"
(Morton, 1997: p169)

Well before surgery, the patient is observed from the time of hand over from the ward staff. Recovery room staff normally consists of trained nurses who are skilled in the management of patients with breathing and circulation disturbances. The recovery room nurses are also the first to welcome any patient who is wheeled through the theatre reception/transfer area. So it is of great importance that a very good communication approach is used between ward and recovery room nurses, both keeping in mind that the patient is normally anxious and attentive to every word said. At this point the recovery room nurse goes through the patient's notes by checking the latest entry from the most recent ward round, blood results, ECG, consent form, any allergy remarks (if any), the premedication list (if any) as ordered by the anaesthetist the day before, whether taken or not as advised, and most particularly the pre-operative check list which contains all information that ensures safety to the patient. When filled/ticked in the ward by the nurse, the checklist is carried out together with the patient. Both for the checklist and the signing of the consent form, parents, guardians or close family members are involved only if the patient is an infant, of a mental disability, or where the patient is unable to take decisions by him/her. As soon as all checks are over and the patient is granted with green light, the recovery room nurse wheels the patient to the anaesthetic room, where a thorough hand over is given to the anaesthetic nurse or anaesthetist.

The recovery room consists of a large open area, where patients are easily seen by the nursing and medical staff. It is the nurse's duty to make sure that privacy is well safeguarded by making use of partitions/curtains, keeping in mind that most of the time patients of both genders are nursed in a recovery room at the same time. It is advisable at this stage that theatre gowns are to be of proper size, thus fitting the patient comfortably. Utilised trolleys/stretchers should be checked prior use from any possible previous patient's blood stains, or any other secretions etc., that both sides of trolley are well attached and engage patients safely. One final check is that trolleys easily tip up and down if need be. The area should be kept at a sensible temperature, ensuring that the risk of hypothermia is minimal to none. At each bay section, wall mounted oxygen supply is available together with a suction apparatus and electrical points. Nurses should have adequate space to work comfortably in, as in various events several actions are taken in such a short time. Monitoring equipment with adequate alarms should have ample space, ensuring eye comfort from one monitor to another. An effective emergency call should be labelled well and noticed by all staff working in the area (AAGBI, 2002).

All patients who have undergone surgery will go through this particular unit, also known as Post Anaesthesia Care Unit (PACU). This is the place where patients, who have had general anaesthesia, sedation or regional, are carefully monitored and are awaiting recovery in order to be discharged back to the ward. Patients who go through this unit vary from neonates/children to adults.

The recovery unit is normally found in a central position within the theatre floor and is easily reached when transporting the post operative patient to the point where observation is fulfilled. The Association of Anaesthetists of Great Britain and Ireland, (AAGBI) (2002) suggests that the area should be ventilated automatically since the air is contaminated by anaesthetic gases, together with a scavenging system for the occasional gas use of an anaesthetic machine. It even stresses that the unit should be kept at low noise levels as possible and the ceiling should be sound absorbent and that lighting levels should not be rigorous.

Recovery nurses on a daily basis carry out routine daily stock taking for disposables, fluids, linen and secure that all items, such as drugs, intubating apparatus, masks with various sizes, oropharyngeal airways, etc., are available. The checks are normally carried out first thing in the morning, before the start of any operation list. Any equipment that is deemed not fit for use by the recovery/anaesthetic nurse, is reported at once both to the designated technicians and the anaesthetist scheduled for the list where the fault has been detected. The equipment available in the unit plays a fundamental part when used. Appropriate standards of monitoring should be carried out until the patient fully regains. Gwinnutt's (1997) list contains: (table 1)

Standard Equipment

- * An oxygen supply with all necessary circuits for delivery;
- * Suction apparatus;
- * An electrocardiogram (ECG) device;
- * Pulse oximeters;
- * Non-invasive blood pressure (NIBP) device;

In addition, one must make sure that all adjustments that connect to the listed items are immediately available, such as adult/paediatric oxygen masks, finger/ear probes, blood pressure cuffs, and other electrical devices. The patient that has been transported into the recovery is normally accompanied by the anaesthetist and anaesthetic nurse. A supplemental amount of oxygen is administered during transfer. The recovery nurse at this particular bay receives the patient, where it is here that a detailed verbal hand over is given by the anaesthetist. An anaesthetic record is even kept on the anaesthetic sheet (Green) in the file. This record normally implicates any changes and trends noted by the anaesthetist from



repeated takes of the either non-invasive/invasive blood pressure, heart rate and rhythm, the fluid balance during surgery itself, and all drugs used.

The patient who is unable to breathe on his/her own can never be left unaided (Walters 1997). The recovery nurse at this point checks that an adequate flow of oxygen is reaching the blood, enabling an adequate cardiac output and correct distribution of the cardiac output to the tissues, thus ensuring that no cyanosis, saturation level (SpO₂ <90%) (normally indicated by alarm) or any other signs of hypoxia are visible. The decent amount of blood flow to the tissues can be estimated from the mixture of blood pressure, heart rate, skin colour and temperature, capillary refill and urinary output (Morton 1997). A normal cardiac output will result in a normal saturation level (SpO₂ >95%). It is vital that the patient's airway is clear at all times, so the patient's position is normally received on a lateral position with the intention that airway obstruction is avoided once secretions/vomitus occurs. The recovery nurse has to be aware of the fact that if anything goes wrong, the anaesthetist must be informed at once. Drains and urinary catheters must be checked and recorded, thus ensuring that their function is in order from both condition and output with a satisfying volume and colour. Unreasonable losses are to be reported to the anaesthetist instantly. Infection control guidelines are to be complied in order to prevent possible chances of spillage containing blood or body fluids. The patient's position should be checked at intervals, easing the mind from any joint or muscular injury that the patient can develop from bad posture.

The consciousness level can be assessed at this time by the nurse so that communication with the patient could begin, enabling in a way the nurse to understand more the patient's protective airway reflexes and the pain score. Gwinnutt (1997) makes use of this description of rigorousness to measure pain (table 2), followed by another table (table 3) in order to assess sedation:

Pain Score Measurement

- 0 = no pain;
- 1 = mild pain;
- 2 = moderate pain;
- 3 = severe pain.

Sedation Score

- 0 = no sedation, patient alert;
- 1 = mild sedation, occasionally drowsy, easy to rouse;
- 2 = moderately sedated, frequently drowsy, easy to rouse;
- 3 = severely sedated, somnolent, difficult to rouse.

If the patient is in pain, a periodic intramuscular (i.m.) shot for pain relief is normally given postoperatively. A very commonly used device on patients, who undergo surgeries with a possible post-operative high pain score, is the patient-controlled analgesia (PCA). Spinasant (2005) declares that prior to surgery, the anaesthetist and/or anaesthetic nurse will discuss post-operative



pain and how it can be controlled. The patient is usually briefed with the final decision. It is suggested that one i.v. cannula is best to be reserved only for PCA use, unless a special giving set is available. Literature establishes that patients who are normally given alternatives feel more confident, comfortable, and reassured about their surgical outcomes. What's more reassuring to the patient is that pain relief is obtained around the clock, with the adult patient setting off the syringe pump by depressing a switch to deliver a programmed bolus dose of morphine intravenously (Gwinnutt 1997) - no need to wait for a nurse to deliver pain medication. It is important that both recovery nurses and ward nurses supervise the function of a PCA pump, making sure that after the bolus dose has been injected, the pump's 'lockout' system comes into effect, excluding any risks of an overdose. Normally the lockout period is set for 5/6 minutes. If on assessment, it is noted that the respiratory rate is less than 10 beats/minute, or a fall in blood pressure is evident and the patient is well sedated, then an anaesthetist must be called for. Respective literatures agree that the following steps must be taken straight away, (table 4);

PCA Overdose Management

- * Stop the PCA
- * Administer oxygen via mask
- * Call for assistance
- * The anaesthetist will decide the need for and the dose of Naloxone.

Small children, disabled patients, those with hand injuries/burns and the elderly can make use of the same device as well, better known as nurse-controlled analgesia (NCA). The nurse at this stage gives bolus doses from a pre-programmed set-up, according to the patient's requirements. The Association of Anaesthetists of Great Britain and Ireland (AAGBI) (2002) accents that children

are more likely to become fidgety and disorientated post-operatively hence they will require a one-to-one supervision until they are discharged back to the ward. One simple test is better known as the AVPU scheme. This abbreviated term, stands for; Awake - responds to both Verbal and Pain stimuli - Unresponsive. The intention of these is to have the patient awake or asleep but responding to the nurse's commands (Morton 1997). It is estimated that the time period each patient would need to spend in the recovery area, depends on the duration and type of surgery itself, the anaesthetic method used, and whether any complications have originated. Some entities, as well adopt a time frame of how long patients should be kept under observation. This is normally 30 minutes. Lunn (1991) relates the post anaesthesia effect to that of a hangover, where a headache, dizziness and inability to focus may persist. The anaesthetist must be informed of the latest developments especially before sending the patient back to the ward. Until the patient is discharged from the recovery unit to the ward, the patient is yet under the anaesthetist's responsibility. The criteria for discharge (Table 5) according to Walters (1997);

Criteria for Discharge from the Recovery Unit

- * that the patient must be fully conscious and able to maintain the airway;
- * breathing is satisfactory;
- * constant cardiovascular system, with minimal bleeding from operated site;
- * pain relief is tolerable;
- * warm

The recovery nurse should note that all documents are filed back to the patient's file, together with all blood results, any hitches that need further attention, fluid balance charts and post-operative instructions for the



ward nurses. Patients who have undergone, for instance E.N.T. surgery are to be checked for any possible risks, such as airway disturbances and that all dressings such as bolsters are in place, and where necessary their face is cleansed from any blood or other secretions. Such stains if ignored might alarm patient's family members who would either complain of bad service or pass out by watching a tiny spot of blood on their relative's gown at the time of arrival to the ward. Another important issue to take into account is that the post-operative nausea and vomiting is well controlled, especially when keeping in mind that elevators are used and that's a time where ward nurses might find themselves helpless, if the patient gets into a vomiting frenzy. As well as stated earlier in this article, good communication levels should once again be in practice between all nurses involved when handover takes place. Recovery room nurses should take into account that each one is responsible for every patient under their care, hence keeping the patient's wellbeing a main concern. The patient's comfort at the actual time of discharge to the

ward should be satisfying, thus symbolising each nurse's professional performance.

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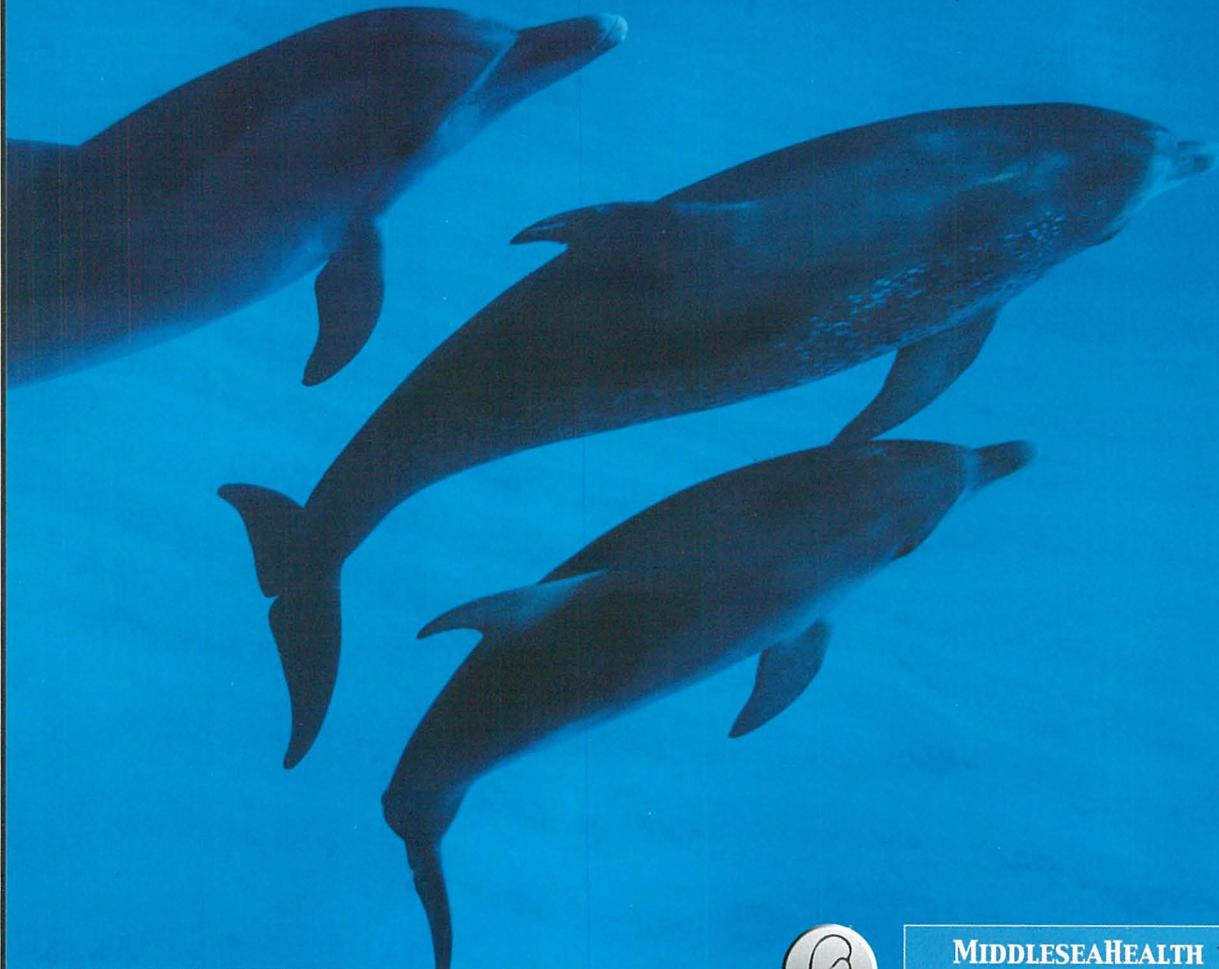
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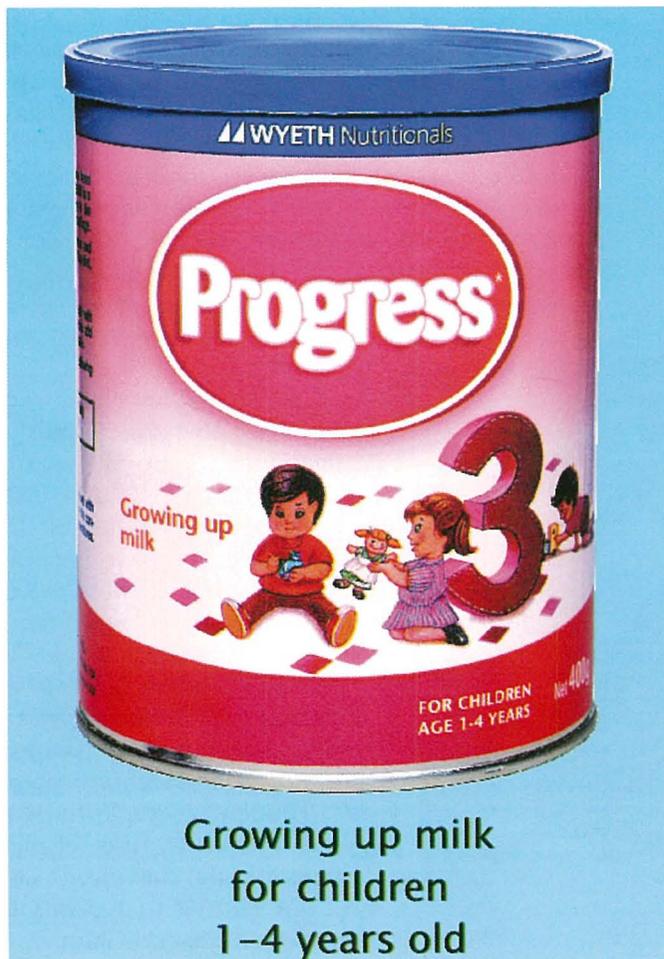
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Asthma and analgesics - aspirin-sensitive asthma (ASA)

Asthma is an increasingly common condition, now affecting 100-150 million people worldwide.¹ Many asthmatics do not realise that common non-prescription analgesics, such as aspirin and other non-steroidal anti-inflammatory drugs (NSAIDs), can trigger an attack.²⁻⁴ Known as aspirin-sensitive asthma (ASA), this condition is under-recognised both by asthmatics and healthcare professionals.

Prevalence of aspirin-sensitive asthma

In the past, studies have shown variation in the prevalence of ASA, ranging between 4-44% of adult asthmatics.^{5,6} This variation is thought to result from the different methods used to determine who is sensitive to aspirin.

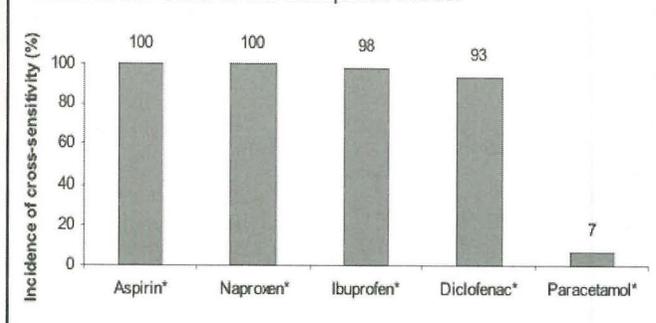
A recent meta-analysis has examined the evidence, with the intention of obtaining more definitive prevalence figures. When determined via oral provocation testing, ASA was found to affect 21% of adults and 5% of children with asthma. Prevalence was much lower when determined by verbal history (adults 3%; children 2%), demonstrating that many asthmatics are unaware that they could be sensitive to aspirin.⁷

Cross-sensitivity

The exact cause of ASA is unclear, but it is thought to result from the way that aspirin inhibits the cyclooxygenase (COX) enzyme.⁴ People with ASA are therefore likely to be cross-sensitive to other traditional NSAIDs (e.g. ibuprofen). Indeed, the risk of cross-sensitivity is between 93 and 100%, depending on which NSAID is taken (see figure).⁷ The ability of a particular NSAID to cause cross-sensitivity is directly proportional to its ability to inhibit COX.

Figure: Incidence of cross-sensitivity with other analgesics^{8,9}

*Reactions can occur at sub-therapeutic doses.



Paracetamol, a recommended alternative³

Paracetamol has no significant effect on blocking the COX enzyme in the periphery, which explains why it is far less frequently associated with cross-sensitivity reactions.^{3,10,11} It can exacerbate asthma in about 7% of people with ASA (less than 2% of all asthmatics),⁷ but the symptoms induced tend to be milder and shorter-lived than those seen with aspirin.¹²

Identify who is at risk

* ASA patients difficult to identify because symptoms are hard to predict and there is no simple test

* Need to exercise caution when recommending pain relievers to asthmatic patients³

* Paracetamol should be first choice compared with aspirin and other NSAIDs, as it is suitable for most asthmatics

* Possible advice could be tailored as follows:

Patient	Advice
People with ASA OR People with asthma and nasal polyps but no definite ASA	Aspirin and other NSAIDs should be strictly avoided and paracetamol recommended instead ^{3,4}
People with asthma but no history of nasal polyps or ASA	Paracetamol should be first choice, however, they may take aspirin and other NSAIDs, provided that they have been given adequate information about the possible risks ^{3,13}
People with no asthma and no history of aspirin sensitivity	Taking paracetamol, aspirin or other NSAIDs is unlikely to exacerbate an asthma attack ³

For those at risk of ASA, paracetamol remains an analgesic of choice.^{3,4,13}

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The deadline for the receipt of abstracts is midnight GMT 15 September 2006.

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Quality public services bring decent work opportunities for young workers

Some key texts on youth and public services have been negotiated during the recent ILO discussion on youth employment (ILO Conference, May 30 to June 16). These will be useful for lobbying both within your union and during collective bargaining and social dialogue with government and multilateral organisations, to promote decent work for young people.

Unions, employers and governments have agreed that: "The provision of adequate high-quality public services, especially in developing countries, in areas such as health care, education, utilities, power and water, is required and will directly generate additional decent work for youth as well as providing an enabling environment for increased private investment and job growth. There is considerable scope to expand economic activity in key sectors through public and private initiatives, which will also help economic and job growth." (See <http://www.ilo.org/public/english/standards/relm/ilc/ilc93/reports.htm>)

The ILO has also agreed to support efforts to strengthen the capacity of workers' organizations to reach out and engage young workers. Unions, governments and employers are committed to addressing youth employment through the involvement of young people in labour market policies and programmes. The key findings from the Committee on Youth Employment, entitled *Promoting youth employment – General discussion based on an integrated approach*, are set out below. The workers group contained many young people, and was chaired by ICFTU President Sharan Burrow. Pia Simonsen represented PSI, and acted as Secretary to the Workers' Group Drafting Team.

The ILO has now committed to:

- Expanding knowledge on the nature and dimensions of youth employment, unemployment and underemployment (paragraph 43).
- Promoting industry training and skills development for young workers through investment in education, training and mentoring (paragraphs 43 & 52).
- Integrating a cross-cutting youth dimension to all its work and in particular, providing age-disaggregated data addressing the youth dimension in its research, studies and reports (paragraph 49).
- Promoting good practice on policies and programmes for youth employment through tripartite meetings. This should include giving special attention to gender issues, HIV/AIDS, and of those facing particular disadvantage due to disability, ethnic origin, labour migration and other specific circumstances (paragraph 48).

- Supporting efforts to strengthen the capacity of workers' and employers' organisations to reach out and engage young workers and employers of young workers to ensure that their specific needs are taken into account in social dialogue processes, including collective bargaining (paragraph 52).

Trade unions have committed to:

- Ensuring worker organisation structures support, encourage and respect the involvement of youth. Urgent action is required to enhance the involvement of young workers, workers' organisations and employers of young workers and their organizations in development, implementation and monitoring of youth labour market policies and programmes (paragraph 17).
- Engaging in social dialogue on national trade, industry, training and wage policies to promote quality decent work for youth (paragraph 19).

Governments have committed to:

- Establishing labour market information and monitoring mechanisms to ensure a regular flow of information on the employment situation for young people. (paragraph 29).
- Strengthening labour inspection and national labour administration, including occupational safety and health protection, in order to avoid precarious employment situations that deny workers basic rights (paragraph 29).
- Providing all young women and men with the broadest possible access to universal, free, quality public primary and secondary education and investment in vocational training, lifelong learning and training opportunities (paragraphs 32 & 34).
- Monitoring and evaluating the relevance, effectiveness and performance of policies and programmes promoting decent work for young people and widely disseminating this knowledge about what works and what does not work (paragraph 38).
- Developing tools to support employers, workers and governments identify areas of work where there are gaps in the application of international labour standards (paragraph 38).

PSI is a global labour federation, representing over 20 million public service workers in 150 countries and 650 unions around the world. For more information see www.world-psi.org. For further comment contact PSI Equality and Rights Officer Nora Wintour on +33 (0)4 5040 1164 or +33 (0)6 3273 0361, or email equality@world-psi.org

Spiritual Care for People with Dementia

A common illness that affects old people is dementia. It presents a major threat to older adults both to their personhood and ability to communicate with others. Dementia is a process of an advanced and incurable deterioration of the cognitive-functional abilities of the brain of older adults. Symptoms related to dementia are increasing confusion, memory loss, and communication problems. How are we to support people suffering from dementia?

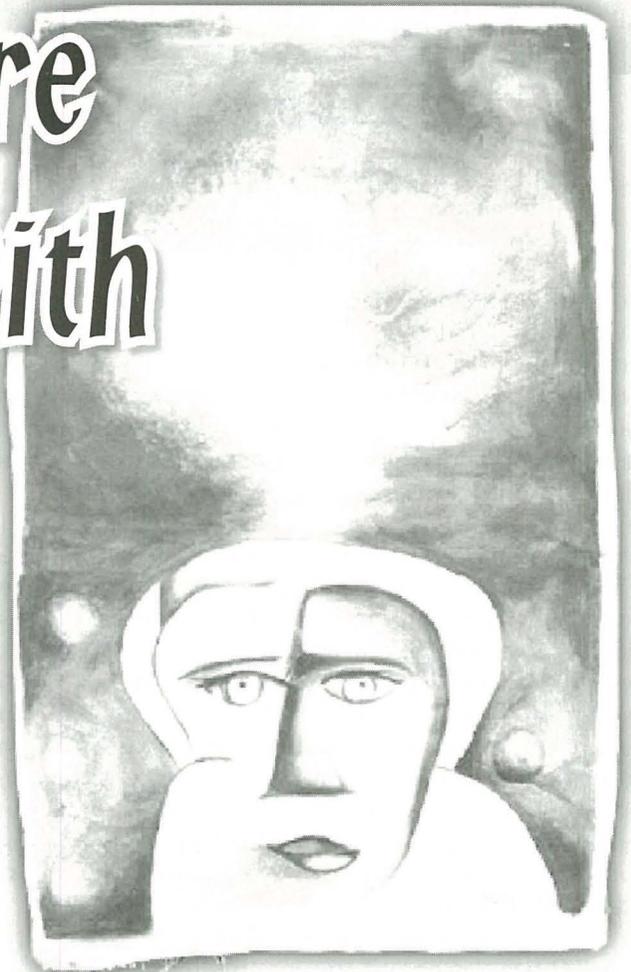
It needs to be said that despite these difficulties, individuals still maintain their capability to comprehend emotional meaning. Hence, any care given to people with dementia has to cater for their emotional well being. Here I propose some strategies, which may help us accompanying these people.

Environment. It is essential that we choose the right environment to interact fruitfully with the person. Private, quite place with good lightning relaxes a conversation while minimises distractions.

Nonverbal. We need to be aware of the hidden messages conveyed by ourselves or given to us by the patient, particularly through tone of voice, eye contact, timing, facial expressions, gestures, body postures and touch.

Verbal. When supporting people with dementia we need to show our sensitivity to their needs via the caring way we talk to them. Some helpful cues would be, pausing between utterances so that they can understand more what is being said, and waiting for the time they need to respond back; using a calming tone of voice; giving a smile; gently drawing the person's attention before starting a conversation; active listening or watching; presenting information bit by bit; and asking questions which have two choices from which to select. Such hints stimulate the person to interact more.

Interpersonal. A caring interpersonal relationship is always the vehicle whereby older adults with dementia can feel loved, accepted and empowered for whom



they are. Some strategies that help bringing about such a relationship are: acknowledging an individual's identity; discussing with them their preferences and activities; cooperating together on explicit assignments; allowing them to express their emotions; and make it easier for them to pursue their intended actions which dementia impedes them from doing.

Relating via life stories. By recounting their life stories, people with dementia have an excellent opportunity to engage, enjoy, and appreciate themselves through their storytelling endeavor. Also, they relive and commemorate once again the achievements they toiled for with all their heart and soul. In this respect, stories become not only personal but also familial legacy. It would be wise if these stories are recorded both to be part of the family history as well as to help the pastoral carer to better comprehend the personal identity of the patient and be able to relate with him/her more fruitfully.

These strategies lessen symptoms like withdrawal, agitation, and aggression. Furthermore, they enable the people with dementia to use the capacities they have, to attain some of their objectives in a conversation, and to involve themselves more completely in every day life.

THE FIRST YEAR OF GCAP

When the global call to action against Poverty (GCAP) was launched at the World Social Forum in Porto Alegre in January 2005, no one quite expected the impressive impact the coalition would have. In less than 12 months, GCAP has grown into the world's largest ever anti-poverty alliance, whose organisations together represent more than 150 million people globally, with national campaigns active in over 80 countries.

Never before have we seen such a diverse range of actors come together with a common rallying cry for an end to poverty – faith groups, women's groups, trade unions, youth organisations, international NGOs, grassroots movements and numerous other civil society groups have all acted together in solidarity in this unique call.

Uniting this diverse array of actors is their call for the elimination of extreme poverty, through an increase in aid quantity as well as aid quality, debt cancellation and trade justice. At the same time, GCAP had demanded that national efforts to eliminate poverty and to reach and exceed the MDGs are developed and implemented in a way that is democratic, transparent and accountable to citizens.

The first White Band Day coincided with the G8 Summit in Gleneagles, the second with the UN World Summit in New York. On these two White Band Days people of every age, colour and creed have marched through villages and cities, organised peoples' summits against poverty, flown kites, released doves, attended concerts against poverty, wrapped iconic buildings in white bands, rated their governments' compliance to MDG targets through shadow reports and testimonials, signed petitions, delivered letters to heads of state; all to publicly demand urgent action from world leaders toward eliminating poverty.

And we have already achieved much. As a direct result of the tireless campaigning by groups prior to the G8 Summit, the G8 announced the cancellation of debts of 18 of the most highly indebted poor countries to the World Bank and IMP. Rich countries announced an increase in aid of \$48 billion by 2010. Many were disappointed by the delayed delivery date of 2010 for the increase in aid and argued for the need to extend the debt deal to more countries. But we should not overlook the importance of what was achieved. The debt deal opened the door for the principle of 100% cancellation. It was also a massive increase in aid that was pledged: most of which came as a result of a number of governments committing to meeting the 0.7% of gross national income (GNI) target. This also throws down the gauntlet to the stingy donor government who are still way off track in meeting their commitments.

But what does this mean for poor people around the world? A lot! Currently 50,000 people die from poverty unnecessarily each day. If the G8 leaders implement their announcement in an urgent manner, we estimate that by 2010 this will fall to around 37,000. Those who have joined the world's largest movement to end poverty can be proud that their voice and efforts will ensure that millions more people will not rest until all of these needless deaths are stopped.

Given the track record of G8 leaders' broken promises, we will be closely monitoring their commitments. And we will continue to press for the debt deal to be extended to include

many more poor countries and for debt cancellation to not be conditional on the implementation of harmful economic policy conditions.

GCAP's White Band Day 2 was timed to coincide with the UN World Summit, which was pitched as a meeting to discuss the progress on the MDGs. Regrettably, as the Summit approached, it became abundantly clear that the development agenda was slipping off the radar.

The few brighter spots in the summit outcome document were chiefly in the areas of women's rights and agreement that governments have a collective "Responsibility to Protect" citizens against genocide, war crimes, ethnic cleansing and crimes against humanity. Governments also made a clear commitment to achieve universal access to HIV prevention, treatment and care by 2010, affirming the commitment made of the Gleneagles G8 in July.

None of these small steps would have even been possible if it hadn't been for GCAP supporters upping the campaigning tempo just prior to the Summit; over 85 countries took part in White Band Day 2. At the same time, millions of campaigners around the world expressed disappointment and dismay at the result of the UN Summit. Instead of seizing on an historic opportunity to take clear steps in the fight against poverty and insecurity, for the large part, leaders simply reiterated promises already made.

At the end of the year GCAP focused its attention on trade injustice. Despite constant calls from people worldwide for trade justice it was desperately disappointing that the WTO talks look set to fail to address any of the needs of the poor. With this in mind, GCAP's third and final White Band Day of action in 2005 took place on 10 December, four days before the opening of WTO Ministerial conference in Hong Kong. GCAP campaigners across five continents were mobilised to demand that the WTO Ministerial delivers trade justice for the world's poor.

GCAP spokesperson Kumi Naidoo's statement of 18 December 2005

"Rich countries have betrayed the world's poor in Hong Kong with their bickering and posturing. By allowing the colossal inequities in world trade to persist, rich countries are trading away the livelihoods of millions of poor women and men seeking a better future for themselves and their children."

"Once again this year the people have roared and rich countries have barely whispered. The wealthiest nations have squandered a critical opportunity to rise above vested and commercial interests to inject development into this so-called 'development' round. While they avoid and postpone redressing the gross imbalances in global trade, millions of women, men and children are denied the basic human right to lead their lives in dignity free from hunger and want."

"By failing to undertake significant reforms in agricultural subsidies and market access and by denying developing countries the policy space needed to determine their own development paths, rich countries are once again shamefully breaking their promises to achieve the Millennium Development Goals by 2015. The lack of coherence between promises made and actions taken is deplorable."

The Future: In the future, the GCAP will continue to pile on the pressure so that all of our demands, particularly those around national commitments to achieve and surpass the MDGs will be met. We will continue to challenge the structures of injustice and inequality.

neqirdu l-faqar! STOP poverty!

THE UNITED NATIONS MILLENIUM DEVELOPMENT GOALS



The eight Millennium Development Goals (MDGs) – which range from eradicating extreme poverty to halting the spread of HIV/AIDS and providing universal primary education, all by the target date of 2015 – form a blueprint agreed to by all the world's countries and all the world's leading developing institutions. They have galvanised unprecedented efforts to meet the needs of the world's poorest.

The Goals

1. **Eradicate extreme poverty and hunger**
2. **Achieve universal primary education**
3. **Promote gender equality and empower women**
4. **Reduce child mortality**
5. **Improve maternal health**
6. **Combat HIV/AIDS, malaria and other diseases**
7. **Ensure environmental sustainability**
8. **Develop a global partnership for development**

"We will have time to reach the Millennium Development Goals - worldwide and in most, or even all, individual countries - but only if we break with business as usual. We cannot win overnight. Success will require sustained action across the entire decade between now and the deadline. It takes time to train the teachers, nurses and engineers; to build the roads, schools and hospitals; to grow the small and large businesses able to create the jobs and income needed. So we must start now. And we must more than double global development assistance over the next few years. Nothing less will help to achieve the Goals."

Kofi A Annan

United Nations Secretary-General



Snooker Marathon Application Form

Name and Surname:

Mobile Number:

Work and Home Tel. N°:

Preferred Participation time:

from _____ to _____

MUMN 10TH ANNIVERSARY CELEBRATIONS

24-hour Snooker Marathon

As part of the 10th Anniversary Celebrations since its foundation, MUMN is going to organise a 24-hour Snooker Marathon at Mt. Carmel Hospital on the 18th September 2006.

This Marathon is going to be held at the MCHS&CC (Mt. Carmel Hospital Sports and Culture Centre) premises from 9 a.m. onwards.

Participants are asked to donate a nominal fee of LM2. All proceeds will go towards **ID-DAR TAL-PROVIDENZA**, of Siġġewi. Those taking part are also kindly asked to collect donations from family members and colleagues.

Attached, please find the Application Form for participating in this Marathon.

Further information will be released at a later date.

Application forms are to be mailed to: -

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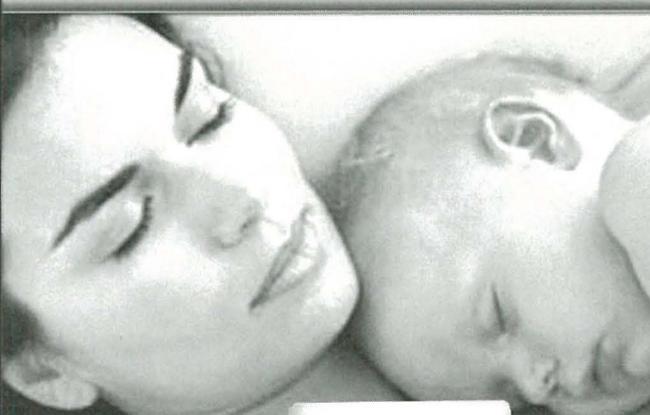
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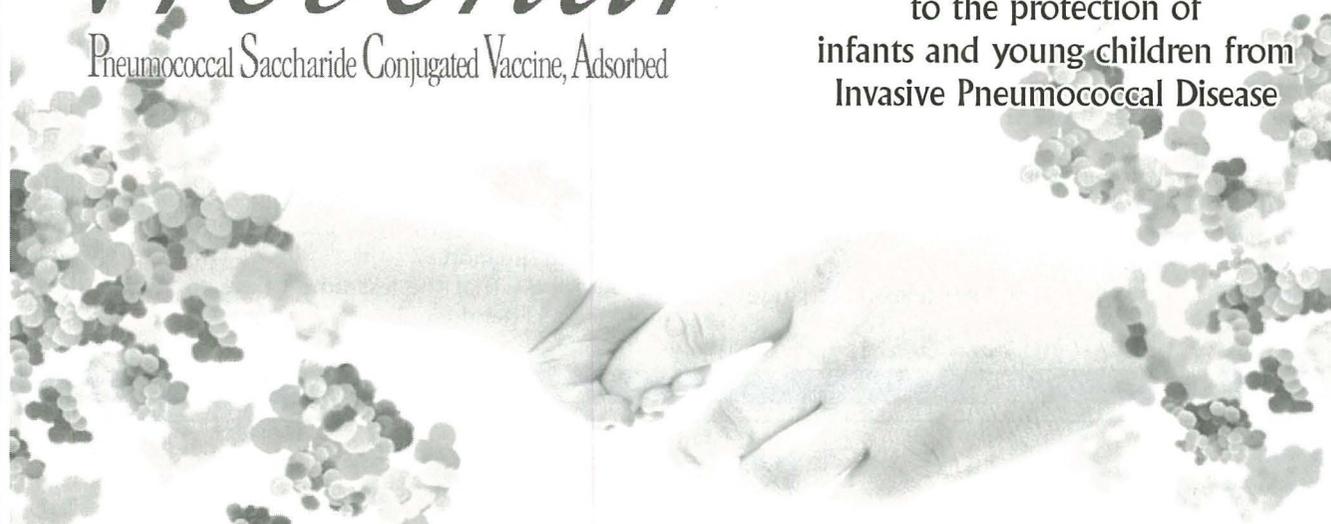
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EJEW NIEQFU FIIT

I'VE LEARNED

I've learned...That the best classroom in the world is at the feet of an elderly person.

I've learned...That when you're in love, it shows.

I've learned...That just one person saying to me, "You've made my day!" makes my day.

I've learned...That having a child fall asleep in your arms is one of the most peaceful feelings in the world.

I've learned...That being kind is more important than being right.

I've learned...That you should never say "no" to a gift from a child.

I've learned...That I can always pray for someone when I don't have the strength to help him in some other way.

I've learned...That no matter how serious your life requires you to be, everyone needs a friend to act goofy with.

I've learned...That sometimes all a person needs is a hand to hold and a heart to understand.

I've learned...That simple walks with my father around the block on summer nights when I was a child did wonders for me as an adult.

I've learned...That life is like a roll of toilet paper. The closer it gets to the end, the faster it goes.

I've learned...That we should be glad God doesn't give us everything we ask for.

I've learned...That money doesn't buy class.

I've learned...That it's those small daily happenings that make life so spectacular.

I've learned...That under everyone's hard shell is someone who wants to be appreciated and loved.

I've learned...That God didn't do it all in one day. What makes me think I can?

I've learned...That to ignore the facts does not change the facts.

I've learned...That when you plan to get even with someone, you are only letting that person continue to hurt you.

I've learned...That love, not time, heals all wounds.

I've learned...That the easiest way for me to grow as a person is to surround myself with people smarter than I am.

I've learned...That everyone you meet deserves to be greeted with a smile.

I've learned...That there's nothing sweeter than sleeping with your babies and feeling their breath on your cheeks.

I've learned...That no one is perfect until you fall in love with them.

I've learned...That life is tough, but I'm tougher.

I've learned...That opportunities are never lost; someone will take the ones you miss.

I've learned...That when you harbour bitterness, happiness will dock elsewhere.

I've learned...That I wish I could have told my Dad that I love him one more time before he passed away.

I've learned...That one should keep his words both soft and tender, because tomorrow he may have to eat them.

I've learned...That a smile is an inexpensive way to improve your looks.

I've learned...That I can't choose how I feel, but I can choose what I do about it.

I've learned...That when your newly born child holds your little finger in his little fist, that you're hooked for life.

I've learned...That everyone wants to live on top of the mountain, but all the happiness and growth occurs while you're climbing it.

I've learned...That it is best to give advice in only two circumstances; when it is requested and when it is a life threatening situation.

I've learned...That the less time I have to work with, the more things I get done.

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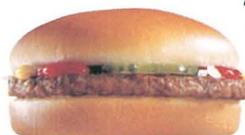
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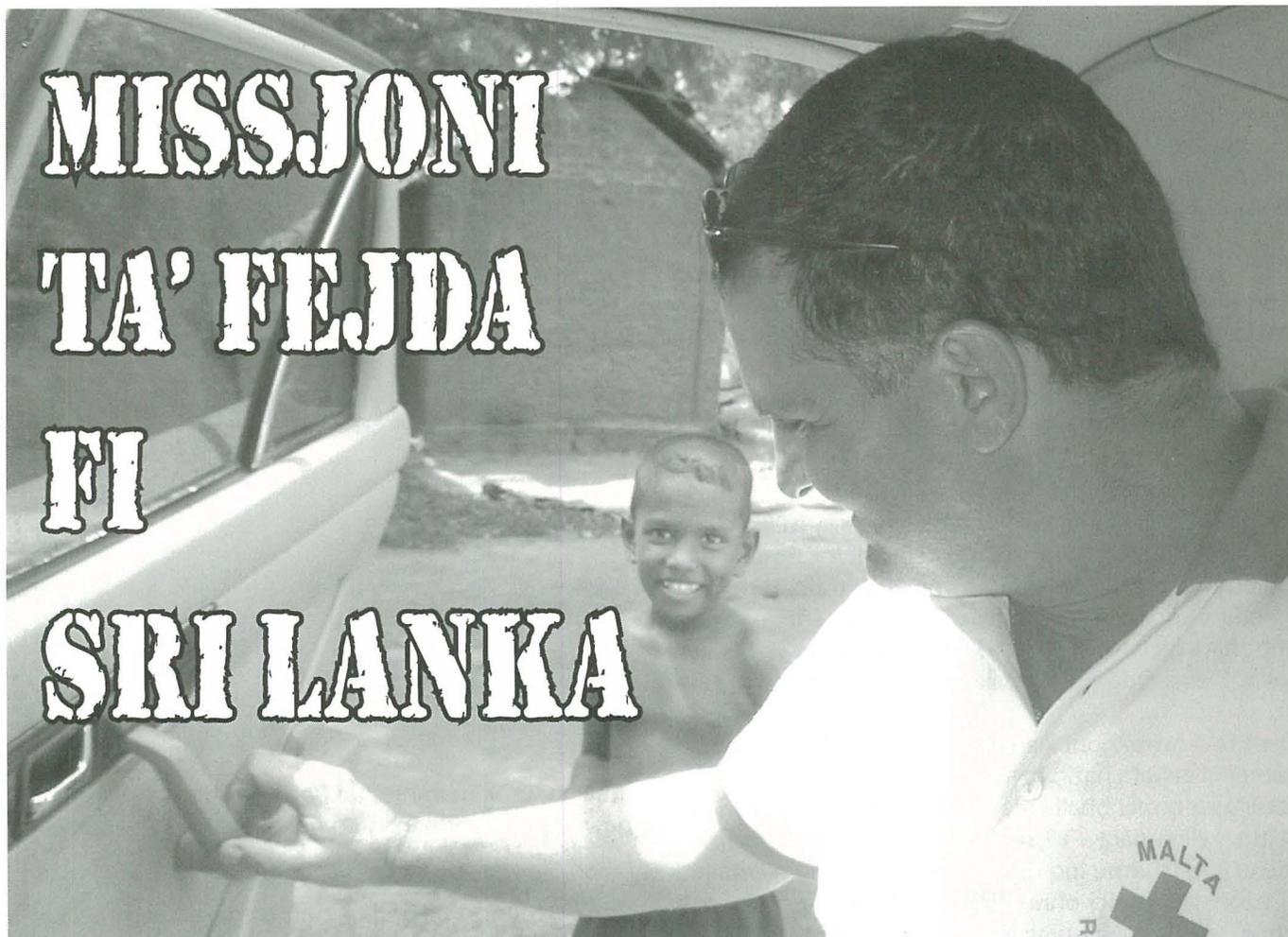
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MISSJONI TA' FEJDA FI SRI LANKA

Konna t-tnejn fuq xogħolna għodwa waħda meta rċevejna telefonata mingħand id-Direttur Ġenerali tas-Socjetà tar-Red Cross ta' Malta (MRC) fejn staqsiena konniex interessati li niffurmaw parti minn missjoni umanitarja internazzjonali biex naħdmu mal-vittmi tas-Tsunami fis-Sri Lanka għal ħames ġimgħat. Għalkemm konna xi ftit sorpriżi, ħadna pjaċir li konna magħżula biex niffurmaw parti mit-tim internazzjonali biex ngħinu f'din il-kawża hekk nobbli. Din kienet ukoll l-ewwel darba li s-Socjetà Maltija tas-Salib l-Aħmar kienet ser tibgħat tim ta' voluntieri biex jaħdmu fi proġett ta' għajjnuna wara diżastru barra mill-gżejjer Maltin fuq skala daqshekk kbira.

Billi kellna ftit sigħat biss biex niddeċiedu, aħna malajr għamilna kuntatt mal-familja tagħna filwaqt li żammejna f'rasna li għandna familji bi tfal żgħar. Huma wrewna support kbir u għamlulna l-kuraġġ biex inkomplu. Kellna wkoll niksbu l-approvazzjoni uffiċjali mingħand is-Superjuri u Diretturi rispettivi tagħna.

Għalina din kienet ser tkun missjoni iebsa minħabba ħafna fatturi, speċjalment id-differenza fil-klima, reliġjon u kultura. Konna nafu wkoll bil-faqar u naturalment bid-diżastru li konna ser niffaċċaw ħames xhur wara t-Tsunami. Madankollu sew il-familji kif ukoll ħbiebna għamlulna ħafna kuraġġ. Kellna wkoll il-vantaġġ li konna nafu 'l xulxin sew, minħabba li

konna ħdimna flimkien bħala voluntiera mar-Red Cross Maltija għal dawn l-aħħar seba' snin.

Dak li konna rajna fuq it-Televiżjoni f'daqqa waħda deher quddiem għajnejna. Wieħed ma jistax jibqa passiv quddiem tant tbatija u mill-ewwel bdejna x-xogħol.

Kif wasalna rajna ma' wiċċna herba! Minkejja li kienu għaddew ħames xhur, madwar il-kosta kollha kien għad hemm diżastru sħiħ.

Ir-rwol tagħna fis-Sri Lanka kien speċifiku ħafna imma ta' sfida kbira. Is-Socjetà Maltija tas-Salib l-Aħmar kienet ġabret somma sabiħa ta' flus mingħand in-nies ġenerużi Maltin u Għawdxin. Għalhekk, wara li ġiet konsultata l-Federazzjoni Internazzjonali tar-Red Cross (IFRC), ġie deċiż li l-aktar mod tajjeb u effettiv kif il-MRC setgħet tgħin, kien billi tibni villaġġ żgħir f'wieħed mill-aktar postijiet fqar fin-Nofs in-nhar tas-Sri Lanka. Il-proġett kien jikkonsisti fil-bini ta' 64 dar permanenti u klinika żgħira biex isservi għall-kura primarja tas-Saħħa f'dan il-villaġġ u villaġġi żgħar oħra fil-viċin.

Il-proġett issemma "Little Malta Village in Sri Lanka". Kwazi n-nies kollha ta' dan il-villaġġ partikulari tas-sajjieda kienu tilfu djarhom, id-dgħajjes, ħwienet u għexieren ta' nies kienu mietu filwaqt li ħafna oħrajn kien għadhom neqsin.

Wiehed mir-rwoli prinċipali tagħna kien li niehdu hsieb ix-xogħol u namministraw il-flus u l-finanzi għal dan il-proġett. It-tir prinċipali tagħna kien li nlestu l-proġett kollu fi żmien stipulat ta' sitt xhur. Imma, aħna u sejrjn bix-xogħol, sibna li dan kien jiddependi minn ħafna fatturi l-aktar minn ħaddiema tas-sengħa u mill-materja prima għal bini, il-klima, (l-istaġun tal-monsoon kien riesaq) u l-permessi mill-awtoritajiet konċernati. Kien hemm ukoll nuqqas ta' materjal għall-bini u għodda, nuqqas ta' ilma, l-ebda protezzjoni għall-ħaddiema u mitt problema oħra.

Għalkemm konna qed inħabbtu wiċċna ma' dawn il-ħafna problemi, irnexxielna nispiċċaw ħafna mix-xogħol li konna hsi bna li nagħmlu. Id-djar inbnew biex ħafna familji setgħu jidhlu jgħixu fihom. Ma kienx ħafif li gġib permess għall-bini ta' Klinika fi żmien qasir, madankollu, ftit jiem qabel it-tluq tagħna lejn Malta, irnexxielna ngibu l-permessi li kellna bżonn mill-awtoritajiet lokali u nbeda x-xogħol fuq it-tħaffir għall-pedamenti. Il-Klinika, mbgħad giet mogħtija f'idejn il-branch tar-Red Cross lokali biex jieħdu hsieb imexxuha u jamministrawha.

Is-sit ta' kostruzzjoni kien jinsab f'parti fqira u remota li kienet effetwata ħażin ħafna miz-Tsunami u nieqsa minn facilitajiet bażiċi bħall-ilma, elettriku, telefon u drenaġġ. Allura kellna naraw kif madwar 80 u aktar ħaddiema li kienu qed jaħdmu fuq das-sit stajna ngibulhom ilma frisk u bżonnijiet bażiċi oħra. Viċin fejn konna qed naħdmu aħna, kellna wkoll nies jgħixu f'kundizzjonijiet ħżiena ħafna go *sheltered homes* temporanji jistennew sakemm ikunu trasferiti għad-djar permanenti.

Matul iż-żmien li qattajna s-Sri Lanka, kellna laqgħat ta' kull ġimgħa ma' l-awtoritajiet lokali u mal-IFRC. Kellna ninfurmawhom fuq il-progress li kien qed isir u niddiskutu magħhom xi problemi li konna niltaqgħu magħhom.



Iltqajna wkoll man-nies tal-post li kellhom jiġu mogħtija dawn id-djar permanenti u ridna nkunu ċerti li dawn id-djar jittqassmu bil-fier lil min kellu bżonn l-aktar.

Konna milqugħin tajjeb ħafna mir-residenti. Huma apprezzaw kull sforz li konna qed nagħmlu aħna biex nagħmlu ħajjithom ftit aħjar. Huma qasmu magħna l-emozzjonijiet tagħhom. Incident partikulari jibqa' ċar f'moħħna. Omm żagħżuġha ħaditna d-dar tagħha biex tintroduċina mal-familja tagħha. Qaltilna li rnexxielha ssalva uliedha kollha barra wiehed. Stajna nħossu d-dispjaċir go did-dar, filwaqt li dawk li salvaw urewna ritratt tat-tifel mejjet. Flaġa nteressanti li nnotajna, madankollu kienet li ħafna mir-residenti kienu ssuperaw l-ewwel fażi tax-xokk u għalkemm kienet iebsa għalihom, kienu qed jippruvaw jerggħu jibnu ħajjithom mill-aħjar li jistgħu.

Din l-esperjenza switilna ta' gid u m'aħna ser ninsewha qatt tul ħajjitna kollha. Meta ġejna lura, domna ftit m'ergajna qbadna r-rutina tal-ħajja Maltija. Għall-bidu ħassejna rwieħna xi ftit disorientati wara esperjenza tant kommoventi. Meta wiehed jiġi lura d-dar, jibda japprezza aktar dak li għandu. Għadna naraw dawk in-nies fuq it-televiżjoni u issa nistgħu nifmuhom aħjar għax għexna l-uġiegh tagħhom mill-qrib. Id-deċiżjoni li mmorru hemm kienet f'waqtha għax għalina kienet esperjenza posittiva ħafna.

Joseph Camilleri

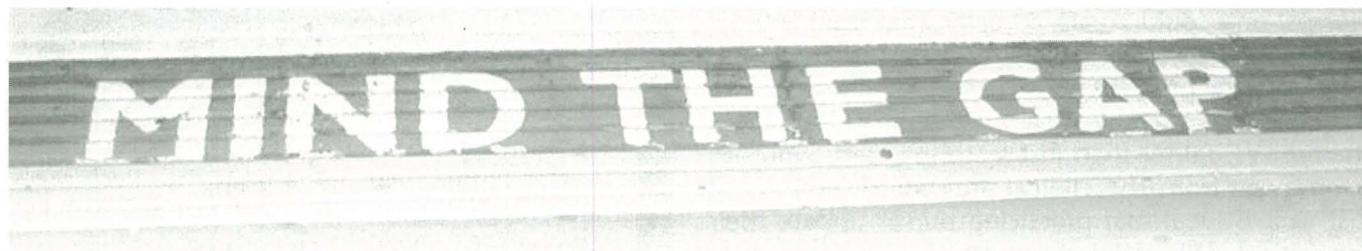
NO M4 KGH

■ joseph.f.camilleri@gov.mt

Edward Gruppetta

a/Principal Radiographer SLH

■ edward.gruppetta@gov.mt



Did you ever go to London and use the underground? You would surely remember the imposing voice saying "Mind the GAP!" This brought some thoughts to my mind.

Being a student was never an easy time in anyone's life, but with today's pressures and expectations, this seems to have become a nightmare, to nursing students as with all others.

The teaching facilities, such as the Institute of Health Care, on the one hand, teach students the theory they need to learn, most of which is based on material obtained from books and literature searches, that preach about the ideal way to practice and how things should ideally be done. At the same time, most of the teaching staff would have studied years before and hence would tend to be outdated or slightly out of touch with the actual reality that exists in real practice. The main emphasis in these institutions is towards theory, rather than towards practice and students' perfecting their practical skills. Clinical practical sessions are minimal or often without the presence of clinical supervisors that are to make sure that the students learn to practice safely and according to the latest up-to-date research findings.

A second reality is found in the wards, as soon as these students are launched into the real world of work. At the workplace, there is the pressure of one's work that forces these new practitioners to cut corners and find short cuts while carrying out their work. Also, they are introduced to a series of malpractices that their colleagues have accumulated along the years and have got away with, and that by that time have become the norm. The management very often only sees the 'good of the organisation'. More often than not they try to avoid the hassles they have to go through as soon as a person comes up with a new idea or something that will need a little thought or effort and that might need some work to set up.

The Theory-Practice Gap is well known and well documented. Several studies have been conducted but none have come up with concrete solutions to bridging the gap. What is the solution? I am surely not coming up with the solution myself, but if one were to use his grey matter one would come up with some suggestions. Students come out of the teaching institutions with an ideal and a great enthusiasm that is unfortunately, quickly dampened



by all the pressures that they find at the workplace, rather than being exploited. If they try to address the management, the managers are too occupied playing with names and numbers and attending meetings. It is up to the new practitioners to tap all the resources that they find. On the workplace there are a number of people that can be easily used as a resource of information and a means of bridging 'the gap' and that are easily accessible to anyone who may request their help. Today the number of Specialist nurses and Practice Development Nurses, whose principle role is to teach practicing nurses to practice according to the latest research and to update their practices to ones that advocate more patient safety and improved care and recovery. These have access to updated literature and also have access to the wards where they can practice with and encourage other nurses to update their own practices. These can act as a valuable resource both to new and to other staff working on the wards. Students themselves can act as valuable resources to other staff whose practices might have deteriorated throughout the years as they worked. By combining the enthusiasm of the new recruits, the expertise and experience of the already practicing nurses, and the theoretical and research-based knowledge of the Specialist and Practice Development

Nurses, one could create an environment of mutual learning and an exchange of knowledge and expertise by the several practitioners. Teaching staff need to be more practice-oriented, ideally being practicing nurses themselves, rather than just lecturing staff, who has been away from the clinical area for several years. Just as it is ideal that practicing nurses update their theoretical skills regularly in order keep practicing, it is also ideal that tutors and lecturing staff update their clinical skills regularly in order to keep teaching students and junior nursing staff. This should become a requirement. This would ensure that the lecturing nurses teach students to utilize resources that exist in the clinical area, such as specialised personnel and equipment as well as other facilities that they would need to work with in the future. Practicing staff would also be updating their knowledge and skills and hence be more available to learn new skills and practice more safely and efficiently. One would also be instilling an attitude of continuous change and learning. Thus, this would bring the nurses at the teaching side closer to the nurses at the practicing side, thus making the Theory-Practice Gap narrower and make the transition of nurses from students to qualified staff easier and smoother.

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Aħna u Huma ■ ■ ■

Ma xtaqtx inkun negattiv fl-ewwel messaġġ tiegħi tas-sena 2006. B'hekk nixtieq ħafna affarijiet sbieħ u aktar ħidma qalb ħutna l-pazjenti. Però ma nistax nħalli nwarra okkażjoni li ġrat għall-aħħar tas-sena 2005. Qiegħed nirreferi għal *get-together* tal-Millied tas-27 ta' Diċembru li sar għan-Nursing Officers, Deputy Nursing Officers jew minn kien *in-charge*. Hija ħaġa sewwa li l-Management tal-Isptar San Luqa jorganizza festini ta' dan it-tip, imma għaliex jiġu mistiedna Mr.X jew Ms.Y u mhux għallinqas żewġ impjegati minn kull Sala bi ftehim ma sħabhom f'okkażjoni bħal din?

Dan jista' jagħti lok għal diskriminazzjoni bejn l-impjegat u ssir qasma bejn 'l-aħna u 'l-huma' u hemm ċans kbir ta' firda. Forsi l-iskop ikun biex dawn il-mistiedna jkunu aktar leali u jilbsu l-ingwanti tas-suf ma' ta' fuq u jużaw il-ponn tal-ħadid mal-oħrajn?

Għalhekk filwaqt li nibgħat l-isbaħ xewqat lil kulħadd nixtieq li kelli l-poter nagħmel *get-together* għal dawk li qed iħossuhom imwarrbin għax żgur li kulħadd għandu rwol importanti u s-servizz tiegħu huwa ta' utilità bżonnjuża għal ħutna l-batuti

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Caring for people with skin problems

Josanne Drago Bason, B.Sc (hons) Nursing MSc Nursing (UK), ■ josanne@waldonet.net.mt

This is a summary of a paper "The impact of psychosocial factors for chronic skin and wound care" presented by Mr. Martin Ward and Ms Josanne Drago Bason in the "Skin and Wound Care through the ages" Conference, held at the Westin Dragonara Resort, Malta on the 1st and 2nd December, 2005.

One of my first experiences when I started work at the Intensive Care Unit was of admitting a patient after surgery for the removal of an advanced stage basal cell carcinoma on his cheek. It was an experience which I shall never forget. Only the suture line was covered with a dressing, thus, to my horror, I could see this patient's facial disfigurement. The right profile of his face was covered with skin ... Just skin – no eye, no ear, no nose, no hair. I was taken aback. I was not prepared to see anything of the sort. I was appalled with this patient's facial appearance. I remember myself checking the ventilator, monitors, IVs, urinary output and all the other stuff without looking at the person in front of me. It was like I was looking after a machine and not caring for a patient. At the end of my duty I felt tired. Tired, not because I had plenty to do, but of struggling with myself to look beyond this person's disfigurement, of struggling with that "something" within me which held me back from doing so, of trying to see Paul instead of a grossly disfigured face with one eye, half a nose and half a mouth.

On looking back and reflecting upon this incident, I cannot help but feel ashamed of myself. It's easy for me to blame my inexperience as an ITU nurse. Perhaps that didn't help, but if I have to be honest with myself, I must admit that I was unable to cope with looking at a man who did not fall within my construct of normality.

This experience also brings to my mind the film "A man without a face", in which Mel Gibson starred as Justin McLeod – a man whose face was disfigured after an automobile

accident and consequently was ostracised by society.

In actual fact, my behaviour and attitude towards Paul was coloured by society's perception of people with skin problems and physical deformity.

Goffman (1964) described three main causes of stigma – physical blemishment being one of them.

Though I'm a nurse and have extensive training on how to deal with patients, I'm only human and part of society, bound to be influenced by it.

Richardson (1964) demonstrated that children as young as four months old smile less when shown three dimensional models of faces that are of abnormal shape. In agreement with this, Rumsey (1986) asserted that children start to express a preference both for more attractive people and for nondisfigured people between the ages of five and ten years. This shows that the response to a person's aesthetic appearance is established within a very young age.

Jones (1984 in Whitehead, 1995) asserted that there is a "striking consensual agreement of what is beautiful, what is plain and what is ugly." Society tends to stigmatise the plain and the ugly in both overt and covert ways. For example, children quickly identify beautiful Cinderella as being good and the ugly sisters as being bad (Whitehead, 1995).

Similarly, attractive and nondisfigured people are favoured throughout life in a wide variety of situations including dating, marriage, education and employment (Rumsey, 1986).

In this respect, all nurses, and not just myself, are exposed to these perceptions of attractiveness and disfigurement from an early age. Nurses are no different from the rest of the population. Although there

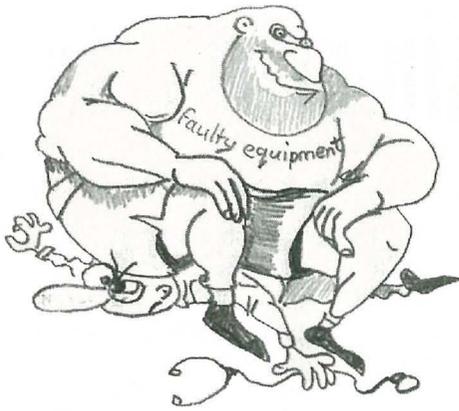
are no studies which investigate the behaviour of nurses with people who have visible skin problems, or who are disfigured Newell (2002), asserted that testimony of such people suggest that while we may wish otherwise, health professionals, including nurses, stigmatise patients with skin problems. In addition, research suggests that only a small minority of health care providers within the Western culture seek to address psychosocial issues within the physical treatment regimes. Very often those who do are unqualified with limited knowledge of what they are doing, except that they "act naturally" with their patients (Ward, 2005).

Holmes' and Ward's assertions are particularly significant for us nurses when it comes to caring for people with skin problems, since the relationship between physical illness and psychological and sociological factors are well documented within the literature (Menzies, 2005; Talerico, 2005). It is clear that despite providing appropriate and well defined physical interventions for a wide range of conditions, unless patients are able to reflect upon, and engage with the treatment processes, their health gain can be limited (Ward, 2005).

Thus, it is of utmost importance for us nurses to be aware of our attitudes and reflect upon our practice. This will enable us to overcome our prejudices and negative attitudes towards distinct groups of patients so that we would be able to provide them with the best possible health care.

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Close your eyes for a moment and imagine that you have just taken charge of a restless, post-op, confused and twice your size patient. You are nursing him on a bed or stretcher as ancient as the pyramids with hardly any adequate side support, if any, and no oxygen and suction equipment close at hand or in sight. It is obviously potentially dangerous but you still use it, because it is there. Not very difficult to imagine is it, as many of us do so every day. Continue to imagine a bit more and this time picture your patient violently falling to the ground as a direct result of the inadequate or absent lateral restrainers notwithstanding your valiant but futile efforts to restrain him. In the process he lacerates his face and sustains permanent scarring. By now you are surely imagining it with your eyes wide open as this situation has taken place many times and will regrettably, happen again in one way or the other on countless occasions more.

Now let's say that this imaginary patient sues you and your employer (whoever that may be) for damages sustained, who do you think will be found legally and financially liable for such a mishap? You may, as so did I in the past, argue that since the inefficient equipment, in use during your routine nursing process, was provided by your employer for as far back as you can remember, he surely must be totally at fault. Well, I am sorry to say, that in such a scenario, you will be found, shockingly, completely

Safe rather than Sorry

at fault. Why and how, you may quite understandably ask.

Your employer may, will and has argued that since you, as a health care professional, knew beforehand that the equipment was obviously of a substandard or of a potentially dangerous nature, one could have refrained from using it and therefore avoided the unfortunate incident. By deciding to go ahead and make use of the respective equipment you have accepted full responsibility and liability as you had a choice, but your patient did not.

In plain simple English that means that all of us are, in every working day, accepting unwittingly full responsibility and liability when using the provided substandard or inadequate equipment, and in doing so are automatically completely exonerating the mentioned equipment provider from being held accountable.

OK, so now that we know the shocking but actual reality, what are we to do, you may also ask.

Now let's say that we choose to do something, but what and how? Getting hysterically militant and raising hell and the dead by

We have two choices. We can choose to do nothing and continue to play Russian Roulette with our daily bread, or do something positive about it.

sounding the war drums will only impinge havoc on the hospital's waiting lists and therefore lose the hard earned public support we enjoy today. On the other hand we can follow these basic steps: -

- **Collect** data
- **Analyse** the data and put it into context

- **Disseminate** information on the matter
- **Stimulate** debate and bring the interested parties to the bargaining table.

The above-mentioned steps have been tried and tested before with favourable results so therefore we do not need to lose time by reinventing the wheel. Some of you have had or are undertaking studies in Occupational Health and Safety (OHS) and if so, do come forward and give guidance. As for the rest of us common mortals, we can do something invaluable by starting the process and providing data on what we can recognise as potentially dangerous in our respective place of work. You can do so by sending an email to: mumn@maltanet.net with the subject name of OHS and voicing your concern or by speaking to your nearest MUMN representative and asking them to record the invaluable data on your behalf.

It is said that we are all born optimists but make no mistake in confusing optimism with utopia. If you are one of those who foolishly have wholeheartedly embraced the utopian belief that once Mater Dei is commissioned, all our existing difficulties will be wiped away and there shall be everlasting love, peace and happiness in heaven and earth, then dream on.

If on the other hand, you are with your feet planted firmly on the ground and your eyes and mind are fully aware of the current situation, then ask yourself whether you are hence forth to be safe rather than sorry and do something **now** about it.

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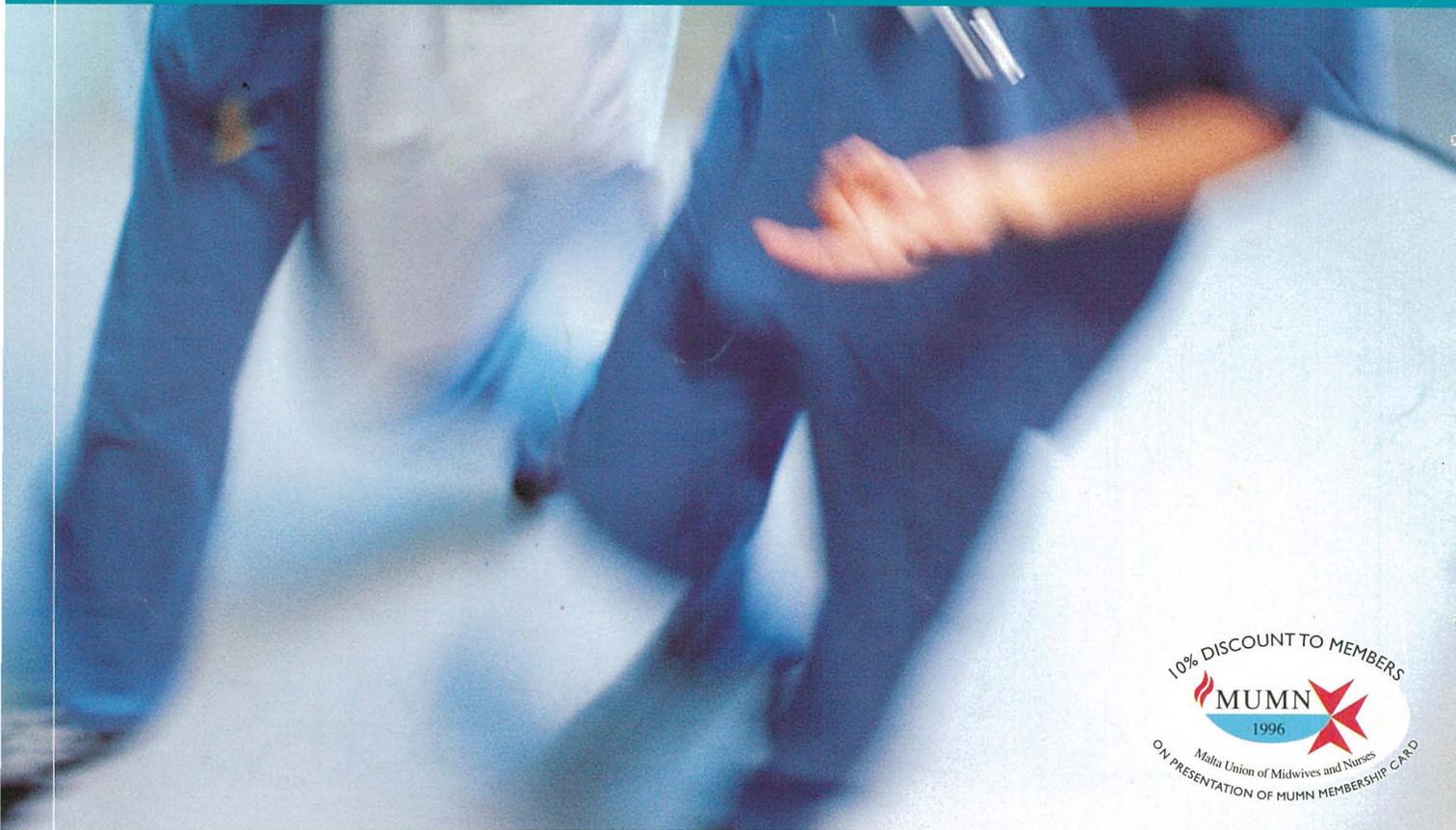
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